The Palgrave Handbook of Male Psychology and Mental Health

Edited by
John A. Barry · Roger Kingerlee
Martin Seager · Luke Sullivan

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This book is dedicated to the memory of Dr. Ross Chernin

Foreword

John A. Barry, Martin Seager, Roger Kingerlee and Luke Sullivan have made a major contribution to psychology by curating and editing the comprehensive *Palgrave Handbook of Male Psychology*. Every chapter in this book adds critical knowledge about how to effectively understand and meet the needs of men. The editors asked me to write the foreword and discuss my thoughts about the evolution of working with men over the coming decades.

This book could not arrive at a better time for professionals, only a few months after the membership of the British Psychological Society (BPS) voted for a new Male Psychology Section that will allow the BPS to "take a lead in promoting awareness, research and understanding of male gender psychology" (malepsychology.org.uk 2018). This represents a watershed moment for the field of male psychology and is worth a moment of appreciation and reflection.

Advances in male psychology are important in relation to many of the health needs faced by men. Despite some overall improvements in life expectancy for men in the United States and United Kingdom (Arias et al. 2017; Robertson and Baker 2016), globally male life expectancy lags five years behind women, and this gap is expected to increase over the next 15 years (Baker and Shand 2017). Of course, the mental health of boys, adolescent males, and adult men remains a particularly important issue of concern. Without a doubt there is more global attention towards the health of men—this can be seen through different public health campaigns across the globe. Suicide, depression and the full range of mental health issues represent significant concerns, and those in the helping professions want and need guidance on how to help. Males represent the majority of those who die

by suicide worldwide (WHO 2011). In the United States, though women are diagnosed with depression at twice the rate of men, men are 3.5 times more likely to die by suicide (Centers for Disease Control and Prevention 2015). Oliffe et al. (2012) noted that the pathway between men's depression and suicide is not clearly understood, but the pathway to suicide prevention is connected to understanding how men experiencing depression formulate their plans and thoughts about suicide. Thus, professionals need to better understand men themselves through gaining direct access to them (e.g., through outreach, health promotion, services that attract men, etc.) and by understanding how to communicate better with men and tailor services to their needs. Many of the efforts in male psychology have focused on the latter—how does the field of psychology adapt and modify services so that we can effectively meet the needs of men? The *Palgrave Handbook of Male Psychology* represents a significant step towards broadening our gendered understanding of the male clients that we see, or hope to see, while offering various ways of making meaningful therapeutic contact with men. In addition, many chapters in this book highlight the changing field of male psychology. That shift can be seen in the emphasis on how professionals work with and alongside male clients in effectively delivering services that are inclusive to men and their experiences, rather than simply delivering gender-blind services to male clients.

A Brief Reflection on My Own Journey into Male Psychology

When teaching about how to effectively counsel men, I often ask if anyone ever had a formal course or even lecture on the psychology of men. Unless someone was in gender studies as an undergraduate, the answer is almost always no. It would also be "no" for me as well as I never had a formal course or lecture either in my undergraduate studies or across three graduate programmes, though I was lucky to find mentors and advisors who helped me into the emerging field of the psychology of men and masculinity. Prior to this informal scholarly education, like most men, I learned about masculinity as a boy through observation, social pressure, and through direct action (often at the end of an insult or insinuation), or by observing—or being the one directing—a comment or putdown towards another. Masculinity was not talked about directly, but indirectly it governed much of my action and how I presented myself publicly.

My boyhood education was full of contrasts and contradictions. I revelled in sport and physicality—these were places that felt free to me. Even though I was smaller than other boys, I was gifted with a competitive edge and grit that allowed me to play with larger, older boys. Yet other settings were not as carefree. Though my father was a psychologist in a small town, I grew up in a rural, more traditional place in the American Midwest, and for the most part my father and the families around us reflected those values. The values and the people around me were primarily blue-collar and white, and public deviations from male gender role norms were not welcomed. I learned that my public behaviour did not always match my private behaviour or my inner world. Yet at some level, I also knew that my experience was not weird or deviant, but rather a game that most of the boys around me had all agreed to play. I understood what not to do as a male in certain contexts. In fact, there were more rules about what NOT to do as compared to what to do. I also understood that these notions had a certain amount of plasticity to them—even though I knew that I should not cry in public, tears often formed in my eyes as I could not really control them.

In real life rarely did I encounter boys or men who were the rigid masculine caricatures that I saw on television—the Sylvester Stallone and Arnold Schwarzenegger action heroes of the 1980s. Boys and men had a bit more complexity to them. In that sense, masculinity for many men was multidimensional as both aspirational and inspirational. No one ever talked about this stuff in public around me, but I had already had the sense that the rules of masculinity were incomplete. My private and intimate conversations with my male and female friends were my evidence, and yet so many rules and restrictions about men were omnipresent and constantly reinforced.

Through my adolescence and early adulthood, most of my ideas and insights about gender remained as internal conversations with myself. Learning about the psychology of men in my doctoral programme (after two master's degrees and many years working in the field) was a true turning-point in my life. Scholarship in the field made sense to me, and digging deeper into men's lives and experiences provided the mirror to better understand myself and the men around me. Reading William Pollack's (1995) "No Man is an Island: Toward a New Psychoanalytic Psychology of Men" was a transformative experience. Learning about James O'Neil's (1981) gender role conflict theory provided a framework for organizing some of the ideas about men, masculinity, and mental health. Importantly, and amazing that it took so long, the psychology of men and masculinities helped me see my male clients as *male* which meant something unique in how they experienced the world and counselling itself. In retrospect, this is something

I knew already and it had influenced my past clinical work, but not in a manner that led to better services for the boys, adolescent males, and fathers that I counselled. The scholarship in the psychology of men and the recently created APA Division 51, the Society for the Psychological Study of Men and Masculinity, became lightning rods for me. I was obsessed with reading all of the research I could find from across the globe.

My early academic career focused on working with men in clinical settings and the emerging notion of "male-friendly therapy". My knowledge-base deepened, but I found that much of what I read and observed was common sense for how I had always interacted with boys and men, but often contrary to my own training in psychology and counselling. A deeper discomfort was growing with the awareness that much of the existing scholarship in the psychology of men was focused on distress, pathology and dysfunction. The knowledge base was skewed towards negative traits and the negative functioning of men. I certainly understood most of the masculinity literature and could adapt my work to it, but the evidence base felt incomplete and seemed to only be part of the story of the men that I knew personally and professionally.

During this time positive psychology was rapidly developing. Emerging ideas of positive psychology already paralleled my Adlerian theoretical view and upbringing—so thinking about men through the lens of positive psychology was the framework I needed. Focusing on strengths, growth, encouragement and health was largely absent from the psychology of men discourse. I knew that men experienced the dark aspects of masculinity but also experienced or strove towards the healthy aspects as well. My clients often expressed shame and deficiency around darker aspects of their lives as men, yet they shared more hope and motivation around more positive visions of the men they wanted to be. Growth and change conversations were inspired by the ideas of the men they could be—akin to what Davies et al. (2010) called *possible masculinities.* These healthy aspects seemed associated with growth-oriented relationships with others as a father, partner or friend, community building notions of service and provision towards the greater good, and ideas around personal and social responsibility. My clinical work often focused on these areas in the lives of clients, and I found that my own connections with men in individual and group settings were not pathological, but simply, healthy.

During this period, I was lucky to be surrounded my other mentors and scholars like Mark Kiselica, Mark Stevens, and Andy Horne. In different ways, it seemed we all were building a perspective within the psychology of men incorporating positive psychology and growth. We had different

discussions and conversations and from these interactions, positive masculinity emerged. We viewed positive masculinity in contrasting alignment to rigid or judgmental notions of masculinity, allowing the space for men to refine and define what being a man means to them. Defining positive masculinity itself can be difficult and hundreds of conversations with people all over the world have not helped me gain complete definitional clarity. Gender and masculinity are constantly evolving due to social and contextual factors, but terms like healthy, prosocial, adaptive, and socially responsible are often in the definitional mix. Further, I am committed to a social justice and inclusive orientation towards understanding men, and so the construct of positive masculinity broadens the concept to marginalized men who have traditionally been left out of much of the scholarly enquiry in the psychology of men.

In my eyes, positive masculinity is a counterbalance to shame (truly, the core emotion for understanding men, see Shepard and Rabinowitz 2013), offering growth, hope, expectancy, and encouragement to men by focusing attention on what is possible and healthy in their lives. This is also inclusive of a common factors approach to successful psychotherapy outcome (Wampold 2010). Importantly, positive masculinity can be a beacon for men as they strive towards answering key questions such as: *As a man, what are you moving towards, and how do you want to contribute?* At a time of so much global transformation around gender and social roles, we need professionals who are able to help men navigate this changing world.

Challenging and Expanding Our Worldview About Gender, Men, and Masculinities

My own journey is exactly that—the process of beginning in one place and being on the road to somewhere else, with my own destination still not fully certain. Learning about gender is my compass, and it has swayed over time. But gender is a universal compass for all people for the simple reason that gender is one of the core organizing identities of human beings. Yet despite increased attention on understanding multiple cultural identities in the psychology literature, it is common to find that masculinity is often ignored in the literature on gender and multicultural counselling (Evans 2013; Levant and Silverstein 2005). For the most part, when scholars write about gender, they are often referring to women rather than the experiences of women *and* men (Addis 2008). Understanding the gendered nature of masculinity is an important cultural competency (Liu 2005; Stevens and

Englar-Carlson 2010) that impacts clinical practice (Whaley and Davis 2007). Furthermore, how scholars and people worldwide are talking about gender has changed dramatically over the past two decades as conversations about gender increasingly expand to include people who identify as transgender or non-binary. For me, this is terribly exciting because it challenges me to think more about gender in society and it seems to bring more discussions about masculinity to the forefront; that is important because if my own journey has taught me anything, it is that we ought to be talking more about the gendered nature of men's lives and how it influences our health and wellbeing.

There are of course different ways of thinking about gender and masculinity. My own perspective is strongly influenced by a social constructivist lens that is inspired by my own contact and work with men of colour and men experiencing marginalization. There are other ways to think about male psychology including, but not limited to, an evolutionary perspective or a biological one. The *Palgrave Handbook of Male Psychology* presents a range of ideas about male psychology that should challenge the reader from any perspective—it is my hope that the challenging aspects lead to better dialogue, discourse and engagement with others about men, masculinity and health. As a field of study, male psychology only benefits from more discussion, scholarly research and discourse across all disciplines and areas of practice. That is why the annual Male Psychology Conference at University College London, started by John A. Barry, Martin Seager, Roger Kingerlee and Luke Sullivan in 2014, has become so important for the growth of the field of male psychology within the UK and internationally.

Part of my own motivation for my work is the acknowledgement that we as a profession could be doing much better for our male clients (see Englar-Carlson et al. 2013). I know that there is unlikely to be consensus amongst scholars on everything about male psychology, but I am unequivocal in the knowledge that all of us want a healthier world and better psychological services for boys, adolescent males and men across the lifespan. That is something that we all endorse. With that goal in mind the *Palgrave Handbook of Male Psychology* is critically needed now and it will take its place as a significant work in the field of male psychology.

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Luke would like to thank baby Ted for coming into his life and his wife for bringing Ted safely into the world. May he grow to be a kind and loving boy.

Contents

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Dr. André Bolster is a Senior Clinical Psychologist working in the Acute Services in King's Lynn, Norfolk. After completing a B.A. in Psychology at Trinity College Dublin, he went on to do a M.Sc. in Counselling Psychology there and then a Doctorate in Clinical Psychology at the University of East Anglia. He has a special interest in Acceptance and Commitment Therapy and other existential models of recovery that focus on helping people to find meaning in the face of life's difficulties.

Dr. Andrew Briggs originally trained as a social anthropologist before training as a Child and Adolescent Psychotherapist at the Tavistock and Portman NHS Foundation Trust. Following this, he worked for over thirty years in NHS Child and Adolescent Mental Health Services (CAMHS) where he setup mental health services for children in care, army families, and children who find it difficult to access the school curriculum. In all of these cases, his interest has been on the influence of the father (present or absent) upon children's lives. He has published journal articles and books on these and other topics.

Belinda Brown, M.Sc. trained in Social Anthropology and conducted ethnographic fieldwork in Poland. Through subsequent work and research

among homeless men, she became aware of the importance of family in men's lives and their vulnerable position due to their more marginal role in the family. Conducting research at The Institute of Community studies, The Young Foundation and University College London, she became interested in how changes in men's position in the family and the workplace were impacting on male psychology and wellbeing. Belinda speaks and writes both academically and for the mainstream media and frequently participates in discussions on radio and television.

June S. L. Brown is a Senior Lecturer in Clinical Psychology King's College London and is based at the Institute of Psychiatry, Psychology and Neuroscience (IoPPN). Her main area of research is in reaching "hard to engage" populations in the community with mental health problems. These include depressed members of the public, black and ethnic minority groups as well as men. She is also researching "Early Intervention for depression and anxiety" with students with mental health problems, adolescents in schools as well as pregnant mothers. She also has considerable experience of managing NHS psychology services, having managed services in the South London and Maudsley Trust as well as in South Birmingham.

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Olive Moloney is a Clinical Psychologist, interested in co-creating spaces where communities define and produce local solutions to meet their needs. Her current role is as a Clinical Coordinator with Jigsaw, the Irish National Centre for Youth Mental Health. Olive is formerly Clinical Director of MAC-UK, where she learned to co-produce services from excluded young people. She teaches and presents regularly, and is a steering group member of *Clinical Psychology Today*, a new Irish journal.

Dr. Rebecca Owens is a Chartered Psychologist and works as a Lecturer in Psychology at the University of Sunderland. Rebecca takes an evolutionary approach to examining various behaviours, including the role of fluctuating testosterone in mating behaviours. She obtained her Ph.D., which examined the role of life history variables in male competitive behaviour, in 2016. This led her to take a different perspective on masculinity and male behaviours than what the dominant discourse promotes, and now she is committed to promoting and supporting unbiased research into sex differences.

Dr. Marco Pellegrini is a Consultant Clinical Psychologist working for Norfolk and Suffolk NHS Trust Secure Services. In the last ten years, he worked with adults in secure services including men and women with personality disorders. Since 1998, he worked with adults with personality disorders in outpatient and inpatient settings, practising a variety of treatments (TFP, SFT, DBT) and finally adopting MBT as his main therapeutic approach and achieving practitioner status. In addition to MBT practice, he set up a MBT skills training accessible to all staff in the NHS Trust.

Deborah Powney, B.Sc., M.Sc., Ph.D. Candidate Following over 20 years extensive experience in industry, working for national and global high profile companies, Deborah returned to academia to pursue a long-held passion

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Luke Sullivan is a Senior Clinical Psychologist. He is the founder of Men's Minds Matter, a not for profit organization dedicated to the prevention of suicide, and also works for South London and Maudsley NHS Foundation Trust, specializing in psychological crisis interventions for people at risk of suicide. Luke is a committee member of the National Suicide Prevention Alliance, co-founder of the Male Psychology Section of the British Psychological Society, the Male Psychology Conference and the Male Psychology Network.

Patricia van Wijngaarden-Cremers (1960) studied medicine and trained in psychiatry at the University Medical Centre in Groningen (the Netherlands). She specialized in addiction psychiatry and started a department for dual-diagnoses in Zwolle. There she discovered that many individuals with addiction also have a neurodevelopmental disorder as well as that (psycho)pathology presents differently in women and men. She combined her interest in

addition, developmental disorders and gender in her Ph.D. thesis "Gender, Comorbidity and Autism" (2015). Currently, she is head of the department for Developmental Disorders (COS) as well as deputy director of training at Dimence GGz a multicentre institute for mental health in the east of the Netherlands.

Prof. Marvin Westwood is Professor Emeritus, Counselling Psychology Program, University of British Columbia. Professor Westwood's major areas of teaching and research focus on development, teaching and delivery of group-based approaches for counselling clients, and men's psychological health. How counselling and psychotherapy approaches can be adapted to be congruent with the "cultures of masculinity" is a core interest area. He developed the UBC Veterans Transition Program to help promote recovery from war-related stress injuries for which he received both the Queen's Golden and Diamond Jubilee Medals in 2005 and 2013. In 2012, he established the Centre for Group Counselling and Trauma, and is currently Senior Advisor to the Centre.

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Christopher works with one of the Trust's Crisis Resolution and Home Treatment Teams. Before joining the Trust he had worked in the substance misuse treatment field in diverse areas of London for many years and was a clinician with Public Health England Drugs and Alcohol Division. Christopher was also Deputy Clinical Director with one of the London Clinical Psychology Training Programmes. Christopher is trained in a range of evidence-based psychological treatment approaches and is accredited by the British Association for Behavioural and Cognitive Psychotherapies (BABCP) as a therapist, trainer and supervisor.

Luke Woodley is Founder and CEO, Walnut Tree Health and Wellbeing Community Interest Company. With 23 years lived experience, 16 years research experience, and over 3 years delivering services, Luke is passionate about helping others to find their own paths of recovery. Luke developed PTSD after serving with the UN in Bosnia in 1993. After leaving the Forces, and despite running a highly successful security business in London, his PTSD deteriorated and Luke suffered the full gamut of symptoms, leading, ultimately, to the loss of his previous way of life. Luke's recovery journey began in 2005, and since then he has been pioneering innovative ways to help veterans and civilians that have brought him to local, regional and national attention.

Sally Zlotowitz is a Clinical and Community Psychologist and Director of Public Health at MAC-UK, an award-winning charity that co-produces services with young people to reduce the health and social inequalities of London's most excluded young people. Sally is Chair of the British Psychological Society Community Psychology Section, co-founder of Psychologists for Social Change and founding member of the Housing and Mental Health Network. The aim of her research, activism and clinical practice is to link social and economic justice, well-being and mental health.

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Part I

Theory

From Fetuses to Boys to Men: The Impact of Testosterone on Male Lifespan Development

John A. Barry and Rebecca Owens

Introduction by John A. Barry

When I started out doing my Ph.D. research on the psychological impact of testosterone in women, I presumed that women with higher testosterone levels would be more aggressive. After all, the literature is full of studies demonstrating that rodents become more aggressive when administered testosterone. However, after measuring naturally occurring levels of testosterone in around 140 women, I found that testosterone did not directly cause an increase in any of a range of self-reported types of aggression (verbal aggression, physical aggression, etc.) or anger. The only finding of this kind was that women with polycystic ovary sydrome (PCOS), a condition in which raised testosterone is often seen, had significantly higher levels of withheld anger than controls. There was little evidence of a linear relationship between testosterone and aggression or anger, and my conclusion was that when testosterone causes unpleasantly masculinising symptoms in women (e.g. facial hair growth), the unpleasant symptoms cause withheld anger (also anxiety and depression), but testosterone does not have a direct impact on anger or other expressions of distress (Barry et al. 2018).

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The moral of this story is that findings from animal studies don't always generalise to humans.

Testosterone Impacts Psychology via Various Pathways

The issue of the causal pathway from testosterone to mood is an important one, and illustrated in various ways by my subsequent PCOS research. The different pathways by which testosterone effects can occur must be clarified before we discuss the impact of testosterone in humans. *Direct effects* occur when testosterone acts directly upon receptors; *indirect effects* occur where the impact of testosterone is mediated via another variable; *activational effects* of testosterone are ephemeral and are caused by testosterone in the bloodstream; *organisational effects* of testosterone occur prenatally and cause permanent changes. When the average person thinks about the impact of testosterone on aggression, they are usually thinking of a direct, activational effect rather than anything indirect, though they might suspect that there are organisational effects of testosterone.

The first section of this chapter will deal mainly with the effects of testosterone on prenatal development, i.e. *organisational effects*, and the second half deals primarily with the activational effects of testosterone.

The Testosterone Family

One important caveat here: when we use the term testosterone in this chapter, we are really referring to the impact of the family of testosterone-like substances, called androgens. Androgens vary in strength (e.g. dihydrotestosterone is 10 times stronger than testosterone), and in specific action (e.g. a key effect of dihydrotestosterone is to increase hair growth, whereas a key effect of testosterone is to increase muscle mass). Often we can't say for sure whether an effect is the result of testosterone or of another androgen, or of a combination of androgens. Testosterone is often presented as a general marker of 'androgenic activity', though the biological reality is more complex.

Androgens originate mainly in the testes, but also come from other organs, e.g. dehydroepiandrosterone (DHEAS) is mainly produced by the adrenal glands. Some androgens are converted into testosterone (e.g. androstendione), and—counterintuitively—testosterone is converted to estrogen (or, more specifically, to the main estrogen, called estradiol, or E2).

Testosterone and Health in Men and Women

Testosterone is considered the 'male hormone' because men have 10 times more testosterone than women do, and because androgens promote characteristics we consider masculine (e.g. muscle mass, penile and testicular development, and hair growth). Indeed it is easy to see how the physiological effects of testosterone might influence aspects of masculinity, e.g. greater muscle mass, strength and energy would make men more likely to have the roles of 'fighter and winner' and 'provider (hunter) and protector' as described by Seager et al. (2014). Estrogen is considered the female hormone because women have 10 times more estrogen than men do, and estrogens promote female-typical characteristics (e.g. breast development and aspects of female fertility). Like Jung's concept of the anima and animus, all healthy men and women have a balance of testosterone and estrogen. An imbalance in the ratio of testosterone-to-estrogen has major implications for physical and psychological health. Although the human organism always strives for homeostasis, certain conditions—such as illness or substance abuse—may make this difficult. For example, women with too much testosterone—a characteristic of PCOS—develop symptoms such as subfertility, weight gain, type 2 diabetes, and depression. Men who experience reduced testosterone levels, e.g. due to androgen deprivation therapy (ADT) for prostate cancer (see Gannon's chapter in this book), may experience symptoms such as erectile dysfunction, genital shrinkage, loss of libido, hot flashes, osteoporosis, loss of muscle mass, breast enlargement, anaemia, fatigue, diabetes, cardiovascular disease, mood swings, depression and cognitive impairment. The importance of a balanced ratio of testosterone and estrogen in men and women is very much like the balance of yin and yang described in Taoism (Fig. 1).

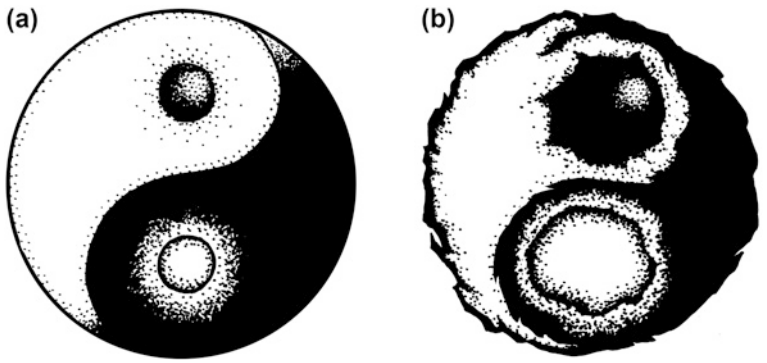

Fig. 1 A non-representational illustration, inspired by the Toaist principle of yin and yang, of (a) a healthy balance of testosteorne and estrogen, and (b) an unhealthy imbalance of testosterone and estrogen (Illustration by Aimée McLernon)

Is It a Sex Difference or a Gender Difference?

We sometimes notice characteristics in which the average man is different to the average woman. If we think the difference is a product of nature (e.g. prenatal testosterone) we tend to call it a sex difference, and if we think it's a product of culture (e.g. fashions in the length of hair) we call this a gender difference. Because so many sex differences in human behaviour are the product of both nature and nurture, the distinction between sex differences and gender differences is often a moot point, thus in this chapter we will use the terms interchangeably, as do authors such as Maccoby (1988) and Hines (2017).

Having suggested that gender is a product of both nature and nurture, we are going to present in the first half of this chapter a list of some of the sex differences that are likely to be mostly the product of nature. Modern technologies have made it possible to explore the subtle differences between the brains of men and women. For example, imaging studies show many sex differences in brain structure and function (Hines 2017), e.g. typically the amygdala is larger in males and shows a sex difference in response to sexual stimuli; women show more interhemispheric connectivity than men; women have a larger superior temporal gyrus and dorsolateral prefrontal cortex, and smaller frontomedial cortex and inferior parietal lobules than men.

Three Models of the Impact of Testosterone

Let's go back to the different pathways by which testosterone can impact psychology. One pathway is from organisational effects of testosterone, so-called when testosterone permanently changes the organisation of the brain of the fetus. These effects happen during sensitive periods of development and are probably more significant than activational effects, because of the impact on neurobehavioral sexual differentiation (Hines 2017). Evidence for the 'classic model' of hormone influence, is mostly based on research in rodents and non-human primates, which typically finds that the presence of testosterone in early life promotes male-typical behaviour, and the absence of testosterone results in female-typical behaviour. For example, Goy and McEwen (1980) found that exposure of the female rodent, fetus or newborn, to testosterone increases male-typical sexual mounting behaviour in later life, whereas castrating male newborn mice increases female-typical sexual behaviour (lordosis). These experiments also cause organisational differences in the brain region called the sexually dimorphic nucleus of the preoptic area (SDN-POA).

However, life is more complex than the classic model suggests, so more sophisticated models have been developed. The gradient model suggests that the amount of testosterone administered will influence the magnitude of the effect of testosterone, and suggests there are individual differences in sensitivity to the effects of testosterone. Also, the mere absence of testosterone does not necessarily lead to feminisation, and there is evidence that estrogens (ovarian hormones) promote female-typical sexual behaviour in rats.

But things are even more complicated. For example, for the development of some male-typical brain and behaviour in rodents, testosterone is converted to estrogen prior to acting through estrogen receptors (McCarthy et al. 2012). Furthermore, these processes differ in different species (e.g. rats differ in some ways to monkeys). Despite this complexity, we should resist the temptation of abandoning evidence-based theory in favour of untestable holistic notions of gender development which stress the importance of multiple forms of explanation (e.g. Overton 2015).

In the following sections on prenatal development, we are presuming that the impact of testosterone is organisational. Note that the examples are of naturally occurring phenomena, rather than ones due to exogenous causes, e.g. medication (such as diethylstilbestrol, DES) or environmental estrogens. Exogenous factors may be important however, e.g. endocrine disruptors in the environment are associated with autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD), and both conditions are generally more represented in boys (Yang et al. 2018).

Impact of Testosterone on Prenatal Development

Typically, if the fetus has no Y chromosome then it will develop into a female fetus. The presence of the Y chromosome triggers the release of testosterone from the fetal gonads at about week 13 of gestation. The levels of testosterone are as high, at this gestational age, as seen in boys during puberty. The male fetus has an X and a Y chromosome, and a female fetus has two X chromosomes. Genes that lie on the X and Y chromosomes impact a range of gender-typical differences, e.g. aspects of intelligence, social behaviour and language (Printzlau et al. 2017).

Variations on the XY/XX theme are possible, but rare. The most common chromosomal anomaly, called Klinefelter syndrome, occurs in around 1 in 600 men, where men carry two or more X chromosomes as well as a Y chromosome. These men produce low levels of testosterone, may be infertile, and

their secondary sexual characteristics are incompletely developed (e.g. less pubic hair). Psychologically, they may be unassertive, have slightly impaired verbal IQ, reading ability and motor skills, possibly due to reduced brain growth (Leggett et al. 2010). Also relatively common, about 1 in 1000 men have an extra Y chromosome (XYY). They are usually taller than average and have higher levels of testosterone. They may be unaware that they are unusual, and indeed are probably not dissimilar to the average man (Leggett et al. 2010).

In some cases the male fetus has the typical XY pairing, but in Androgen Insensitivity Syndrome (AIS) typical male development is thwarted because the cells have defective androgen receptors. Such individuals will appear at birth to be girls, or will have some degree of genital ambiguity or malformation, e.g. hypospadias. The 'complete' cases (CAIS) are usually raised as girls, and retrospective assessments suggest that their childhood behaviour is female-typical and are usually happy with their female role (Hines et al. 2003). Their condition is usually undetected until puberty, when investigations into the lack of menstruation reveals the absence of internal female reproductive organs. The incidence rate for CAIS is low (less than 1 in 10,000), and rates for the less severe cases (partial, or PAIS) are higher but difficult to estimate due to being undetected in many cases.

Prenatal Testosterone and Autism Spectrum Disorder (ASD)

Given that autism is 4 times more common in males, and Asperger Syndrome (AS) is 9 times more common in males, ASD has come to be thought of as a male condition. However, it could be that female autism is under-diagnosed (see chapter in this book by van Wijngaarden-Cremers). The 'extreme male brain' theory of autism (Baron-Cohen 2002) suggests that ASD is an exaggeration of male-typical traits, such as lower empathy and more systemising, caused by prenatal testosterone. There is some evidence supporting this theory, but not all experts in ASD are convinced. Interestingly, preoccupations around transgender feelings are more common in people with ASD than others (see chapter in this book by van Wijngaarden-Cremers).

Evidence supporting the extreme male brain theory includes that on congenital adrenal hyperplasia (CAH) and empathy, and PCOS and autism. The 16 PF 'tendermindedness' subscale taps empathy, and women generally score higher on it than men. However, girls with CAH score lower than other girls on this

subscale (Mathews et al. 2009). Research from a large GP database suggests that autism and ADHD is more common in women with PCOS (Berni et al. 2018), and if PCOS is caused by elevated prenatal testosterone, this could suggest that elevated T is related to autism. Further research, and more direct evidence (though hard to find—see "Criticisms of Studies of the Biological Influence on Sex Differences" section below), is needed to clarify any links between testosterone and ASD.

Impact on Girls of Prenatal Testosterone Imbalance

Some of the clearest evidence for the impact of androgens on human behaviour comes from the study of CAH. The incidence of CAH is about 1 in 10,000 births. About 90% of cases of CAH are caused by 21-OH deficiency, which leads to the overproduction of adrenal androgens. The levels of androgen experienced by the female fetus can be similar to the levels experienced by boys during the prenatal testosterone surge, and such girls are typically born with some degree of genital virilization. In some cases, the clitoris is enlarged to the degree that it is mistaken for a penis, but more usually they are diagnosed before birth, receive hormonal treatment and the genitals are feminised surgically.

Studies from different countries and using different methodologies have found that girls with CAH show increased interest in male-typical behaviour (in play, toy preference, activities and playmates) and reduced interest in female-typical behaviour. These behaviours are not fully explained by environmental factors, such as the expectations of their parents. The more androgen experienced prenatally, the more male-typical the behaviour (Nordenström et al. 2002), which suggests an organisational effect of androgen, and supports the gradient model of testosterone exposure.

Contrary to the gradient model, male fetuses are thought not to be impacted by additions of androgen from other sources. This is possibly because (a) it is part of normal male fetal development to experience a large surge of T, which might constitute a ceiling effect making additional androgen superfluous, or (b) due to feedback mechanisms reducing testicular androgen production to compensate for the elevated adrenal androgen production. Overall the evidence suggests that boys with CAH don't show atypical behaviour in the way that their female counterparts do (Pasterski et al. 2007). There are possible medical complications for boys with CAH which might lead to stressful hospital visits and procedures, but these are not related to androgens, and probably don't impact their behaviour significantly.

3D Mental Rotation

Previous research has established a link between testosterone and performance on 3-dimensional mental rotation tasks. The task that shows the most consistent sex difference is the Shepard-Metzler 'cubes' (Shepard and Metzler 1971), a puzzle-like test where participants are asked to view a drawing of a stack of cubes, and are asked to imagine what it would look like if viewed from different angles. In general, men perform better on this task than women (Peters et al. 1995), but a single dose of testosterone (an activational effect) can improve scoring on this task in women (Aleman et al. 2004). Men with prostate cancer on ADT perform less well in spatial cognitive abilities (Cherrier et al. 2009). Barry et al. (2013) found that women with PCOS who had elevated testosterone scored significantly higher on this task compared to healthy female controls; scores were positively correlated with testosterone and negatively correlated with estradiol.

fMRI and Mental Rotation

fMRI research into mental rotation has found that different brain regions are activated depending on whether the image presented is abstract, such as the Shepard-Metzler objects, or more personally relevant objects, such as hands (Seurinck et al. 2004). Some studies using fMRI have found that men and women show different patterns of neural activation whilst performing the mental rotation task (men in the parietal areas, and women in the right inferior frontal), even after sex differences in scoring are controlled. This may be due to the use of different solving strategies, with women using a serial categorical processing approach and men using a coordinate processing approach.

Some evidence suggests a prenatal origin of sex differences in mental rotation ability. For example, female twins who have a male co-twin, and are thus exposed prenatally to the male twin's testosterone surge, perform better in mental rotation than female twins who have a female co-twin (Vuoksimaa et al. 2010). Imperato-McGinley et al. (1974) found that ten XY CAIS individuals (genetic males who are impervious to the effects of testosterone) did less well than male and female healthy controls on this task. Also, studies of prepubertal children (e.g. Quinn and Liben 2008) as young as 3 months old (Moore and Johnson 2008) appear to show that the typical sex difference exists even then. The fact that the sex difference appears before puberty suggests that circulating levels of testosterone (i.e. the activational effect) are not

the sole explanation for the sex difference. However, there is some evidence of a minor testosterone surge in male newborns, which theoretically could cause an activational effect.

Not all evidence supports a prenatal cause of mental rotation ability, for example, the evidence from studies of CAH is mixed and only marginally suggests masculinisation of ability (Hines 2017). Also, as with many cognitive abilities, there is evidence that scores on the mental rotation task increase with practice and even expectancy, though typically the gains are small and don't explain the sex difference in the general population. Overall the evidence suggests that mental rotation ability is the product of some combination of the organisational and activational effects of testosterone, plus any practice on the task that has been done.

Perceptions of (Circulating) Testosterone and Aggression

When considering activational effects of testosterone circulating in the bloodstream, there is a popular misconception surrounding its function—that testosterone *causes* aggression in humans. This misconception has contributed to the popular perception that men are more aggressive than women, because testosterone is the 'male hormone'. This conclusion is based on a fallacy derived from oversimplified and incomplete information. Firstly, this does not consider the organisational effects of testosterone, which largely dictate the effect of circulating testosterone (e.g. quantity and effectiveness of testosterone receptors). Furthermore, the evidence regarding circulating testosterone levels seems to suggest a relationship with species-specific, culturally sensitive, social dominance behaviours. Testosterone *may* lead to aggression in humans, but the evidence is not consistent. Humans are not bound to a narrow range of behaviours in order to dominate, as is the case in some less complex species. Humans may demonstrate dominance in a number of given specialities, ranging from academic achievements, creativity, physical domains and even in cooperation and altruism.

The following sections will discuss some of the research that has contributed to the misconception that testosterone causes aggression, and challenge this by encouraging the integration of an evolutionary perspective to give a holistic view of the function of testosterone in men.

The 'Mouse Model'

The belief that circulating testosterone levels cause aggression is known as 'the mouse model' of aggression, because this belief originated from animal research, in particular laboratory rodents. In various studies, e.g. of hens and rodents, there have been consistent findings of a positive relationship between testosterone and aggression whereby testosterone administration increases aggressive behaviours and gonadectomies decrease aggressive behaviours. However, there are mitigating factors, such as cultural context and social variables, when we attempt to generalise such findings to humans. Furthermore, it is now known that circulating hormones have a bi-directional relationship with behaviour, and therefore testosterone causes aggression in humans, and aggressive situations increase testosterone. This is an adaptive response which would allow an individual to remain vigilant and defend themselves in threatening situations. It is difficult to experimentally alter testosterone levels in humans, but research using naturally occurring samples suggests that testosterone may *indirectly* increase aggression. This is because individuals with more antisocial personality traits are more likely to take steroids (Perry et al. 2003) and engage more in risky behaviours (Miller et al. 2002). Furthermore, these relationships between testosterone and antisocial behaviours are suggested to be mediated by impulsivity, in that people who are more impulsive are less able to control their aggressive and antisocial tendencies, independent of testosterone (O'Connor et al. 2002). It is even possible that individuals who take testosterone supplements are more motivated to dominate because they feel bolder and braver due to an increase in their physical size, though this is a hypothesis that has yet to be researched. It is clear that the mouse model alone is too simple to explain these behaviours in humans. Also, the existing research on humans, based on correlational evidence rather than controlled studies (e.g. randomised controlled trials, or RCTs), makes it difficult to control for potentially confounding variables.

An Integrated Perspective—Incorporating the Ultimate (Evolutionary) Approach

Archer (2006) suggests that integrating an ultimate (evolutionary) perspective facilitates understanding of the role and function of testosterone by providing appropriate context. By considering the environment humans evolved in and are therefore adapted to, it can provide appropriate context in which to generate and test appropriate hypotheses about the function of testosterone in humans, and to then understand how this may present differently in

contemporary humans cross-culturally. He suggests that the *challenge hypothesis* provides a much more informative framework for understanding the role of testosterone in human behaviour. The challenge hypothesis suggests that testosterone varies in the sex who is least obligated to offspring development—usually the male—across many different species in a way that regulates mating and reproductive behaviours. In less complex species such as Syrian hamsters (De Lorme and Sisk 2013), testosterone is more likely to increase aggressive behaviours for resources, status and mates because they are unable to achieve dominance in other ways. Humans are much more complex and are able to achieve dominance in a wide range of ways, such as by engaging in cultural displays. Therefore, whilst some species may show a very narrow range of testosterone-supported behaviours, evidence suggests that these behaviours are much more varied and diverse in humans. For example, Dabbs et al. (1997) showed that, in comparison to people with relatively low levels of testosterone, people with relatively high levels of testosterone experienced more 'restless energy'. They experienced higher levels of arousal, an urge to socialise with friends, they were more pro-active in their approach to problem-solving, wanting to 'get things done' straight away, and they had a distinct intensity in their approach to any activity they were engaged in, regardless of the nature of that activity. Dabbs et al. also suggested that individuals with high testosterone levels felt their energy was constrained by external environments, which caused frustration. Thus, the environment and context (e.g. social and cultural norms) are important in determining what dominance behaviours look like and how they are expressed cross-culturally.

There is a lot of evidence that supports the challenge hypothesis in humans, suggesting that testosterone levels function to support dominance-striving behaviours in men (Mazur and Booth 1998) in culturally sensitive ways. There is evidence that a range of behaviours that could be classed as dominance-striving increase substantially around adolescence, when there is a surge in testosterone, peak around the ages of 25–30 years, and decrease relatively slowly into old age (Miller 2000), which suggests a role in mating behaviours. However, if testosterone supports dominance-striving behaviours in order to secure resources and mating opportunities, testosterone should not decrease in men at this age if they have yet to secure mates. Evidence supports this, suggesting that unmarried men do not decrease their dominance-striving behaviours in middle age (Kanazawa 2000, 2003). Though marital status is a crude indicator of an innate motivation to pursue mates, the theory that testosterone fluctuates to support such dominance behaviours in a mating context has been successfully adapted, providing supporting evidence cross-culturally

(e.g. when considering variation in mating systems). Furthermore, it would not make sense for testosterone to simply promote aggressive behaviours in dominance-seeking contexts generally because this would lead some men to never succeed in dominating and securing resources and mates; adaptive strategies must be flexible in order to be individually adaptive. For men to be able to dominate in different ways promotes their own fitness; ancestral men who could not adapt to their environment had fewer opportunities to pass on their genes and increase their fitness. Ainsworth and Maner (2012) demonstrated that men typically only resort to aggressive means to achieve dominance when they were unable to dominate by other means. Comparative evidence supports the suggestion that testosterone only promotes aggressive behaviours when status is threatened, for example, baboons resort to aggression only when there is instability in the social hierarchy (Sapolsky 1991). It is therefore vital that when examining the function of testosterone and its effect on human behaviour that we embed this notion of fluctuation appropriately within the relevant context.

Evidence for the Ultimate Perspective of Testosterone

If the function of testosterone is to promote dominance-striving behaviours in order to promote fitness, then there should be evidence of testosterone fluctuating in men relevant to motivations for status and resources. Indeed, there is evidence that suggests single non-fathers have higher levels of circulating testosterone than non-fathers in committed relationships, who in turn have higher levels of testosterone than fathers in committed relationships. This variation becomes more nuanced when broken down further; non-fathers in relationships have testosterone levels comparable to single non-fathers if they report a sexual interest in other women (McIntyre et al. 2006), and when they report being less committed to the relationship (Edelstein et al. 2014; Farrelly et al. 2015). In committed non-fathers who aren't interested in other women, their testosterone levels decrease further during the transition to fatherhood (Gettler et al. 2011; Perini et al. 2012), the extent to which is dependent on the amount of direct care they provide, whereby more care is associated with lower levels of testosterone (Gettler et al. 2012). Testosterone has a complex relationship with sexual desire in general; it seems to promote sex drive in men, especially interests in casual sexual activity, and in women testosterone supplements can increase

a low sex drive. Taken together, such research supports the suggestion that testosterone increases around adolescence to support dominance-striving behaviours which aid acquisition of resources relevant to status striving and mating opportunities. Testosterone levels typically decrease around the age of 25–30, then more slowly from around the age of 40 (Uchida et al. 2006), which largely coincides with the acquisition of status and mating resources. It is suggested the function of this is to divert energy away from competition and risk-taking and to promote nurturing and bonding with a partner and offspring. It is important to note that these typical ages of increases and decreases in testosterone are averages, and more importantly are by-products of innate psychological motivations. Evidence for this comes from the increase in testosterone levels following divorce in middle-aged men (Mazur and Michalek 1998), the elevated testosterone levels in polygynous men (Alvergne et al. 2009), and the evidence discussed above, suggesting that testosterone fluctuations are independent of external cultural sanctions, and instead reflect, and are affected by, internal innate psychological processes to increase fitness.

Further evidence for the suggestion that testosterone fluctuates to support culturally sensitive dominance behaviours in men is demonstrated by fluctuations in various forms of cultural outputs which map onto the lifetime fluctuations of circulating testosterone levels. Specifically, it has been noted that cultural outputs typically increase around adolescence, peak at age 25–30 years, then gradually decrease after the age of 40 years, with the exception of mitigating factors (e.g. not having mated, mating earlier, following a breakup, being motivated by additional mating opportunities). Scientific achievements, music outputs, art and sport have all been highlighted as following a similar, sex differentiated lifetime trajectory. If testosterone simply caused aggression in humans, then there would be no consistent fluctuations in such domains.

Testosterone and Prosociality

Evidence is now emerging which suggests testosterone may promote prosociality in some contexts (Wibral et al. 2012), consistent with the suggestion by Roberts (1998) of a *competitive altruism* strategy employed in some instances, whereby men compete to be the most altruistic or cooperative. Such strategies are suggested to have been successful particularly in ancestral men who were unlikely to have been successful in aggressive displays of dominance. This, again, reiterates the importance of taking a holistic,

integrated approach to understanding the function of testosterone and its effects on human behaviour, whilst also considering context in which an interaction occurs.

An expansion of the reciprocity theory of altruism, competitive altruism suggests individuals may compete to demonstrate prosocial characteristics and behaviours, such as cooperation and altruism. This is not to gain direct reciprocation from the beneficiary; instead it acts as a *costly signal* indicating one's desirable characteristics. Costly signalling theory (BliegeBird et al. 2005) is proposed to occur particularly in the context of competing for resources and mates and involves engaging in context-specific self-sacrificial behaviours in order to demonstrate dominance. Integrating these theories with what we have discussed so far suggests men are more likely to engage in competitive altruism than women, especially under status threats and when mating opportunities present, consistent with the suggestion that men have an innate motivation to dominate in culturally sensitive ways. Indeed, there is evidence of this, for example, men are more inclined to donate to charity, and donate more to charity, when the fundraiser is an attractive female (Roberts 2015). As is the case with fluctuations in testosterone levels, altruism is increased in some contexts when status is threatened. Research shows that altruism towards the in-group is higher in men with high levels of testosterone when faced with out-group threat (Diekhof et al. 2014; Reimers and Diekhof 2015). This allows the individual to directly signal their prosociality to an audience as well as promote in-group cohesion, increasing the likelihood of demonstrating dominance.

Correlational research is often criticised for not showing the direction for cause and effect, however Wibral et al. (2012) provide causal evidence of a prosocial effect of testosterone in men. Men who received a testosterone supplement told significantly fewer lies than men who received a placebo, despite the fact their lies could not be identified, and lying would result in greater monetary payoffs. The authors concluded that testosterone could have decreased the propensity to lie in these participants, or it could have increased status concerns. However, it could be argued that either of these options equates to increased prosociality and context-specific dominance—by self-sacrificially telling the truth. Men who received the testosterone supplement may have been more motivated to demonstrate their honesty, despite the cost associated with this, as this is a prosocial trait valued more in potential allies and mates than deceptively gaining larger pay-offs. New research also supports the suggestion experimentally that testosterone enhances behavioural flexibility in men (Diekhof and Kraft 2017).

Negative Views of Testosterone Create a Negative Placebo Effect

Overall, the evidence discussed suggests that the conflation of aggression and testosterone is nothing more than an ill-informed stereotype and that integrating an ultimate perspective allows a clearer, more nuanced understanding of the role and function of testosterone in humans. Further support for this comes from evidence of a placebo effect of testosterone. Eisenegger et al. (2010) showed an increase in prosociality in individuals who received a testosterone supplement in comparison to those who received a placebo. However, they further demonstrate evidence of a 'false-belief' effect, whereby participants who believed they had received a testosterone supplement but actually received the placebo demonstrated more stereotyped negative behaviours associated with testosterone. Specifically, participants who received a placebo but believed they had received a testosterone supplement were significantly less prosocial than others in the placebo group, who were also significantly less prosocial than those who received the testosterone supplement. This suggests that the participants believed that testosterone causes antisocial behaviour, i.e. they believed the 'mouse model' stereotype of men. Though this does provide compelling evidence of the dynamic and contextually sensitive nature of the role of testosterone, consistent with the evidence discussed so far, it must be acknowledged that Eisenegger's research used a female-only sample. In some respects, this allows a clearer understanding of the role and function of testosterone, because women have much lower levels of testosterone than men, therefore we might more clearly see the effect of the supplement. It also suggests that a negative stereotype exists of testosterone, possibly connected to negative views of masculinity and men (see chapters by Seager and Barry). A replication of this research using male participants would be interesting.

What Does This Mean for Men?

Overall, the research discussed in this chapter points to the positive impact of testosterone on men. Men need a high ratio of testosterone to estrogen (~10:1) for psychical and mental health. Circulating levels of testosterone can motivate men to 'do their best' in a given situation, promoting flexible behaviours according to cultural and contextual parameters. Consistent with an evolutionary framework, men have an innate motivation to dominate in particular contexts, and this can be positive and prosocial rather than aggressive in humans. Testosterone has been shown to have many positive aspects,

including elevated generosity, cooperation and altruism, as well as increasing physical and mental health and wellbeing in hypogonadal men. Evidence also shows that congruence between internal and external indicators of gender is important for promoting mental health and wellbeing, therefore female-to-male transsexuals report positive effects on their wellbeing by taking testosterone supplements, allowing them to embody their gender and outwardly express this. Evidence of placebo effects of testosterone indicate that, rather than testosterone and masculinity being inherently 'bad'—aggressive and negative—societal perceptions of testosterone and its function are fundamentally negative. These perceptions have become ingrained in society, contributing to the conflation of testosterone and aggression. This may have negative effects on individuals, particularly individuals taking testosterone supplements for health or cosmetic reasons. It is therefore important to take a fully integrated view on testosterone and its function; this encourages a complete understanding of the ultimate function of testosterone as well as variation in how it is manifest according to proximate factors.

Criticisms of Studies of the Biological Influence on Sex Differences

The major weakness of the 'nature' explanation is that experimental evidence for the influence of prenatal androgens in humans is impossible due to the ethical considerations of deliberately manipulating hormone exposure of the human fetus. Thus the 'nature' explanation relies on evidence from 'natural experiments', such as comparing cases of CAH to non-effected siblings (Hines 2005). The validity of phenotypic markers of prenatal androgen exposure, such as finger-length ratio, have been criticised both methodological and theoretical grounds (e.g. Manning and Fink 2008). For example, studies that don't find correlations with prenatal testosterone are less likely to but submitted for publication, thus skewing the literature. But we don't know the extent of such an effect, or whether indeed the effect is more likely to go in the other direction. In regards CAH and CAIS, there is the problem, inherent in research on rare conditions, that the sample size is inevitably small.

Evolutionary approaches to studying psychology are often criticised for being reductionist 'just-so' stories of human evolutionary development that generate hypotheses that are difficult to test. However, it is important to note that evolutionary approaches precede more proximate areas, such as biological evidence. Applying an evolutionary perspective to, for example,

sex differences in hormones and their fluctuations, and sex differences in brain structure and responsiveness, provides context in which to understand these different functions that can help to generate testable hypotheses about human behaviour. Whilst the 'environment of evolutionary adaptedness' can be debated and speculated about, we have clear evidence that some behaviour is related to biological sex differences, therefore evolutionary approaches to understanding psychology and behaviour must surely have merit.

Another criticism is that it is easy to measure sex differences on many variables, thus we should be wary of Type 1 error (false positive results). However this criticism is weak because many sex differences are replicable, and it would be unwise to dismiss findings of clinical or theoretical relevance. However, it is of course plausible that researchers are influenced by their own preconceptions about gender stereotypes to the degree that this impacts how they interpret their findings. This criticism applies to researchers whether they appear to focus on gender differences (alpha bias) or gender similarities (beta bias). For example, the work of Janet Hyde (2005) has been very influential in the social sciences, and her 'gender similarities hypothesis'—with the notion that 'there are more similarities between men and women than differences'—has become axiomatic. However, Hyde's hypothesis is based on the flawed notion that because there are more similarities, any differences are unimportant. By this logic, we could say that because mice and humans share 95% of their genes, the differences between mice and humans are unimportant. Readers of the present chapter might come to the conclusion that some of the differences between men and women are not only of statistical significance, but are of clinical significance and profound human significance. Hyde based her hypothesis on a meta-analysis (2005), which is flawed in failing to include research on many variables that show a sex difference (such as those listed in Ellis 2018) and toy preference, a behaviour that shows a large sex difference and which dozens of studies stretching over decades have replicated (Todd et al. 2017). Hyde's reasons for these omissions are unclear, but the effect of the omissions is to bolster her case that gender differences are caused by context rather than biology. There is compelling evidence that sex differences in cognition and behaviour are seen internationally (Ellis 2018), and the fact that they are found worldwide and, in many cases, map onto our notions of gender (e.g. men are more competitive, interested in sports, work-orientated and fearless) suggests that masculinity is to some degree innate.

We have looked at the evidence that sex differences in behaviour are influenced by prenatal biological factors, but life is complex, and there exceptions and anomalies to take into account. For example, the testosterone surge at

about 13 weeks prenatally should, in theory, influence the postnatal play behaviour of a female co-twin, but this effect is not always found in (e.g. the study of over 6000 twins by Iervolino 2003). In a review of sex differences in the brain, McCarthy et al. (2012) conclude that the majority of sex differences are caused by sex hormones acting in the adult or childhood, rather than prenatal development. This makes the question of whether sex differences in brain structure are due to nature or nurture somewhat moot, though reinforces the notion that they are due to both.

When it comes to gender and sex differences, causality is complex and inevitably involves some influence of nurture (i.e. parenting, culture, etc.). However as stated above, we shouldn't let the complexity of this reality cause us to oversimplify our approach to these questions, nor overcomplicate it. At all times good methodology, dispassionate interpretation, and openness to debate are key.

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The Challenges for Boys and Men in Twenty-First-Century Education

Gijsbert Stoet

Introduction

Boys do not do as well as girls in education. Because most of a person's formal education takes part in childhood and adolescence, "the gap" refers primarily to the gap between boys and girls rather than a gap between men and women. Therefore, the gap is sometimes called the "boy problem" (e.g., Hamilton and Jones 2016) or even the "boy crisis". In this chapter, I will use the term "boy problem".

We know of the widespread nature of the boy problem because of the availability of school results from around the world. In today's world, children are not simply sitting tests and exams in the classroom; the numbers are collated and used by all sorts of governmental agencies. These aggregated or anonymized data are often made public. Further, there are a number of large-scale international educational surveys, such as the Programme for International Student Assessment (PISA), which give detailed information about student performance around the globe.

The boy problem varies from location to location. This chapter focuses on Great Britain. The situation in the UK is similar to other economically developed Western countries, including the USA, Australia, and European nations. Even so, countries differ in the degree to which boys and girls perform or

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participate differently. In particular in Africa and some South-Asian countries, girls rather than boys fall behind (Stoet and Geary 2019).

Not only does the boy problem vary between countries, it also seems to have changed over time.

It is difficult to determine how exactly it has changed over time, because reliable and comprehensive data sources become sparser the further one goes back in time. We know that the English O-level data show that adolescent boys and girls did, roughly, equally well up to the mid-eighties. That said, some older academic manuscripts reported a boy problem as well. For example, Johnson's (1938) article titled "Girls do better than boys in school" (referring to certain US data). Similarly, Kilpatrick's (1951) thesis on school performance in Texas (US) found that girls performed better. And going back even further in time, Hunt (1991) reported that in early twentieth-century England, more girls than boys attended school (as is the case today). Thus, the boy problem may not be an entirely new problem, although the lack of reliable comprehensive data limits our understanding of its history. Further, the nature and purpose of education have changed enormously over time, which renders older data of less interest to today's world.

The boy problem, as such, became discussed in the late 1990s. This increased interest has become known as "the boy turn" (Weaver-Hightower 2003). The interest has resulted in a range of books about boys' problems for the general public, such as "Raising Cain" (Kindlon and Thompson 2000), "The war against boys" (Sommers 2001), "Boys adrift" (Sax 2016) and "21st century boys" (Palmer 2009). Fascinatingly, the authors of these books come from very different academic disciplines.

The interest in the boy problem has not only resulted in journal articles and books, but also in a number of reports written by charities or governmental institutions (e.g., Harland and McCready 2012; Hillman and Robinson 2016; Younger and Warrington 2004). Even so, despite 2 decades of increased attention for the boy problem, we still have not yet found a solution.

This paper is divided into three parts. Part I is about the current situation at different stages in the English educational system. Part II is about possible causes. Part III focuses on solutions.

Today's Boy Problem in Great Britain

Great Britain consists of 4 "devolved" parts, namely England, Wales, Northern Ireland, and Scotland, each with their own Department of Education. Despite some important differences, there are many similarities between educational

regulations in these regions, especially between England, Wales, and Northern Ireland.

Pre-primary Education

Pre-primary education has different names in different countries and is typically not compulsory. In the UK, pre-primary education is officially known as "early years" education. It is an opportunity to playfully develop or strengthen a variety of skills and to learn to socialize. In England, the government sets expectations of what children should learn as part of the so-called *Early Years Foundation Stage* (covering children between birth and 5 years old).

The requirements of "Early Years Foundation Stage" were introduced in 2008 and are controversial among child and educational practitioners (Richardson 2013). The expectations include being able to write simple words and sentences, count to 20, and do simple addition. These are relatively high expectations compared to past expectations in England and compared to countries where reading and writing are formally introduced at age 6 (the majority of countries) or even age 7 (Finland and Estonia).

Many English children do not meet the expectations set out in the Early Years Foundation Stage, especially boys. For example, boys scored lower in 16 out of the 17 Early Learning Goal subject areas ("technology" was the only subject where boys and girls scored equally, Cotzias et al. 2013). Note that not all the 17 goals are "academic", it also includes basic skills, such as being able to go to the toilet independently. In any case, the boy problem in English education already starts before children have even started primary school.

Despite some criticism, I would like to point out, though, that the Early Years Foundation Stage has clear advantages, such as standardizing what can be expected from pre-school education. The observational assessments of how children develop a range of different skills can help parents and teachers to better support their children. This may be particularly beneficial for those children who are more likely to fall behind (including boys).

Primary Education

Primary education is for children, roughly, for the ages from 5 (depending on country, see above) to 11. Primary education is the same for all children—although there are separate schools for children with special needs. In England, boys have far more special educational needs than girls across all age groups

(around 7% points difference, Department for Education 2017). In the United States, we also see a gender gap in special education needs (Oswald et al. 2003). I do not have data for all countries, and special education needs might be defined differently across cultures, but I suspect that this gender gap in the need for special education is an international phenomenon. This means that broad solutions need to be developed, rather than just focusing on specifically British issues. For example, while one may argue that British boys fall behind because primary school starts unusually early, this does not explain why the boy problem is also found in Finland (Finnish boys fall particularly behind in reading comprehension, Stoet and Geary 2015).

This larger number of boys in special needs classes is not surprising given that young boys are more likely than girls to suffer from attentional disorders, stuttering, and dyslexia (e.g., Halpern 2011). Further, boys are far more likely to suffer from colour blindness, which makes it hard or even impossible to understand coloured lesson material, especially when the colours are key to understanding (Todd 2018). Such problems can continue throughout life, limiting career choice and reducing quality of life in the workplace (Barry et al. 2017).

Secondary Education

In England, Wales, and Northern Ireland children will sit GCSE exams at age 16 and, optionally, A-level exams at age 17 or 18 (Hillman and Robinson 2016). These exam results for each school-subject are made publicly available for both genders. The GCSE target scores are between A* (highest) and C (lowest; note that the grading system is in the process of being changed to a numerical system). For example, the 2015 dataset has 49 subject areas. Of these, only mathematics and English are compulsory subjects. Across all subjects, 8% of girls and 5.2% of boys get the highest grade, which is an A* grade, and 73% of girls get a score between A* and C compared to only 65% of boys. This is a considerable gap. If we split the data up by subject, we find that in 46 out of 49 subject areas, more girls than boys get A* grades. There are only 3 subjects for which this is different in the UK: mathematics and the categories "other sciences" and "other technology" (both have relatively small numbers of students).

If we look at the compulsory subject English, we see that 73% of girls get a grade between A* and C compared to only 58% of boys, again a big difference. According to recent research (Sutton Trust 2015), one of the concerns is that bright boys from poor backgrounds perform lower than expected

based on their test-scores carried out at age 11. Thus, it seems there is something (unknown) that forms a barrier towards their success between the ages of 11 and 16—future research is necessary to determine exactly what this is. One possible explanation are the different effects of puberty on boys and girls (Dekker et al. 2013).

The situation is slightly different in the A-levels (the optional level of upper-secondary education needed for higher education entry). One of the problems with understanding these data is that only 45% of participating students are boys (in the latest 2018 data), which is important to take the results into account. The A-levels have been reformed in the past few years. Until 2013, there was a clear gap in the percentages of boys and girls achieving the A grade across subjects. In the 2018 data, when A-levels exam data were based on final exams following a 2-year study period, girls still did better than boys in the majority of subjects, except that for the top grade A*, the percentage of boys was higher (but because boys are underrepresented, as noted, still more girls than boys may actually have received a top grade). In other words, at the very high end of the achievement distribution, we see that boys do well, but this is not true for the majority of male students. Also, even though the percentage of boys with an A* is higher, there are actually more girls than boys getting an A* in absolute numbers, which is expected, given that in 2018, there so many more girls sitting A-levels.

Apart from exam data, we have many useful data from international educational surveys such as the PISA. PISA is a large and expensive international project in which around 70 countries participate and is one of the most influential educational surveys (OECD 2003). Every 3 years, thousands of children from each country sit a 2-hour test which measures their abilities in three domains: Reading, Mathematics, and Science Literacy. The test is the same for all children, although translated into different languages to ensure it is culturally neutral.

In 70% of countries, girls outperform boys (Stoet and Geary 2015). This lead of girls, however, was not found in the UK or the United States. In both of these countries the relative advantages for girls in reading and boys in mathematics cancel each other out, while boys and girls score similarly in science literacy. This is quite a contrast to the British GCSE exam data results, in which boys fall behind in nearly all subjects! The difference between UK exam data and PISA data can possibly be explained by the fact that GCSE exams cover far more subjects than PISA tests, and because GCSEs are more sensitive to homework, which boys do less of (Hillman and Robinson 2016).

Tertiary Education

Tertiary education follows secondary education (e.g., university education or vocational training). It is well known that there is a growing gender gap in university enrolment; every year, more females than males go to university. In 2015, UK girls were 35% more likely to enter university. This gap was twice as large as the gap in 2007 according to a report by the Universities and Colleges Admissions Service (Weale 2016) and the gender gap in admissions in 2015 was the highest on record (Hillman and Robinson 2016). Women now make up more than half the students in 2/3 of university courses. It is most likely that the large and growing participation gap in tertiary education is a cumulative effect of years of gender gaps across the educational track. The situation is similar in other Western countries (e.g., in the United States, there is a 5% point difference in college enrollment, Musu-Gillette et al. 2017).

Causes

How well a child performs and behaves at school depends on many different factors. For example, a child which lives in an emotionally stable family with parents who set good examples (e.g., reading with children at home) will likely benefit educationally, yet such positive factors may be counteracted, for example, by poor diet, poverty, or noisy surroundings (which distract from homework).

Just like any child's success of learning is related to many factors, so is the boy problem. Some of these factors are biological and others are sociocultural. Being able to identify and effectively counteract the most influential of factors will increase the likelihood of managing the boy problem more effectively. And please note that "biological factors playing a role" does not mean that their influence cannot be dealt with—for example, puberty is a biological factor, and schools and teachers can very well (and typically do appropriately) deal with its challenges by looking after children's emotional and physical well-being. Similarly, ageing is a biological factor, and the way to deal with it is creating age appropriate material, which all schools do (although there are issues where practitioners do not agree, in particular issues around religion, gender, and sex).

Identifying all the causal factors of the boy problem is complex. For example, one of the direct and indisputable causes of boy's underperformance, in particular in secondary education, is that they do not spend as

much time on their homework as girls (e.g., Hillman and Robinson 2016). That is good to know, but it raises further questions of what the cause is of boys not spending enough time on their homework. Do boys not do as much homework as girls because of a lack of motivation? Is that because the teaching material is not as engaging for boys as it is for girls? Do parents and teachers possibly not encourage boys as much as girls to do homework? Do boys possibly lack the concentration abilities that girls have? In short, each cause is likely part of a complex chain of causes, and it will take much time and effort to fully understand these.

The implication of the complexity of the causal chains behind the boy problem is that whenever someone has a *simple* solution for it, it is most likely not realistic. For example, the link between self-confidence and achievement is, most likely, reciprocal (Fraine et al. 2007).

In order to create a realistic view on solutions for the boy problem, we first need to map out all the different factors playing together in causing the boy problem. Here, I identify 4 different types (or classes, or domains if you will) of causes: (1) Cognitive causes, (2) Attitudinal/emotional causes, (3) Social causes, (4) Physical causes. And even these different domains are not entirely separate, given that physical factors will underlie many of the other factors.

Cognitive Causes

Human brain development is a slow process. The human brain keeps developing up to the early twenties. Brain development is complex and is influenced by many factors. Boys and girls go through the same stages, but at slightly different speeds at different times. Further, boys and girls have different levels of vulnerability for a number of disorders, as explained below.

Slower Language Development

It is well accepted that boys develop language skills more slowly than girls. For example, at age one, the vocabulary of girls is larger than that of boys (Bouchard et al. 2009). A Norwegian study showed that one-year-old girls raised by low-educated mothers have a larger vocabulary than boys of highly educated mothers (Zambrana et al. 2012). This is astonishing because we know that parental education is one of the best predictors of children's success in school (Davis-Kean 2005). In other words, the education of a mother cannot compensate for the gender difference in vocabulary development. Further, language disorders such as stuttering and dyslexia are more common in boys than in girls (Halpern 2011).

At age 15, boys fall behind girls in language comprehension tasks in all countries, that is, it is a universal effect (OECD 2016). Given that language is key for understanding teachers and for expressing one's knowledge in all school subjects, it may well be that language plays a key role in the boy problem.

Slower Brain Pruning and Later Maturation

Speed in maturation is not only an issue in early language development (i.e., boys developing vocabulary more slowly). The pruning of brain cells takes place in the teenage years; brain pruning is an important aspect of normal brain development. It is the removal of unnecessary connections between nerve cells. This is part of normal development and leads to a more efficiently fine-tuned brain. It has now been shown that the pruning process starts earlier in girls (Lim et al. 2013), namely between the ages 10 and 12. In boys it starts between the ages 15 and 20. That is a relatively big difference and can explain part of the growing gap between teenage boys and girls.

Attitudinal Causes

Children's positive attitudes towards school, in general, decline during primary school, and this effect is stronger for boys than girls (Haladyna and Thomas 1979). On the other hand, Canner et al. (1994) reported a steeper decline in girl's positive attitudes towards school with the onset of puberty. Even in their study, though, boys still scored lower in regard to satisfaction with school, commitment to classwork and reactions to teachers (Canner et al. 1994, Table 4). This is a good example how boys and girls can change their attitudes at specific times in development and both genders showing less or more vulnerable times. In regard to the boy problem, however, the poorer school attitudes of boys likely play a role in the bigger picture of lower achievement.

Of course, attitudes towards school are complex, and when children become more independent, they will develop different tastes for leisure time activities. Video gaming is, for many, a very attractive leisure time activity. Academic research shows that "pathological gaming" is almost entirely a male adolescent issue (Gentile 2009; Gentile et al. 2011). For example, (Lemmens et al. 2011, p. 45) state that "In general, pathological involvement with video games seems mostly restricted to adolescent boys. In line with previous findings, the vast majority of adolescent girls showed neither signs of excessive nor pathological gaming". Further, the authors state that these children's lives are disrupted by the displacement of other important activities, including learning and social contacts.

Further, the games are so easily available, typically on the same computer where our children need to do their homework, that it is easy to understand why children cannot withstand the temptation.

Social Causes

Boys are more likely than girls to drop out of school. While we may find it tempting to blame social situation or a possible lack of purpose and view on masculinity, or a lack of proper male role models for this, the situation is actually not that clear.

Some researchers have argued that the absence of fathers is a major issue (e.g., Flouri and Buchanan 2002; Santrock 1975), and there is some evidence that this affects boys more so than girls (Bertrand and Pan 2013). This may in part have to do with the fact that mothers more easily identify with their daughters than sons, the authors argue.

There have been multiple calls for more male teachers. Interestingly, parents view male teachers not only beneficial for boys, but also for girls (McGrath and Sinclair 2013). Research addressing whether boys do better with male teachers shows a different picture. A meta-analysis of Carrington et al. (2008) found that children taught by same-sex teachers do no better than others. Further, a study of 21 European countries found that boys do not benefit from male teachers in their reading and maths skills (Neugebauer et al. 2011). Last but not least, boys in Islamic countries often fall behind girls (Stoet and Geary 2013, 2015), despite often taught by male teachers. If male teachers really have such a positive effect on boys, one would have expected that boys are at least as good as girls in those countries.

Putting these studies together, one may argue that the male role model at home is much more important than a male role model in the classroom. That said, it might also be the case that the positive effect of at least some male teachers in a school may be that male teachers have better ways of dealing with boys because they have been boys themselves, and have experienced in childhood the "rough and tumble play" or "rough-housing" that is more common among young boys than girls (DiPietro 1981).

Finally, a study of college students in Norway concluded that social background and personal characteristics cannot explain why more boys drop out, though it is possible that the school system itself might cause this by treating boys and girls differently (Almås et al. 2016). Note that this study is mostly relevant to tertiary education, and that effects of social background on the boy problem appear important earlier on (Bertrand and Pan 2013).

Physical Causes

Lifestyle

A major problem playing into the boy problem is our increasingly sedentary lifestyle (Tremblay et al. 2011). We know that it is good for children to be physically active and run around between sessions of homework (Janssen and LeBlanc 2010).

English boys (in the 1990s) consumed similar amounts of alcohol as girls, and smoke less than girls (Sutherland and Willner 1998). Boys consume more energy drinks (Lee et al. 1999), which are largely banned in the UK for children under 16. The consumption of these drinks may well play a role in concentration problems and disrupted sleep patterns (Calamaro et al. 2012). Boys also are more likely to consume illegal drugs.

Finally, it should be pointed out that today's children are more at risk of interrupted sleep and lack of sleep due to mobile phones or other modern media. It is not entirely clear whether this affects more boys than girls. Some studies have reported that boys are more likely to have TV or game console in their bed room (Van den Bulck 2004).

Endocrine-Disrupting Chemicals

The exposure to a range of chemicals due to pollution and contact with plastics is responsible for disruption of the normal hormonal household, which in turn may influence attentional disorders, such as ADHD (Polańska et al. 2013). This is true for both boys and girls, although it affects boys and girls differently. For example, girls start puberty much earlier than in the past at least in part due to endocrine disruption. Sax (2016) argued that because girls start puberty earlier, the puberty-onset gap becomes larger—or in other words, the asynchrony in bodily development between boys and girls grows larger.

Why We Should Try to Resolve to Boy Problem?

Idealistic-humanistic reasons are based on the idea that it is simply unfair that one specific group underperforms. On the other hand, *utilitarian reasons* to tackle the boy problem are partially based on the idea that education is good for the economy (e.g., OECD 2014). Thus better educated boys will be in the interest of the common good. Furthermore, larger number of boys failing in school

increases the likelihood of them becoming involved in delinquency (Shader 2004). Finally, the lack of highly educated men causes a difficulty for women to find a partner with similar levels of education (Birger 2015).

Altogether there are many reasons to care about underachieving boys. There are, however, alternative views. There are those who argue that there is not really a boy crisis and who call the concern for boys falling behind "hysteria about boys" (Mead 2006). The argument is that both boys and girls have gained in terms of educational performance over time, but girls just more so than boys (Mead 2006). Therefore, it is argued that boys do not really have a problem.

Similarly, Reed (1999, p. 93) set out to "attempt to deconstruct the discursive complex around the subject of the 'underachieving boy', and to critique its composition and effects from a feminist perspective". Her main argument appears to be that the available data on the gap are too unreliable to draw the conclusion that boys fall behind. Further, she argues that "the current emphasis on boys' performance in schools might suggest that boys are disadvantaged when it comes to progress through employment hierarchies. In fact, it is still the case that a glass ceiling operates for women and, on average across the employment sector, men's pay is significantly higher than women's, with large number of women trapped in low-paid and part-time work" (Reed 1999, p. 97).

Another position is the one that views programmes to help boys as based on "anti-feminist", "homophobic", and "right wing" sentiments. (Jóhannesson et al. 2009). For example,: "The production of such global citizens is unlikely to occur when those who are the most privileged in a society are deemed to be victims, as with the way in which the boys' debate has developed and is developing" (Jóhannesson et al. 2009, p. 322). Similarly, the National Union of Students in the UK criticized the Higher Education Policy Institute's report (Hillman and Robinson 2016) which called the gender imbalance in university enrolment a national scandal. In response to this report, the NUS stated that the Higher Education Policy Institute had taken a complex issue and turned it into "a battle of the sexes". The underlying sentiment seems to be that as long as there are more males than females in top positions, there should be no institutional help for underachieving and underrepresented boys. This view ignores the problems of many boys. Further, this view ignores the fact that dealing with the boy problem not only benefits boys, but is also beneficial to women and the common good.

Even though dealing with these issues will be particularly beneficial to boys, there are certainly also girls that suffer from these problems. For example, even though fewer girls than boys have attentional problems (Sobeh and

Spijkers 2013) or a gaming addiction (Gentile 2009; Gentile et al. 2011), there is no reason why the girls that do have problems should not also benefit from the same programmes to help boys with these issues.

What Can Be Done

As noted earlier, there are *no simple solutions* to the boy problem, given that multiple factors play a role. That is particularly true because the boy problem is very broad—that is, we are talking about a problem that affects, potentially, half the population of school children. The larger the group one is speaking about, the more complex the solution will be, by definition. One way to deal with the complexity of solutions is to consider different classes of factors that play a role (as discussed in the previous section of this chapter).

The Cognitive Factor: Interventions Related to Sex Differences in Cognitive Development

There are numerous interventions to help children with the development of their language skills, including speaking, reading, and writing. Some of these problems are so obvious (e.g., stuttering) that they will typically lead to interventions, while other problem are just a matter of degree, and will only lead to direct interventions if children fall below a certain standard (e.g., attentional problems).

There are a few language-related approaches specifically targeted at boys. One of these is to provide boys with reading material they find interesting. Given that boys and girls often have different interests, it is important for co-educational schools to choose material that appeals to both boys and girls, where possible. Further, independent reading can be encouraged by providing boys with books they like; this includes specific fiction and non-fiction.

The National Literacy Trust wrote a review of children's reading habits and found that nearly twice as many boys as girls do not enjoy reading (Marsh 2015). Sometimes, boys are more sensitive to selected reading material than girls. For example, boys prefer books in which the main character is a boy, whereas girls do not have such a preference for the gender of the main character. In the past years, specific boy books have become more popular, and schools can help to add these to the existing library to increase boy's reading appetite.

Another important cognitive factor is that between the ages of 10 and 15, there are very clear sex differences in cognitive development (Dekker et al. 2013), with girls better in cognitive tests of goal setting. This is particularly relevant given that secondary education starts for these children. Children are given more responsibility, for example, in regard to home work. Boys will struggle more with this. A solution would be to give children more specific goals and less responsibility. Alternatively, being aware that many children are simply not yet ready for more responsibility can help teachers and parents to better support these children.

The Attitudes Factor: Interventions for Non-cognitive Factors Related to Learning

Boys and girls differ considerably in their attitudes to learning. For example, it is now well established that boys spend less time on their homework and show more behavioural problems at school. Dealing just with those two problems can make a considerable difference in academic performance and emotional well-being.

It is often argued that boys have a stronger need for "running around". Of course, this is good for all children, not just for boys. In any case, there are now more and more schools ensuring that children get an opportunity to move around, sometimes even in the classroom.

One reason why children do not spend enough time on their homework is because they have more interesting things to do. Boys are far more likely than girls to spend much time on video gaming. Schools and parents need to guide boys in this regard. Reducing access to video games can only be a positive thing. It is a major challenge, given the attractiveness of the video games. The addictive nature of these games combined with the needed time investment to master these games is most problematic—children not only spend too much time on them, they also do not get sufficient healthy exercise and fresh air. In other words, we are dealing with a combination of problems that can amplify each other.

The Social Factor: Interventions Related to Sex Differences in Social Attitudes

Boys and girls have different social attitudes. This is true at all ages, but of course, changes even more strongly after the onset of puberty. Boys in general take more risks to impress their friends and potential girlfriends.

While typically girls focus much on their looks to attain social status, boys focus more on specific behaviours to attain social status; some of this behaviour is undesirable and interferes with education. This is something that really makes boys' lives harder (even when they might not be aware of that themselves at that age).

One approach to deal with this for parents and schools is to guide boys' desire to show off through leisure activities with a competitive element, which includes but is certainly not restricted to sport.

It is important for society as a whole to create sufficient opportunities where boys can thrive, and this is often problematic in densely populated cities, where there is less time for sports and more opportunity for problematic behaviour.

One of the paradoxical situations is that while boys are interested in showing off, they rarely do this in academic efforts. It would be helpful if boys could be encouraged to do so, but often boys do not think this is "cool". To some degree, a boy can gain more peer admiration by doing something that crosses social norms and is risky—doing this may be a way to gain group status, display independence and strength. In the stone age, these would probably have been desirable traits, but in the modern densely populated and built-up world, the risks are different.

Some have argued that a solution to the boy problem might be single-sex schools. For example, in single-sex schools, post-pubertal boys and girls may influence each other negatively. One of the strong proponents of this has been Sax (2016), citing differences in brain and sensory mechanisms. At the same time, this view is heavily criticized by others who argue that the differences between boys and girls are modest (Eliot 2013; Halpern et al. 2011). In response to Halpern et al. (2011), Park and colleagues (2013) pointed out that their own work clearly showed benefits of single-sex education in Korea, where children have been randomly assigned to mixed or single-sex schools. The latter is extremely relevant, given that the benefits of single-sex schools are often indistinguishable due to selection (e.g., in the UK, single-sex schools are rare and often attended by children with a higher socio-economic status, which in itself is a good predictor of performance). In a more recent study of Korean data, Sohn (2016) argued that benefits of single-sex education are small. Further, Saudi Arabia is a good example of a country in which boys are not only taught in single-sex schools mostly by male teachers. The boy problem in Saudi Arabia is, however, particularly large. In short, there is at this point too little evidence to claim that single-sex schooling would resolve the boy problem.

The Physical Factor: Interventions Related to Physical Health

Education is a mental activity. And yet, as we have seen before, mental activity requires a healthy lifestyle. You will probably have heard or read that especially boys need sufficient time to "release their energy" through physical activity. The reality is that today's children just do not get enough physical activity (Salmon et al. 2011). This is clearly reflected in today's obesity rate among children in the UK and other countries—nearly a third of British children between 2 and 15 years old are overweight or obese (Health and Social Care Information Centre 2015).

This is relevant to the boy's problem, because boys suffer more than girls from a lack of activity (Haapala et al. 2014). It is also the case that the rate of obese English boys is higher than that of girls from a young age, and rises to a 4% point difference at the end of primary school (22% boys vs 18% girls at age 10–11 are obese; Baker 2018). That said, not all studies found reliable gender differences in moderate exercise (Norris et al. 2018).

When it comes to the physical factor in the boy problem, it is not just physical activity that counts. Another important factor is sleep. Children require more sleep than adults. For example, a 15-year old still requires 9 hours of sleep. Today's 15-year olds often sleep less than 9 hours. This is true for both boys and girls due to modern media.

Caffeine has tended to evaded people's attention as a psychoactive substance (Calamaro et al. 2009). Caffeine is an addictive stimulant that affects cognitive functioning and attention, and which is associated with unpleasant withdrawal symptoms (Nehlig and Boyet 2000). Caffeine, and caffeine withdrawal symptoms, directly interfere with concentration and sleep patterns (Calamaro et al. 2012). Studies consistently find that caffeine consumption is greater among boys than girls (Lee et al. 1999). It is mostly consumed through soft drinks, and boys consume these more than girls (Harnack et al. 1999). A solution to this problem might be to regulate the sale of high-caffeine drinks to those over the age of 18 (as has is now the case in parts of the UK). Additionally an information campaign is necessary to inform parents and teachers about the risks of caffeine.

Parents and schools can help with instilling a healthy lifestyle in children. It is important to control children's access to digital media, and also to give a good example.

Further, adolescents are likely to fall victim to alcohol and drugs, some of which again can be more of a problem for boys than for girls. For boys there is a stronger "showing off" and risk-taking factor involved. In the past

years, much progress has been made to raise the awareness for the risks of these products, but for children, such messages are difficult to understand and far from their lived experience. Therefore, explaining the long-term benefits of abstaining from alcohol and drugs need to be better explained, and probably more regularly. Further, society needs and can do more to reduce access to such products.

Finally, the role of endocrine-disrupting chemicals has been mentioned. There are no simple solutions to deal with that. Ultimately, only governmental regulation can resolve this issue, and there is indeed a growing awareness about this.

Concluding Remarks

The average boy does not do as well as the average girl in school. As a consequence, far fewer boys participate in the A-levels and tertiary education. We know that young males are far more likely to be unemployed than young females. This is an issue that needs addressing, but there are no simple solve-it-all solutions. Instead, many different factors play a role, and each of them needs to be addressed. For example, it is currently not entirely clear what British boys do instead of A-levels and tertiary education—we need to find out so that we can ensure that boys get the best opportunities for future satisfactory employment.

So far, there has been little governmental attention for the boy problem. The government could have a real impact by giving more attention to the various issues affecting boys more than girls. Further, solving the boy problem will require a cultural change on how children are raised in a world so full of readily available forms of entertainment, in particular digital; parents and families need to be strongly involved in a solution.

Finally, I would like to point out that there are also girls at risk of the problems listed in this chapter. The most equitable way forward is to create problem-centred solutions. To me it seems unfair and unethical to exclude girls from programmes to help with a number of specific problems boys suffer more from, just as it is unfair and unethical to exclude boys from interventions in areas in which girls do need more help than boys (e.g., encouragment for STEM subjects). Thus, we need to make sure that we give more attention to the problems boys suffer from, but we should not exclusively see this as more attention *for boys*, but rather as attention *for specific sets of problems*. That way, everybody will be a winner!

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Deconstructing Dad

Robin Hadley

Introduction

The global trends of declining fertility rates and increasingly ageing populations have been extensively documented (Kreyenfeld and Konietzka 2017). Because of the demographic, economic, and social transformation, there have been significant changes in the morphology of families. Families have become 'beanpole shaped' (Bengtson 2001, p. 6) with increased vertical (grandparent-parent-grandchild) ties and reduced horizontal or lateral (siblings, cousins) ties (Dykstra 2010). Moreover, the way people 'practice family' is complex, as kith and kin relationships change with time and circumstance. The range of familial forms has moved on from the traditional 'nuclear family' to include different types such as: bio-legal, chosen, claimed, fictive, genetic, and reconfigured families (Jones-Wild 2012). It is only relatively recently 'childlessness' has been recognised as a substantive research subject in the social sciences. Previously, many social scientists had focused on childbearing age, fertility rates, family formation and practices, relationship dynamics, social networks, and marital status (Dykstra 2009).

Historically, the discussions surrounding reproduction have centred on women and 'maternal processes' (Hinton and Miller 2013, p. 248). Subsequently, the vast bulk of socio-cultural discourse has focused on women and their experiences (Culley et al. 2013; Marsiglio et al. 2013).

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Concomitantly, there has been a failure to examine men's experiences of reproduction. Consequently, Inhorn et al. (2009) argue that men have become the 'second sex', in all areas of scholarship concerned with reproduction. Moreover, Inhorn (2012) reasons this is because of the 'widely held but largely untested assumption' that men are not interested and disengaged from, reproductive intentions and outcomes (Inhorn 2012, p. 6). There is a vast canon of material surrounding motherhood and an increasing volume on non-motherhood (Letherby 2012) and fatherhood (Miller and Dermott 2015). By comparison, there is a paucity of material concerning *not* being a father.

Definition of Terms

The construction of parenthood as natural, unconscious, and spontaneous reinforces traditional gender roles with women defined as childbearing/nurturing and men as providing/protecting (Connell 1995; Lupton and Barclay 1997; Morison 2013). Childlessness involves individuals negotiating two core socio-cultural traditions: pronatalism (idealisation, promotion, and veneration of biological parenthood) and heteronormativity (the primacy of heterosexual and biological family practices). 'Childless' adults have been often viewed as a binary of 'voluntary' or 'involuntary' childlessness (Allen and Wiles 2013). However, the childless are a heterogeneous group whose members form a 'continuum of childlessness' (Letherby 2010; Monach 1993) with distinct groups at either end. Others locate themselves at different points at different times as personal circumstances change. In addition, many research studies have used terms such as 'infertility', 'voluntary' and 'involuntary' 'childlessness', 'childless' and 'childfree' inconsistently and without discretion (Beth Johnson Foundation/Ageing without Children 2016; Letherby 2010). Many studies have included a conflagration of the never married, expected-to-be-childless, childless-by-choice, childless-by-circumstance, those who have outlived children, or whose children have left home (Dykstra 2009; Murphy 2009). Terms such as these carry both positive and negative connotations depending on context, intent, and location. Parents may become 'functionally childless' through geographical absence, bereavement, estrangement, miscarriage, and stillbirth (Allen and Wiles 2013, p. 215). Familial disruption and estrangement is a significant issue for many people including those who are viewed as not conforming to socio-cultural pronatalist and heteronormative traditions. For example, the experience of many gay, lesbian, bi-sexual, and trans- people (LGBT) highlight the embeddedness of generational and socio-cultural inequalities

(Westwood 2016). I acknowledge the complexity surrounding many of the terms related to childlessness and ask the reader to bear them mind.

Family and Fatherhood

The majority of societies prize men who are virile, strong, and fertile with biological fatherhood holding significant symbolic status (Elliot 1998). Over the last few decades the topic of fatherhood has been subject to increased scrutiny in Western societies (Miller and Dermott 2015). Men report an interconnected range of themes which influence their wish for fatherhood: appropriate age/stage; company in later life; fulfil role; genetic legacy; give pride and/or pleasure; match siblings and peers; relationship culmination; and status confirmation/enhancement (Hadley and Hanley 2011; Owens 1982; Throsby and Gill 2004). Fatherhood is an important component of social structure that assigns 'rights, duties, responsibilities and statuses' via cultural, legal, and societal precepts (Hobson and Morgan 2002, p. 11). Fatherhood encompasses three discrete types (Morgan 2004): 'Father' (biological or social) is the specific relationship between a man and a child. 'Fathering', refers to everyday parenting practices while 'Fatherhood' describes the socio-cultural conceptualisations of being a father. The complex interaction between father, fathering, fatherhood, grandfatherhood, personal, familial, and socio-cultural practices and policy has been increasingly acknowledged (Brannen and Nilsen 2006; Hobson and Morgan 2002).

In many societies views of men's parenting roles has moved on from the traditional 'provider/disciplinarian' to an ideal of 'involved fatherhood'. In this form of parenting men are encouraged and expected to be both intimate and involved parents. However, a number of studies have highlighted the tensions and limits between cultural expectations and conduct surrounding 'involved fathering' ideals (Ishii-Kuntz 1995; Miller and Dermott 2015). Gatrell et al. (2015, p. 235) demonstrated how contemporary fathers struggle to balance breadwinning and 'the need, or desire, to engage in childcare'. Moreover, 'stay-at-home-dads' (SAHD's) reported strong social pressure to conform to the traditional provider role (Shirani et al. 2012). However, active involvement in home life and childcare has been found to be fundamental to fathers' sense of identity (Shirani et al. 2012, p. 279). Nonetheless, some 'new fathers' reported their work relationships improved because they 'could share that experience' (Goldberg 2014, p. 158). Socio-cultural and economic change has been shown to have influenced fathering practices between generations: younger men expect to be included in child

care (Brannen and Nilsen 2006). In the USA, fatherhood has been shown to significantly positively affect both social and community engagement—including older men whose children have left home (Eggebeen and Knoester 2001, p. 387). In contemporary families grandparents increasingly occupy an important role in providing care with, on average, a greater number of older adults being grandparents, for longer, to fewer children (Timonen and Arber 2012, p. 3). Research into grandparenthood has until recently focused on grandmothers (Mann 2007). However, contemporary research has highlighted the contradictory and complex role of grandfatherhood in familial practices. Particularly in the event of family estrangement (Tarrant 2012).

Childlessness

Much health-research views men and women in stereotypical gender roles: the former as provider/breadwinner and the latter as nurturer/carer. For women, there is an ubiquitous association of motherhood to women and concomitant exclusiveness of reproductive interventions to the female body (Throsby and Gill 2004). Consequently, women's health has been heavily associated with familial circumstances while men's health has not been associated with relational or parental activities (Weitoft et al. 2004, p. 1449). Studies that report differences between the health of parents and 'childless' people tend to be based on census, health, mortality records, and have highlighted the poor health outcomes for the latter (Dykstra 2009; Kendig et al. 2007; Weitoft et al. 2004). In addition, older men in relationships have better health and socio-economic outcomes than solo-living men of equal status (Dykstra and Keizer 2009; Keizer et al. 2010). However, Dykstra (2009, p. 682) argues that childlessness is seen as a 'non-event' and treated as 'non-category'. As a result, data on childlessness has seldom been gathered.

In the United Kingdom (UK) The Human Fertilisation and Embryology Authority (2014, p. 15) report that in 2013 74.4 percent of all In Vitro Fertilisation (IVF) treatments failed to result in a live birth. The diagnosis of actual or potential infertility has considerable implications for mental and physical health, social stress, relationships, and wellbeing (Fisher and Hammarberg 2017; Greil et al. 2010; Lee 1996). The psychological effects of male infertility have been measured at a similar level to those suffering from heart complaints and cancer (Saleh et al. 2003). Those for whom IVF treatment is unsuccessful are classed as 'involuntarily childless'. It is problematic to precisely identify the population of people who are involuntarily childless because people who do not seek treatment are not recorded (Boivin et al. 2007;

Monach 1993). The failure to account for non-treatment seekers has led to the criticism that much infertility research cannot be generalised to the wider population (Greil et al. 2010, pp. 142–143). Involuntary childlessness may also result from social contexts and more people are defining themselves as 'childless-by-circumstance' (Cannold 2000). Circumstances that affect reproductive intentions and outcomes include age, class, economics, education level, occupation, location, and sexual orientation. Moreover, socio-cultural expectations and life course factors such as early years attachment, the timing of exiting education, entry into the workforce, and relationship formation and dissolution also significantly influence people's fertility decisions. Financial considerations, partner selection, life satisfaction, age, and men's attitude to family, health, women, work, and leisure all influence procreative decision-making (Hadley and Hanley 2011; Hadley et al. 2018; Parr 2007, 2010; Roberts et al. 2011).

A significant element in the falling fertility rate is the increased age of women having their first baby (Berrington 2015; Kreyenfeld and Konietzka 2017). Commonly, the 'biological clock' has been viewed as main determining factor in women's procreative decision-making. However, Cannold (2000, p. 415) identified the important influence of a 'social clock' on women's fertility intentions. Cannold's (2000) social clock was formed by the attitudes of family and friends, and socio-cultural factors such as age/stage, economic considerations, and partner suitability. Generally, men have been reported both as not concerned about fatherhood and as fertile from puberty until death. However, social clock factors also influence men's procreative intentions and outcomes. For example, men have reported their awareness of a biological urge and a sense of running out of time to become a father deepened from their mid-30s onwards. In addition, men also described feeling being 'off-track' compared to peers and expressed concern regarding how age would affect the quality of their interactions with any future offspring (Goldberg 2014; Hadley 2008; Hadley and Hanley 2011). Moreover, there is growing recognition of the correlation between older fathers and babies born with genetic issues (Goldberg 2014, pp. 19–20; Yatsenko and Turek 2018). An international literature review found that psychological stress, age, alcohol consumption and smoking negatively affected semen quality (2011). Furthermore, less than 2% of fathers of birth registered in England and Wales in 2016 were aged over 50 (Office for National Statistics 2017). Nonetheless, there has been little attention paid to how men experience and negotiate the 'male procreative social clock'.

In Europe it is estimated that approximately 25% of men are lifetime childless compared to 20% women (Tanturri et al. 2015). In the UK it was not possible

to supply a national estimate of the level of childless men because male fertility history, unlike women's, is not recorded at the registration of a birth (Office for National Statistics 2014). Recent analysis of two British cohort studies found that, at age 42, 25.4% of men and 19% of women had no biological children of their own (Berrington 2015). A number of factors account for the absence of men's fertility outcomes. First, the historical attitude that fertility and family formation are relevant only to women (Greene and Biddlecom 2000). Second, there is a structurally embedded view that men's data is unreliable and difficult to access (Berrington 2004). Finally, in the vast majority of countries data on men's fertility history or intentions is not collected. Only collecting female fertility intention and/or history data reinforces the veneration and promotion of pronatalism: reinforcing ideal types of womanhood equalling motherhood and manhood as successful virility (Hadley 2018b; Letherby 2002a).

There has been a wide-ranging debate in the feminisms regarding reproduction encompassing Assistive Reproductive Technologies (ART), family, motherhood, and non-motherhood (Letherby 2012; Tong 2009). Tong (2009, pp. 2–4) argues all feminist perspectives hold a view on reproduction from those who consider reproductive technology as a means of liberation and control, to those who contend 'biological mother hood is the ultimate source of women's power'. Moreover, it was feminist researchers investigating the effects of ART, who identified the invisibility of men's experience. Furthermore, they highlighted the impact infertility treatment had on men's perceptions of their masculinity, their emotions and identity and their place in society (Letherby 2002b; Throsby and Gill 2004). Conversely, Masculinities literature seldom acknowledges the impact infertility has on a man's identity. For example, infertility is absent from Connell's (1995) pivotal book. Similarly, the *Handbook of Studies on Men and Masculinities* (Kimmel et al. 2005) has no reference to age, ageing or grandfatherhood. Research examining masculinity has concentrated on younger men in education, crime, employment, the body, sexuality, and fatherhood (Arber et al. 2003; Inhorn et al. 2009). More recently there has been a broadening of approaches from the 'single model of unified masculinities' (Morgan 2002, p. 280) to views that see masculinities as adaptive, emergent, and fluid over the life course (Coles 2008; Inhorn 2012; Simpson 2013).

The change in fertility trends over the past half-century has led to an exploration of the factors that influence fertility behaviour, decision-making, and parenthood motivation (Langdridge et al. 2005). Measures evolved from a 'cost–benefit' approach to include attitudes and intentions (Schoen et al. 1999). Schoen et al. (1999) found that fertility intentions were reliable predictors of fertility behaviour. A postal survey study

measured the fertility intentions of 897 childless married couples (excluding those pre or post infertility treatment) in the UK (Langdridge et al. 2005). This study uniquely accounted for the fertility ideations of both female and male 'intenders' and 'non-intenders' (Langdridge et al. 2005, p. 125). 'Intenders' cited aspiration and bond with child, centrality of the family, bond between parents, and give love, as main reasons with male respondents also highlighting 'biological drive' as a motivational factor. This finding has been supported in a study to find if the common perception that women were 'broody' (desired motherhood) and men were not bothered was valid. An online survey was deployed to measure the level of broodiness between women and men, non-parents and parents (Hadley 2009). The results revealed that a higher number of childless men desired parenthood (51.9%) than did not (25.9%). Non-parents showed similar levels of desire for parenthood, with women indicating slightly more than men. Women and men parents demonstrated an equal desire *not* to repeat parenthood. Cultural and family expectations were common influences for both non-parents and parents. 'Biological urge' and 'societal duty' were statistically significant for men who were parents: non-parent men, although just missing the $p = 0.05$ standard, indicated 'personal desire' and 'biological urge' ($p = .061$). Non-parents were more affected by 'Yearning', 'Sadness', and 'Depression' than parents. Non-parent men had the highest reactions to 'isolation' and 'depression'.

Male Childlessness

The childless 'are vulnerable - a group at risk of social isolation, loneliness, depression, ill health and increased mortality' (Dykstra and Hagestad 2007, p. 1288). A tri-country study identified links between older childless people and poor health behaviour (Kendig et al. 2007). Compared to men with partners, formerly married childless men's behaviour included depression, excessive smoking and drinking, sleeping difficulties and worse physical health. A Swedish study identified lone non-custodial fathers and lone childless men's 'emotional instability and willingness to take risks' as a factor in their increased risk of death through suicide, addiction, external violence, injury, poisoning, lung and heart disease (Weitoft et al. 2004, p. 1457). Psychological studies into childlessness are mostly based on those who have sought infertility treatment and focused on the early stages of adjustment to infertility. Webb and Daniluk (1999, p. 12) found that pre-diagnosed infertile men 'felt pressure from society, family members, friends and partners to

have children' and that being a biological father was a tradition and a right. On receiving a diagnosis of infertility, the men felt infertility confronted their masculinity: 'grief, powerlessness, personal inadequacy, betrayal, isolation, threat and a desire to overcome, survive and positively reconstruct their lives'. An international review of anthropological studies demonstrated how male infertility had a significant effect on masculinity, 'Men who fail as virile patriarchs are deemed weak and ineffective' (Dudgeon and Inhorn 2003, p. 45). However, Fisher and Hammarberg (2017, p. 1298) argued that compared to community norms only infertile men with 'acute and situation-specific anxiety' had clinically significant psychological symptoms. Men are said to experience greater existential stress over involuntary childlessness than women (Blyth and Moore 2001). While Yalom (2008, p. 9) argues there is a 'longing to project oneself into the future…biologically through children transmitting our genes'. The behaviours stereotypically associated with masculinity—emotional detachment, denial of emotions, risk-taking, aggressiveness, objectivity, and control (Lee 2003)—have been linked to a fear of intimacy and emotional vulnerability (Vogel et al. 2003), However, Wong and Rochlen (2005) argue that men have the same emotional experience as women, but lack the resources to express their feelings. Furthermore, many men are socialised to perceive the expression of emotions as a weakness. Consequently, emotional inexpressiveness has become an ideal for, and an expectation of, many men.

Discussion

The lack of literature and research on childless men has implications for a range of stakeholders: policymakers, academics, social and healthcare service providers, and mental and physical health practitioners. Lohan (2015, p. 215) highlighted how men are absent from the literature 'on family planning, fertility, reproductive health and midwifery'. However, within the large quantity of infertility literature there is an increasing acknowledgement of the impact of infertility has on men. The growth of social media has led to a large range of grassroots support and campaign groups giving voice to different aspects of childlessness. Many of the groups highlight the need for men's experiences to be acknowledged and actively campaign for men's experience to be acknowledged by policy and health institutions.

As noted earlier men's fertility, outcomes are excluded from national datasets and this feeds a significant absence in terms of policy. The relationship between womanhood and motherhood is maintained through only collecting the data on women's fertility intentions and outcomes.

By not documenting men's fertility intentions and history, the masculine ideal remains unchallenged within institutional structures. For example, Daniels (2006) highlighted how the USA government were unwilling to fund studies into the effect of toxins on sperm compared to similar studies on women's fertility. Daniels work highlights how 'ideal' types of manhood and womanhood are embedded in social structures. Lloyd (1996, p. 451) drew attention to how the very low male participation rates in infertility research had been 'condemned to be meaningful' without any grounds to justify the denunciation. There is emerging evidence that health professionals negatively view men who do not conform to masculine stereotypes (Dolan 2013; Robertson 2007; Seymour-Smith et al. 2002). Fathers reported 'a lack of support from healthcare practitioners and government policies' (Machin 2015, p. 36) with a notable absence of support from NHS staff before and after the birth (ibid, p. 48). A literature review of infant feeding found that men felt excluded and isolated from perinatal processes as evidenced by non-inclusion in antenatal classes and a lack of advisory material for fathers (Earle and Hadley 2018).

The absence of men's lived experiences from academic studies has also been observed despite the volume of discussion surrounding 'masculinities'. Hearn (1998, p. 768) highlighted how men's non-existence in social science theory and everyday life: 'men are implicitly talked of, yet rarely talked of explicitly. They are shown but not said, visible but not questioned'. Morgan (1981, p. 96) highlighted the 'taken-for-grantedness' of embedded gendered social relations in the social sciences. He (Morgan 1981, p. 93) argued that men's gendered experience was ignored because they were used as a standard: 'men were there all the time but we did not see them because we imagined that we were looking at mankind. He recommended '…taking gender into account is "taking men into account" and not treating them – by ignoring the question of gender – as the normal subjects of research' (ibid, p. 95). Connell's (1995) widely quoted concept of 'hegemonic masculinities' has been criticised for essentialising men into a static and limited typology and not reflecting 'ever-changing social strategies' of men's performance of gender (Inhorn 2012, p. 45). Moreover, as only a fraction of men achieve the dominant ideal most men 'often feel *powerless* rather than *powerful*' Bennett (2007, p. 350. Original italics). Moller (2007, p. 266) contends hegemonic masculinities restricts the understanding of masculinity to specific framework of 'domination, subordination, and oppression'. Studies reporting on 'hegemonic masculinities' have often focused on power and structure and not accounted for the ways physicality and embodiment interact with gender practice over the life course (Calasanti and King 2005; Inhorn 2012).

Furthermore, Hearn (2004, p. 59) proposed a move from hegemonic masculinity to 'go back from masculinity to men'. As Kaufman (1994, p. 152) advocates 'there is no single masculinity or one experience of being a man'. Failing to account for the existence of men who do not reproduce highlights a significant absence of critical insight by scholars of men and masculinities.

Compared to the literature that demonstrates the changes and trajectories over the lifespan in parenthood and family life (Umberson et al. 2010) there is little consideration of the pathways 'childless' people navigate across the life course (Allen and Wiles 2013). Therefore, exploring the timing of events, roles, expectations, and age is central in understanding the behaviours of 'childless' men. The majority of lifespan models regard development as complete on entering adulthood with the exception of Erikson, whose model encompasses the complete life span (Grenier 2012; Laceulle 2013). Erikson and Erickson's (1997) seventh stage theorised the significance of 'adulthood' (generativity versus stagnation) in middle and late adulthood (Erikson and Erickson 1997; Brown and Lowis 2003). This stage is commonly associated with parenthood and with 'establishing and guiding the next generation' (Erikson 1964, p. 267) and acknowledges the wider societal and temporal context. The eighth stage, 'maturity' (ego-integrity versus despair) is characterised by a retrospective acceptance of life as it has been lived and that death will occur in the near future. Failure to achieve, or retain, ego-integrity results in despair (Brown and Lowis 2003; Erikson and Erickson 1997). Not achieving parenthood directly impacts on men and women's generativity and can be linked to the feelings of 'outersiderness' and loss reported by involuntarily childless people (Hadley 2018a, b; Letherby 2002a, b, 2010).

Much infertility literature concentrates on the 'acceptance' or the 'resolution' of an individual's involuntary childlessness. Letherby (2012, p. 10) argues that the losses and absences that are implied with the terms 'infertility' and 'involuntary childlessness' do not reflect the difficulties people experience. The acceptance of non-parenthood involves navigating a complex bereavement that involves losses around; existential meaning; substantial emotional and biographical processing; and relational dynamics (Daniluk and Tench 2011; Greil et al. 2010; Lee 2003; Letherby 2012). Doka's (2002) concept of disenfranchised grief acknowledges how social and cultural norms may deny support, ritual, legitimation, public and private recognition of a person's loss (Corr 2004, p. 40). Complex bereavement and disenfranchised grief are both associated with infertility and by extension, apply to those who are childless-by-circumstance. For men, the losses surrounding fatherhood include the potential father–child relationship, the role of father

(and later grandfatherhood), access to social scripts, exclusion from the intimate parent-child-family bond and associated wider social relationships, and community engagement (Earle and Letherby 2003; Hadley 2018b; Hadley and Hanley 2011).

It is important for academics, practitioners, and professionals to acknowledge how 'Childlessness is a shifting identity within various storylines across time and circumstances' (Allen and Wiles 2013, p. 208). Dalzell (2007, p. 67) identifies that within psychotherapy 'the heteronormative constructs of family-parent prevail'. The outdated notions that men are unaffected and not interested in reproduction are 'false and reflect out-dated and unhelpful gender stereotypes (Fisher and Hammarberg 2017, p. 1307). Fisher and Hammarberg (ibid.) identify that 'infertility specific anxiety' is common among men (or whose partners) are being investigated or under treatment. Moreover, they advise that 'men prefer to receive psychologically informed care from the infertility treatment team to specialist psychological care' and recommend that therapist have the training skills to 'manage intense psychological distress and interventions to enhance couple communication' (Fisher and Hammarberg 2017, p. 1287). Nelson-Jones (2006, p. 438) suggests therapists examine men's perceptions of their role. He proposes that men's therapy uses some of the goals of feminist therapy including a client 'valuing himself on his own terms, gaining freedom from sex-role stereotypes'.

The challenge for therapists is to recognise that the effects of childlessness are unique to the individual and shapes their interactions on many levels. For example, male factor infertility draws pejorative reactions and compromises both social and self-identity. As Yalom (2008) identified reproduction is a significant existential element of identity. Not becoming a father can make engaging with others difficult because men are validated by successful virility in all arenas: biological, social, and economic. The cultural implications of not reproducing was highlighted by Dyer et al. (2004, p. 963). Their study demonstrated how infertile South African men were viewed and treated as lesser: 'you are a man because you have children'. Similarly, Jager (2015) described the issues he and others have faced negotiating the stigma of childlessness in Judaism. Inhorn's (2012) anthropological study highlighted how Middle Eastern men were rejecting traditional practices by engaging with ART and pharmaceutical technologies in order to fulfil their cultural agenda.

The research methods used to collect and analyse data on childless people for the most part are quantitative surveys. However, sample sizes are relatively low and generalisability limited. Many attitudinal surveys of reproductive intentions are delivered on university campuses and in different

countries. Issues arise regarding socio-economic and cultural generalisability. The majority of childlessness studies are based on people who are pre, during, or post ART treatment. Many studies have a far greater number of female respondents than male. This is accounted for because the majority of ART treatment is centred on the female patient with whom many practitioners and researchers form a strong relationship. Men often report feeling excluded from ART treatments. This highlights the issue of power in the research process: patients may comply with requests because they think that access to treatment will be dependent on participation. Men are still often castigated for non-participation and their reactions written-off as 'typical man'. There is some inequality here as women who do not participate are not viewed in the same manner (for example see, Hadley 2014). There are a growing number of qualitative and mixed-methods studies. Again, there are issues concerning sample size, generalisability, and verification.

Conclusion

Parenthood is seen as 'natural' for women and 'learned' for men (Blyth and Moore 2001; Letherby 2010). However, the social scripts that the men have access to are limited. Moreover, men may view their childlessness as a 'secret stigma' (Whiteford and Gonzalez 1995). Therefore, male involuntary childlessness may be viewed as a discreditable attribute compared to the 'master status' of fatherhood—a prestigious status that 'overrides all other statuses' (Becker 1963, p. 33). The voluntary and involuntarily childless are stigmatised, and subject to social disapproval, both medically and socially because they challenge the dominant traditional pronatalist cultural norms of most societies. The assimilation of social media into everyday social activity is a recent arena that the childless have to negotiate. I argue that involuntary childless men do have an emotional and long-lasting reaction to not becoming a father. However, there is a lack of recognition of how the loss of identity, role, and emotional experience affects men. Moreover, there is little societal resource available for the men to draw on for support. Involuntarily childless men often use the term 'missing out' to describe their feelings and thoughts. Even those who had gone through infertility treatment use the word 'missing' rather than loss, bereavement or grief (Hadley 2015, 2018b). In addition to 'missing out' in an important element of their expected identity, involuntary childless men are 'missing' from significant social structures: academia; government (national and world); health and social care; and wider social discourse. It is time to listen and mark our words—for we are legion.

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The Impact of Father Absence on Child Mental Health: Three Possible Outcomes

Andrew Briggs

Introduction

This chapter is a discussion of three mental health related outcomes for children and young people when their father is absent. These outcomes are: ADHD, self-harm and sexually inappropriate behaviour. By absent father I mean a father who may be physically present within the child's life but is psycho-emotionally or physically unavailable for his children. Whichever way he absents himself, or is made absent from the family, in itself has an impact upon his children's development. However, the point of this chapter is to discuss mental health outcomes that specifically derive from the relationship the mother has with their children once the father is absent. This relationship may even be a cause for the absence of the father. The chapter starts with a brief discussion of absent fathers and then moves on to discussing the child and mother relationship. The final section draws on clinical material from my thirty-five years work within English NHS Child and Adolescent Mental Health Services (CAMHS) that helps us understand the importance of a father's absence on the emotional well-being and mental health of his children. The clinical material comes from psychoanalytic consultations and psychotherapy with mothers and their children. It demonstrates how effective work of this nature within the child/young

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person–mother relationship can lead to a significant amelioration in the symptoms presented by the child/young person.

Absent Fathers

The positive impact of a present father on the development of their children is well documented in the research literature of neuropsychology, psychobiology, and various disciplines within psychology. I have no space here to present or discuss this, so will simply mention several recent examples, representative of the clinical and research concerns of those interested in absent fathers that illustrate the need for fathers being present.

The Need for a Present Father

In a recent article Allan Schore (2017) demonstrates that between eighteen and twenty-four months fathers play a fundamental role in regulating the aggression of their children of both sexes. Rough and tumble play between many fathers and their children especially helps boy toddlers control their testosterone-induced aggression, through imprinting their left brains. This aspect of the role of fathers allows for their children to develop into self-regulated young people in society. In his earlier book Schore (1994), reviewing neurobiological research on mother–infant attachment, saw infants being in a very difficult situation when their mothers are depressed. Because of the unpredictability of her responses the infant's responses mirror this. The mother then begins to withdraw. Because of the infant's need for a reliable attachment figure, in order to develop neurobiologically, socially and emotionally, he turns to the father. The absence of the father in this scenario would be near catastrophic. Nicholas Davidson (1990) presented data for preschool adolescent children admitted as psychiatric patients to hospitals in Canada, South Africa, and Finland. Eighty per cent of these came from homes without fathers.

Father and Fatherhood: Towards a Definition

For conceptual and clinical purposes, I am referring to the father as the biological male who was part of the conception of the child. These fathers (biological fathers) may later become absent through death, estrangement from their partners and families, through the children being adopted or taken into care, or through the original plan (implicit or explicit in either father or mother)

being to only provide the mother with sperm. Explicitly planned acts as sperm donor include the assisted pregnancy of usually lesbian or transsexual couples, and the surrogate mother for gay couples. I have found it useful to see the biological father as the father, and anyone else taking the role of father as actually being in a paternal role. This makes use of the psychoanalyst and psychiatrist Wilfred Bion's (1959, 1962, 1965, 1970) differentiation between maternal and paternal functions, which he did not cite as gender specific. Thus, a biological father can offer both a maternal and paternal function to his children, as can an adoptive male or female in the parental role. So too can a foster father or mother, and either partner in same sex or transsexual couples with children.

The Role of the Father

In the psychoanalytic literature the role of the father is as follows:

- To protectively embrace the mother and baby
- To provide a buffer for the mother from the potentially overwhelming needs and demands of their baby
- To enable a necessary developmental separation of baby from mother.

When the relationship of the mother and infant is troubled the role of the father—as protector of both mother and infant, and as enabling some separation of them—is *critical* to the infant's development. Indeed, a father who is emotionally available to the infant and mother, and can hold the infant in mind, can provide the physical and emotional holding of the infant normally associated with an emotionally available mother. However, this is rarely the case for the children and families that are the focus of this chapter. Often the mother is emotionally available enough but has such a poor view of fathers that she does not know (or would not allow herself) to rely upon her partner, whether or not he is emotionally available. This is a double negative as far as the infant's development is concerned. For those infants where the father is physically absent this double negative also applies. Before discussing the three outcomes of an absent father I want to spend a few moments thinking about what the emotional availability of the father means in terms of development.

Father's Presence

As the infant begins to recognise that its mother has a relationship with someone other than him the father begins to become important in development in a different way. This is often termed *triangulation* but in

psychoanalytic theory and practice this term has a different meaning from that used by family therapists and others.

In order to begin moving towards establishing an individual identity, and then physical and emotional independence, the human infant begins by seeing the father ***in*** him or herself. This person is seen as different to him/her and to the mother, not least because he is a physically different entity and cares for the infant differently than the mother. The infant then recognises that he has a relationship with mother and with this other one (father). He has two relationships. He then notices that father has a relationship with mother. This he recognises as a relationship he is excluded from. Soon he can put together that these two have a relationship that he is excluded from, but has a relationship with both individually that excludes one of them at the time. This is one way psychoanalysts see the birth of learning for humans. Whilst they may have laid the foundations of a mind through the initial realization that their need for sustenance can be met through a cry, and the arrival of a nipple on the end of a breast or bottle, it is the recognition of difference and exclusion that begins the process of taking in information from sources outside of oneself and the mother–infant dyad. This is triangulation.

Fathers therefore have a critical part to play in the development of their children. Partly it is the protection of the mother–infant dyad, partly it involves the protection and maintenance of the nuclear family as a unit (thus the other children in the family are included), and partly it is about providing early experiences of difference and healthy exclusion for the infant, and maintaining this as the infant develops through adolescence. As with their role as providers of rough and tumble (see above), fathers are there to help their children repress those emotions and impulses that are too dangerously anti-social, and to help them learn to self-regulate other emotions. *It is all this and more that is not present when fathers are absent.*

Children with Absent Fathers: Their Relationship with Their Mothers

During my time in CAMHS I saw several thousand families, over half of which had no father present during the work. This is for several reasons. Firstly, clinic opening hours are not favourable to fathers attending if they are the major breadwinner. Secondly, even if the opening hours did allow attendance, many men do not see their family's emotional and mental life as a concern for them. Thirdly, lack of attendance is the result of society poorly addressing men as emotional beings with the same susceptibility to mental ill-health as children and mothers. Fourthly, mental health practitioners'

training predicates their thinking about families around mother-centric dependency models. At worst this means they have no, and at best they have a limited, place for fathers in their "meta" and practical bodies of knowledge. Fifthly, through their own experiences of their own fathers, many women actively ensure that their children's fathers do not attend CAMHS. Sixthly, for many children their biological father does not live at home. For some children this has always been the case and of these some have never met their fathers. For other children the exit of the father was witnessed as acrimonious, leaving them damaged by the trauma of witnessing arguing parents. For many there is no new partner of their mother, so nobody offering a paternal function as a male or female. It is the fifth and sixth groups of mothers and children that this chapter will be concerned with.

Three Mental Health Outcomes

The three mental health outcomes for children discussed here are based upon the context of a father's absence from his child's life coupled with that child's emotional and mental development becoming based upon the mother's "parasitic" relationship with the child. The term "parasitic" conceptualises what happens when the infant meets the mother's needs. These needs can be for someone to depend upon her, to carry some of her projections and feelings about the infant's father and eventually (as child and adolescent) to share and promote her views about the father and fatherhood. For Bion this relationship is doomed to be destructive.

Parasitic Relationship

Bion (1959, 1962, 1965, 1970) based his concept of the parasitic relationship on his formulation of the mother–infant relationship as the prototype for a containing relationship. The mother's role is to contain her infant's anxieties through accurately perceiving and transforming the infant's signals of a particular anxiety. For example, the apprehension and understanding that a particular cry means hunger and so need for a feed. The infant recognises that he has been understood when the bottle or nipple arrives in his mouth. Here the mother as container is containing the infant as the now contained. A parasitic relationship is a corruption of the container-contained relationship. This corruption may be at the start in the form, for example, of a wilful neglect of the infant's needs or may creep with time. It is based upon the child no longer being seen as the contained but as the container

for the mother. In this it is a reversal within the container-contained. Bion (1970, pp. 95–96) sees such a reversal as mentally destructive for the development of the infant into childhood and onwards. In the early stages, being caught in such a relationship ensures that the experience of separateness and difference cannot be established. From a psychoanalytic stance, experiencing separateness and difference is absolutely fundamental to healthy identity development, discernment and the capacity to reflect upon and learn from experiences. Without the presence of the father within the infant–mother relationship therefore, ADHD, self-harm and inappropriate sexual behaviour represent just three possible outcomes of such a parasitical relationship.

Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is a diagnostic label for children and adults presenting with significant problems with the following:

- Attention
- Impulsiveness
- Excessive activity

Diagnostic criteria for ADHD have tended to focus upon inattention and hyperactivity but have not included the emotional dysregulation many practitioners recognise in their patients. The DSM V is a clear example of this. However, Russell Barkley (2015) sees emotional dysregulation as a core component of ADHD. Barkley points to the neglect of the emotional aspect and more especially the lack of control of emotions in people with ADHD. He discusses the "effortful inhibition" and the "top-down self-control of emotions …. particularly those pertaining to the self-regulation of frustration, impatience and anger" as being missing (or largely missing) in those with ADHD. Other authors (e.g. Rapport et al. 2013) focus on how training young patients to develop and use this inhibition within themselves strengthens what workers in the field of ADHD term 'executive functioning'.

The link between an absent father and a patient with ADHD is through boundary and role. Along with the promotion of the recognition of separateness and difference (and thus the beginnings of the use of the mind to find out, learn and think) the father is an embodiment of a boundary.

- The father is different to the mother—there is a boundary between them.
- The father is different to the infant—there is a boundary there.

- The father has a relationship with the mother from which the infant is largely excluded—that's another boundary.

Recognising boundaries allows the infant/child/adolescent to see where he stops and the father begins. Internalising boundaries allows for emotional regulation. Internalising a father allows for emotions to be held in check that might otherwise run riot. At a very early stage in the infant's development, and this gets remembered through the other life stages, the experience of difference can be felt as very painful such that there is an acquiescent identification with something so different (bigger than the infant, has different things to say to the infant than the mother and physically holds the infant differently). This identification is the basis of the executive functioning that developmental psychologists and others discuss in terms of what is missing for ADHD patients. This is what is missing when fathers are absent and, in some cases, it can open the way for the now exclusive relationship with the mother to become parasitical.

"Jimmy"

Jimmy was referred to CAMHS aged 8 by Community Paediatrics who had already made a diagnosis of ADHD. The referral listed symptoms conducive to ADHD: an inability to concentrate in class, distracting his fellow pupils, finding it difficult to remember simple instructions and refusing to allow adults to help him by repeating things to him and trying to help him follow what he was supposed to do. Recently Jimmy had been disrupting fellow pupils at school and in a separate incident had been restrained by teachers after starting a fight with a boy who had made an offensive remark about his mother.

Jimmy attended the first session with his mother. His older siblings (sisters) were at school and his father was living in another county with a new family. Almost immediately Jimmy's mother told me that Jimmy "is just like his Dad," by which she meant "he is all over the place … can't keep still … drives me mad … won't do what he is told." For the first ten minutes of the session Jimmy seemed invisible as his mother told me how difficult he was to manage, and just how like his father he was that she was worried "he'd be the same." Every so often she would look at Jimmy and say "Don't worry mate. We'll be through here soon and you can have your McDonalds on the way back to school." Far from sounding like a carrot to keep Jimmy calm for his session, this seemed more like a communication between equals; equals who were not taking a CAMHS assessment seriously. I observed Jimmy to be

quietly getting on with drawing whilst his mother talked about his similarities to his father. When I asked her what she hoped from a CAMHS intervention she said "that he can just concentrate at school more." When I pointed out all the similarities with his father that she seemed concerned about she replied "You'll never sort that out (and to Jimmy) will he mate? You're just like your Dad and always will be." To the same question Jimmy told me that he wanted to be like other boys in his class. He was hesitant when I suggested this might be so as to concentrate and get on. It was clear he wanted to speak with me on my own. His mother returned to the waiting room.

Jimmy told me that the other pupil's comment about his mother had hurt him very much, but not as much as his mother repeatedly referring to him as if he were his father. He spoke to me calmly, thoughtfully and with certain desperation. With his mother back in the consulting room I offered to see them together for sessions aimed at understanding their relationship, and what part in Jimmy's difficulties an absent father played.

The work, weekly sessions, lasted six months. The material of some sessions demanded that I then saw one or other individually for a while, before resuming with them both together. Jimmy immediately responded well to me, and by the end we were able to see that he had benefitted from my being a male. His mother was initially very hostile to suggestions that her relationship with Jimmy's absent father had any bearing on Jimmy's diagnosis of ADHD. However, by the end she was able to say "I had such problems with my own father I couldn't bear living with Jimmy's. I was deliberately difficult, so he had to give up and leave. Then I stopped him seeing Jimmy." Jimmy's father had left when Jimmy was three months old. Through our work Jimmy's mother was able to see that she had "slipped Jimmy into the space in my mind where his dad had been." This space was not simply the one formerly occupied by a partner who did not do as he was told and was all over the place, and did not concentrate and get on with his life. It was a space marked companion. For all her complaints about his father, Jimmy's mother came to recognise that his father had been her companion, and that she could not bear having such a companion because this stirred up feelings from her relationship with her own father. She was caught in a circle, with Jimmy slotting in where his father had been pushed out. Jimmy told me just how difficult he felt about having to hear about everything that went on in his mother's life, and the feeling that she wanted him as a grown up not as a child. Our work together, with his mother present, linked this to his concentration problems at school and home. He told me that he felt his head was too full up and could not take in new things that were said in class and elsewhere. He could not discriminate what to remember and what to forget. He could not see school as different to home whilst his head was so full of his mother's agenda and concerns.

What both of them acknowledged they got from me was a very real sense of difference to both of them, with both individually able to say they had some relationship with me. Such triangulation helped dispense with the parasitical aspect of mother's relationship with Jimmy.

The presence of me the psychotherapist, as the third corner in the triangle replacing the absence of Jimmy's father, had a significant effect on his development in CAMHS. Jimmy's mind was full of his mother and yet he was able to use a male psychotherapist in much the way he might have used a father's presence. I was the different person in the room—male and adult. My being different and separate actually allowed both he and his mother, individually and together, to use me as an object for processing their experiences and emotions. The outcome was that school reported to me that Jimmy was now more able to concentrate in class and that his learning was showing signs of improvement. They had therefore decided to seek a reassessment by the paediatrician, something that I wrote in support of.

Self-Harm

There are as many reasons for self-harm as there are people who do self-harm. Self-harm, amongst other things, helps people to regulate emotional states that are felt otherwise to be too overwhelming. Here I want to focus on one of the two main methods of self-harm described in the NICE guidelines[1]—cutting.

"Rachel"

Rachel, an only child, was seventeen when she was referred to me following an admission to a paediatric ward via A&E. She had cut her wrist very deeply with a kitchen knife, which required stitches. This had not been her first trip to the hospital. She had been self-harming since the age of 11, often requiring her to attend A&E. She had been known to social services since her first ward admission. However, social services appeared to not judge her as high risk because in their assessment her mother was attentive and concerned about her.

Mother and Rachel attended the first session. Rachel sat looking vacantly at the floor as her immediately distraught mother explained that she had

[1]Self-Harm: Longer-Term Management. National Clinical Guidance Number 133.

always done what she could for Rachel, and therefore could not understand why she kept cutting herself (thighs, upper arms to start with, then forearms and now her wrist). Whilst one might easily have said mother's presentation was indicative of trying to absolve herself of blame, it was also the case that she appeared genuinely frightened that Rachel might one day kill herself. As I listened, this fright seemed to be about the fear of such a loss, and that such a loss would be the loss of something more than a daughter. As this came to mind Rachel, some twenty minutes into the session, suddenly sat up and told her mother to "Shut-up being so self-pitying. You want to know why I do it. I'll tell you. I am sick to death of your leaning on me." Rachel made sense of something for me in this moment. That she could be so strident and cutting into her mother's oration suggested that she was robust, was prepared to push back at her mother, and to cut into her mother as she did herself (physically). This preferred method of self-harm was therefore a choice that both conveyed and was based upon the desperate need to experience separation and difference. This spoke to the absence of a father who could offer boundary reinforcement, triangulation for experiencing and developing difference and who also could open up a space for thinking about emotional life. By the end of this assessment I had offered to see Rachel on her own weekly for ten sessions, in order to explore her reasons for cutting her body, and to help her understand her feelings about her mother. In the absence of a colleague to provide a space apart for the mother from this arrangement, I also saw her fortnightly in between Rachel's scheduled sessions.

Rachel's Absent Father

Father had left home when Rachel was nine years old. Mother had been distraught but also was determined not to work towards any reconciliation. Night after night she had cried through dinner and beyond, leaving her daughter very worried about her emotional well-being. Six months after the father's departure, mother had a breakdown and Rachel had to prepare all meals and take on all the domestic chores. Mother increasingly used her as a confidant. Rachel felt uncomfortable being with her friends, as she was aware that her mother was at home in such a state. When she began self-harming at 11 she was unaware why she did so. By the age of 17 she was aware that she did so because she wanted to distract herself from, as she said, "the incessant feeling, like a plague of locusts, chasing me around my head so I don't have anywhere to go." This chasing plague was, of course, her

mother and her mother's unspoken insistence that Rachel devote herself to being her container. What Rachel actually needed was a father, both actually outside her and also inside as an internalised other by whom she could feel contained.

Mother's Absent Partner

Rachel's mother began her own sessions by fiercely denying the existence of Rachel's father, to the extent that it took a mild comment from me about an "immaculate conception" to bring her begrudgingly to "accept he must have been around for that part." With this early acceptance of his, apparently somewhat short-lived, presence we began to discuss her feelings about him—"Yes, he had been around for nine years, and yes that was significant…. But it isn't now and wasn't much then. Rachel was always a mummy's girl. She always was with me. She didn't want him or him her." Acknowledging what she had just said, I moved into asking her why Rachel might now, apparently, be saying that Mummy is Rachel's girl? Mother became furious. She yelled "Have you any idea what it is to live with someone who lies about what he spends his income on? Who lies about how much he drinks? Who lies about why he is late home from work?" Several sessions later, once the anger about this and other admonishments had abated, I asked whether he had always lied. It appeared not and slowly she told me of how she had always watched her husband "like a hawk," and not wanted him near her or Rachel. Agreeing that this might not have been helpful to any of the three of them, she went on to say that she watched him because she had never trusted men. Men either left her or they abused her. She told me she was abused by her own father from the age of 9 to 16. Her own mother had denied the possibility on the numerous occasions when she confided to her, often saying that she was making up stories to get her father into trouble.

Rachel's mother had also had a need for a containing and boundaried mother, and an impulse-regulating and non-abusive father. She had needed an emotionally aware and present parental couple to help her, but she did not have these. When Rachel was 9 years old, her much mother-watched father eventually left the home. This had been reported to me as the same age that Rachel's mother had reported experiencing her first abuse by her own father. I pointed out this coincidence, asking—"Could it be that at that age Rachel's mother had felt at her most vulnerable? If so, could it be that, without a professional intervention to help her, she had held onto the

pain of that first experience of reporting abuse to her mother? Could it be that when Rachel became 9 her mother was triggered into projecting the pain into both her husband and daughter, forcing the one to leave and the other to self-harm?" These were very fundamental questions pointing to a very sensitive area within mother's psyche. We agreed to extend the work for another ten weeks, increasing the frequency to weekly. Rachel was also offered and agreed the same temporal extension for her individual work with me.

Mother's Present Psychotherapist

After a first session of what can be best described as self-righteous explanations for why she had every right to use her daughter as "a prop and confidant," Rachel's mother began to accept that she was using her daughter in the absence of a containing mother, partner and psychotherapist. I pointed out that her own mother had dismissed her concerns about something so painful that had negated her as a child and made her into an adult before she was ready. She agreed and said that this comment was "really helpful. Really … it holds me." She then began to show deep remorse for how she had treated Rachel's father. She said she had always kept him "at arm's length" and had become suspicious when "he tried to understand me, get to know me, said he wanted to be there for me." She told me that she had always been very "controlling of men," seeing them as "something to be used and ended with, not to be valued otherwise." Clearly these positions were held because of her relationship with her parents, both of whom had made it near impossible to have faith in intimacy, containment, and containment through intimacy with a partner. By the end of our work, Rachel's mother recognised that she had made Rachel an adult prematurely, mirroring one outcome of the abuse by her own father. This helped her to begin to position herself more appropriately as an emotional container for Rachel.

Rachel's Present Psychotherapist

Rachel was very keen to tell me all she experienced and felt in life, and especially in relation to her mother. In life she had very limited experiences, largely because of being driven to attend to her mother's needs. She gave examples of feeling "chased back from school by the feeling I couldn't delay by talking with friends." She talked of being "constantly hounded

by feeling claustrophobic. I couldn't escape unless I found a place to cut myself. The first time was such a relief. It was being naughty that was the relief. The sharp blade felt like nothing. The relief was more powerful." Soon the sequence of finding somewhere secret, cutting and feeling relief became established as a form of unthinking escape. Rachel said that after the first few times, she knew the moment had been lost in which she could feel and think about what it was she was escaping from. That moment, the tiny moment in which thought might have been possible, was extinguished and with it the opportunity to self-regulate her feelings through thinking about them and giving herself a protective boundary to fend off more self-harm. Throughout the time of our work together Rachel did not self-harm. She said that talking with me about her experiences at times when she had cut helped her to "reflect". Alongside this we had been talking about her cutting into her mother during the assessment session. She began speaking about how used she felt by her mother and that change was necessary so that her mother could support her. During the penultimate session she said "You know. Talking to you like this makes me think of my dad. I haven't seen him since he left. I miss him, but I don't have enough memory of him to know what I miss about him." I suggested that our sessions had been a space away from her mother and that maybe this is what she needed from a father. Someone who is different but a person who can be relied upon to help her think about things, rather than act on them in the absence of having anyone to help her. Rachel began crying deeply for the remainder of the session.

After finishing the scheduled individual sessions, as is my practice, we met for a review. On this occasion mother and daughter spoke of starting to understand each other better as people with needs. Mother apologised for "loading myself onto.." Rachel. Both agreed that it would be a good idea if mother approached her ex-husband about meeting again. She had much to say to him and she knew Rachel did too.

The effect of the absent father on Jimmy and Rachel was essentially the same. Both had been left with mothers unable to offer anything other than a parasitical relationship with them, which acted as a vehicle for their transmitting their feelings about their ex-partner (the children's father) into them. This had dire consequences for their development behaviorally, emotionally and in terms of their mental health.

The final mental health outcome I want to discuss here is sexually inappropriate behaviour. The case I will now present is one where an older adolescent was accused of rape.

Sexually Inappropriate Behaviour

Most types of sexually inappropriate behaviour in children and adolescents that present to CAMHS derive from these young people having themselves been exposed to sexually inappropriate behaviour at some point prior to their coming to the attention of concerned adults. Some have been exposed to video or online porn. Others have been exposed to live sexual activity involving adults and/or other children. Invariably there is an adult somewhere in the story who has started off a chain of abuse via the abuse of a child or young person. There are, however, some children (especially boys) whose behaviour is the result of an overly-indulgent mother and an absent father. My previous comments about self-harm's prevalence and meaning also hold true for this behaviour.

"Rob"

Rob was referred to me at the age of 17 after being sent to trial for the rape of a fellow college student whom he had been close to. The trial had not gone through because the victim retracted her allegation. Despite not consenting to the sexual act, the victim had come to believe that Rob himself did genuinely believe she had given consent. He had been very remorseful at the time showing this frequently during his interrogation. Rob had been open to our services for many years, being under psychiatry for his ADHD. My consultant colleague took the view that his mother (who we will call "Daphne") was the context for Rob's difficulties. She was concerned that Daphne was resistant to any consideration of family-based psychotherapy for her and Rob (her only child). Daphne had staunchly argued that ADHD is a one-person problem, and that Rob should receive medication and regular reviews for this.

"Daphne and Rob"

I began my involvement by seeing Rob with his mother, and then decided to see Daphne for several sessions before seeing Rob for his own sessions. My initial session with them both had revealed something very insular about both. Daphne skillfully dissected everything put to her. It made her impervious. One could not offer the most innocuous idea to her without feeling that she had detected it leaving my mind. Before it reached my tongue, she had decided upon the way she would question it. I was surprised at how

hesitant Rob was to allow himself to have an idea, let alone articulate it to me. He did not seem to have an idea of a containing parent who was open to containing him. He certainly did not know how to deal with me as a male interested in offering him support.

"Daphne"

Work with Daphne was very difficult. Firstly, she did not see the point of it as Rob "got into a tangle with that student because he has ADHD and, as everyone knows, ADHD is a genetic problem and nothing to do with the environment provided by the parents." She moved from this to an attempt at analysing what she imagined were my reasons for being a psychotherapist, and one working on "*this forensic case*." Daphne was highly articulate. She worked as a barrister helping the police with profiling in very serious forensic cases. Profiling did not seem to be simply the product of her professional training. Her own psyche appeared to attune to everything forensically, making an image of it, and then dissecting the evidence to fit or refute aspects of what she had profiled. Invariably she dissected everything I suggested so that we remained in a mono-dimensional world devoid of spontaneity, creativity or connection. In such a world, she was able to be in control. It soon became apparent that this control was to ensure not simply that emotions had no part in profiling *or the profiled*, but also that she could not be given things to think about that would challenge her way of thinking.

I don't usually challenge patients as strongly as I needed to challenge Daphne. I began by suggesting to her that she had given me an idea of her as a hands-off mother who coped with family matters in the way that she coped with work matters—with a mind that was looking to dissect but not link up with what was being communicated. After several weeks of her saying that I didn't make sense because to dissect something involves some sort of engagement with it, Daphne let me make another observation—that her persistence with getting things right made me wonder about Rob's early years. Surely babies and young children need some slack? Daphne was more open to thinking about Rob's early years. She had been completing her training. The pregnancy had come at the wrong time. She was a trainee who had fallen in love when she meant to qualify at the elite level. The two things didn't go together and from there (she only just qualified) she blamed Rob's father for coming into her life. She loved Rob as a baby but began to hate the father simply because he had disrupted her life. She kept him away from caring for the baby and then from playing with him as a toddler. By the time Rob was

three, the father had left the home angry at not being allowed to parent his son. "*Yes,*" she said, "*I am very controlling. I only just qualified because my tutor wrote in mitigation that I was pregnant*." She kept Rob close for fear of losing him—"*I have smothered him and made it so that he probably can't breathe without thinking of me*."

"Rob"

I offered Rob weekly sessions immediately following on from offering Daphne the same. I saw them both for just over a year. For the first few sessions Rob was very remorseful about raping his fellow student—"*despite her saying that I didn't, I know that she didn't want to. I did. I didn't use force but I know she wasn't up for it. She seemed reluctant and disinterested. That was all*." Rob corrected me when I said it seemed she thought he had not recognised that she did not want to have sex with him. He said "*It was rape. I knew what I was doing. She must have thought so, otherwise she wouldn't have allowed herself to be interviewed by the Police. Call it rape please, even if it's covered up now*." We discussed how he had got close to her from day one of his course, and that he thought they had formed a friendship. After several weeks we moved from his softer feelings to the ones involved in raping her.

Rob spoke a great deal about the sense of liberation he felt in having control over the girl and "*getting rid of something into her*." There was the evacuation of the feeling of being controlled as he controlled the girl and, as he said, "*did what I wanted for the first time ever*." We were able to see this freedom as freedom from being controlled by his mother. The rape was an act in which he had a moment of freedom, as certainly this would not be something his mother would want him to have done. However, it was freedom only up to a point. Rob's chosen form of evacuating his mother from inside him was not an accident. He told me he knew that his mother blamed his father for her pregnancy, and thus for Rob's birth. Rob was very interested in philosophy and had long had an argument in his mind (only) about causation in human relationships. He did not at first see a valid link between his mother's pregnancy as a student, and his forced sexual intercourse with a student. Rob had been in touch with his father from whom he understood he had been a planned baby, because at the time his mother thought she could qualify well and also carry a baby. Added to this, she had loved Rob's father, at least until the baby was born. After her disappointing qualification she blamed Rob's father for everything. Interestingly, Rob could not understand why initially she was not more condemning of his raping the fellow

student. In one session, he became extremely angry as he concluded that her not being condemning was a sign of her being out of touch with reality, and too interested in closing the gap between them. He had felt liberated by this gap but he was aware his mother sought to close it "*somehow…anyhow*."

The work with both Daphne and Rob concluded with two months of weekly joint sessions for them. Daphne discussed just how controlling she had been of Rob, and just how she missed his father. At this point Rob broke into deep sobbing, crying out to his fellow student how sorry he was. Mother and son both sobbed together with Daphne saying that she was so sorry for "*making Dad go… and just when you … when I needed him most. None of this would have happened*."

Daphne recognised how Rob's rape of the student was partly an act of liberation from feeling suffocated by an omnipotent mother who constantly thought for him and explained him to him. Further, this was a mother who had used him as a companion now that she lived in a world without his father.

Addendum to the Case

What I have very quickly described is psychotherapeutic work to address a parasitical relationship. It was a complicated case made so not least because of the allegation of rape being redacted. I have seen many other cases where this parasitical relationship often produces a development beginning with stealing, moving to more serious stealing or fire-setting, sometimes leading to sexual excursions that are intrusive and unwanted by those intruded into and ends with a serious sexual offence (including rape). At each stage of this horrendous trajectory there is an opportunity for these developments to be halted. Understanding what the behaviour is trying to draw attention to is critical to such halting. Daphne and Rob worked hard to understand their relationship and how it contributed to the outcome that was acted out by Rob. Daphne had effectively got rid of Rob's father. She was able to accept in the end, however, that had she not done so, the father's presence could have supported her parenting of Rob and could have potentially prevented her from inappropriately projecting her own intense feelings and needs into that relationship.

As a footnote, after the end of the work Rob's father and Daphne sought help from me to bring them closer together as parents. They worked through Daphne's original rejection of him, and his own feelings of not challenging her sufficiently before leaving the home. They were then able both to be present but not intrusive for Rob, putting their efforts towards

giving him space to develop as a late adolescent/young adult. Rob's father was a man very able to bring his difference as a parent and human being into the mix. He was sufficiently benign to help form a family based on a triad, not a dyad. For my part this second piece of work left me aware that, had Rob's father been present from the outset of his life, then Rob would have developed a concept of difference. Difference was, presumably, not in mind when he crossed the boundary with his fellow student. This case illustrates one cause of intrusive sexual behaviour and rape. It does not, however, account for a great number of different causes and motives in other cases.

Concluding Comments

I have chosen these three cases because they are representative of the diverse presentations of children, young people and their mothers that nevertheless have a common causality for their mental health outcomes. They are just three of many cases that I have seen over the years where the absence of the father, often instigated by the mother, allows for a parasitical relationship to take hold with disastrous consequences for the emotional development and mental health of the children. The absent father has a very powerful presence, in that the consequences of his absence have such pervasive and damaging results. However, I hope that I have also demonstrated how significant amelioration is possible with correctly focused and emotionally attuned psychotherapeutic interventions.

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Cognitive Distortion in Thinking About Gender Issues: Gamma Bias and the Gender Distortion Matrix

Martin Seager and John A. Barry

Introduction

The seed that grew into my (JB) interest in Male Psychology was planted at a seminar on clinical psychology during my undergraduate degree at a respected English university in the mid-1990s. The group had spent a lot of time exploring possible theory-based reasons for female depression (e.g. the female gender role leading to learned helplessness), but then swiftly glossed over the subject of high male suicide rates with a "humorous" remark: "men construct more lethal methods because they are better at DIY". This raised a few giggles at the seminar, and the group quickly moved on to the next topic. However it struck me as odd that my educators—and psychologists in general—appeared to have little serious curiosity about the causes of a fatal issue like suicide. I presumed that this would change, but I heard the same DIY explanation in 2016 at a public talk on gender at LSE, also greeted with giggles from the audience. Clearly this phenomenon—a cognitive distortion involving the minimisation of the importance of male suicide to the point of near-invisibility—was difficult for people to overcome.

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Cognitive distortions can be defined as "the result of processing information in ways that predictably result in identifiable errors in thinking" (Yurica et al. 2005). Since the 1960s, a growing number of distortions have been identified. Aaron T. Beck (1967) originally identified cognitive distortions in his work with depressed patients. The six errors he identified were: arbitrary inference; selective abstraction; overgeneralization; magnification and minimization; personalization; and absolutistic, dichotomous thinking. Since that time others have extended Beck's list. In this chapter we are postulating a newly identified cognitive distortion, gamma bias.

Gamma Bias and the Gender Distortion Matrix

A range of examples of gamma bias are described in the gender distortion matrix, and they fall primarily under two categories: magnification and minimization. *Magnification* is defined as "the tendency to exaggerate or magnify either the positive or negative importance or consequence of some personal trait, event, or circumstance" (Yurica et al. 2005). *Minimization* is defined as "the process of minimizing or discounting the importance of some event, trait, or circumstance" (Yurica et al. 2005).

Table 1 describes the gender distortion matrix. It is a 2 × 2 matrix, and in each of the four cells, the experiences, behaviours or characteristics of men and women are either *magnified* or *minimised.* The matrix describes how it can be *good* or *harmful* to *do* certain things or *receive* certain experiences. Unlike either alpha bias (magnification) or beta bias (minimisation), each cell demonstrates that certain gender issues are both magnified and minimised. Whether an aspect of the gender issue is magnified or minimised depends upon whether the issue is related to men or women.

In this paper we argue that there is much evidence in everyday experience, and some in research, which supports the existence of gamma bias. Note that we do not suggest that gamma bias is eternal and unchangeable. To the degree that it is changeable, we suggest that it is very important that we

Table 1 *The gender distortion matrix*, describing examples of gamma bias i.e. situations in which aspects of our perceptions of men and women are magnified (upper case/italics) or minimised (lower case)

	GOOD	HARM
DO (active mode)	*FEMALE* male (celebration)	*MALE* female (perpetration)
RECEIVE (passive mode)	*MALE* female (privilege)	*FEMALE* male (victimhood)

rectify, or at least recognise, these distortions. When discussions of gender are distorted, this misshapes the narrative and warps our public attitudes, policies and conversations about gender. For example, as a result of widespread gamma bias we tend to believe that:

- men are more harmful than helpful
- women are more helpful than harmful
- men are more privileged than disadvantaged
- women are more disadvantaged than privileged.

Examples of Each Type of Distortion

We list below some preliminary examples of the very public ways that these distorted attitudes to gender are reinforced continually in the English-speaking or Western world. Examples will at this stage be brief and schematic, but hopefully sufficient to demonstrate the face validity of this new hypothesis, which will be subjected to rigorous empirical testing in research over the coming years.

Doing Good (Active Mode) (Celebration/ Appreciation)

Female Magnification

- We celebrate women publicly—for their gender alone—in the archetypal realms of beauty, fashion, sexuality and motherhood.
- The UN has got four days dedicated to women: International Day of Women and Girls in Science, International Women's Day, International Day of Rural Women and International Day for the Elimination of Violence against Women.
- The Royal Society in the UK and other institutions worldwide have at various times held "Wikipedia Edit-A-Thon" days, when people are encouraged to add the names and achievements of women to Wikipedia, in order to make women in science more visible (Huffington Post 2012).
- Suffragettes—female suffrage has been selectively celebrated in writings, films and the media as a gender issue, minimising the lack of suffrage for half of the male population in the same historical period.

- The careers and achievements of women in science, politics, business and education are actively promoted and celebrated as a gender issue.
- Women in the military and emergency services are celebrated for their gender and not just their actions.

Male Minimisation

- We do not celebrate men collectively for their gender alone, only the particular achievements of individual men.
- The UN has no special day to celebrate men. In many countries International Men's Day has been celebrated on November 19th since around 2010, but this is not recognised by the UN.
- The heroism within the military and the emergency services is often remarked upon in the news. However, the almost exclusively male gender of the heroes is not marked. In ceremonies to pay tribute to war heroes we acknowledge their brave deeds but not their masculine gender. We also include women when celebrating war sacrifice so that celebrations become gender-neutral rather than gender-specific. Recently, the rescue of a group of boys by male cave divers in Thailand was celebrated, but not marked as a gender issue or as an example of positive masculinity. In the Titanic disaster in 1912 most men were drowned (80%) but most women (75%) were saved. Men were clearly acting heroically to protect the women and children, but this, though a famous story, has not been celebrated as a story of positive masculinity.
- Working class sacrifice—the complete physical infrastructure and security of the UK and other nations has been built and maintained almost exclusively by working class men. This is reflected in the fact that to this day in the UK men account for 96% of deaths at work. The same picture is found across the world. Clearly men continue to do the heavy, dirty and dangerous jobs in all societies. However, males who are builders, miners, firefighters, quarrymen, road workers, deep sea fishermen, scaffolders, steeplejacks, navvies and who occupy many other dangerous professions are not celebrated for their gender in a positive way. The image of male builders, for example, still tends to be more "wolf whistler" than "DIY SOS" hero.
- Male suffrage—the vote for men has never been celebrated as a gender issue even though 44% men also only got the vote for the first time in 1918 and at a time when men had been sacrificed in large numbers in World War One for the protection of society.

- We do not celebrate fatherhood or male childcare. Indeed in many ways public attitudes towards men as caregivers of children are negative, ambivalent and even suspicious, even amongst politicians (Dench 1996).
- Male sexuality is typically viewed in public life and policy as a source of harm, threat, abuse and power. The joy and positivity of male sexuality is rarely celebrated today, except indirectly through the arts.

Doing Harm (Active Mode) (Perpetration/ Toxicity)

Male Magnification

- Negative attitudes towards masculinity have become widely accepted in mainstream public discourse in recent years. In contrast to the "women are wonderful" effect (Eagly et al. 1991), contemporary men are subject to a "men are toxic" effect. The notion of "toxic masculinity" has emerged and has even gained widespread credence despite the lack of any empirical testing (see chapter on masculinity by Seager and Barry). In general terms it appears as if attitudes to men have been based on generalisations made from the most damaged and extreme individual males. An example of this is the case from 2016, when a young woman called India Chipchase was raped and murdered. There were two men in her story: the rapist/murderer, and her grieving father who movingly stated "I will never get to walk my daughter down the aisle". However, the media attention following this tragic event focussed almost exclusively on a sense of urgent need to teach boys and men in general to respect women. This suggests that in terms of public attitudes, the rapist/murderer was being viewed as more representative of masculinity than the victim's father.
- The concept of 'rape culture' has also developed and gained credibility, originating in the USA in the 1970s. However, in 2012 figures for the USA as a whole show that 0.6% of adult males had been registered for sexual offences (including rape), meaning that 99.4% were not. Even allowing for some inevitable under-representation, and whilst recognising that one rape is one too many, the evidence suggests that the vast majority of adult males are not sexually violent or dangerous. The public perception, however, is very different, especially in an age of "#MeToo" and "Enough is enough".

- In the UK and elsewhere the image of domestic violence and intimate partner violence (IPV) is almost exclusively one of male perpetrators and female victims. This is reflected in "treatment" approaches to IPV such as the "Duluth model" which is aimed exclusively at males (see chapter by Powney and Graham-Kevan). It is also reflected in the provision of places in refuges for victims of IPV. In 2010 in the UK, for example, whilst male victims accounted for at least 33% of IPV victims, less than 1% of a total of 7650 refuge places were available for men. Research evidence of equal levels of IPV by females (e.g. Archer 2000) is still not being reflected in public attitudes in this area (Seager 2019, in this volume Chapter 12).

Female Minimisation

- We have already seen (above) that evidence of equivalent levels of domestic and IPV by females (e.g. Archer 2000) is not reflected in public attitudes or policies.
- There is evidence that women receive less severe sentences for the same crimes (e.g. Starr 2012; Mustard 2001).
- The high level of online emotional abuse by women (cyber-bullying) (e.g. Marcum et al. 2012) is not reflected in public attitudes or policies.
- 52% of men in a sample of high-security prisoners who had committed serious offences against women and had been sexually abused in childhood were found to have been abused by *female abusers acting independently of men* (Murphy 2018). However, the picture of sexual abuse portrayed in the media does not reflect this complex gender picture of sexual abuse. Those who propose a social transmission theory of "toxic masculinity" would have to take account of the fact that male children spend significantly more of the developing years in the company of adult females than adult males.
- Parental alienation, a diagnosis newly added to the ICD-11, is a form of child abuse involving one parent alienating their child from the other. Evidence has long shown that the father is more often the victim and the mother the perpetrator (e.g. Bala et al. 2010). Briggs, in another chapter in this volume, also shows examples of clinical cases in which mothers have alienated children from fathers prior to psychotherapeutic intervention.

Receive Good (Passive Mode) (or Privilege)

Male Magnification

- The whole sociological concept of "patriarchy" (see also chapter on masculinity by Barry and Seager) is predicated on the idea that it is a "man's world". Specifically, society is viewed as inherently privileging and advantageous for men and organised in ways that empower men and disempower and exclude women. This bold and sweeping hypothesis has received widespread acceptance despite being subject to relatively little academic evaluation, let alone being subject to empirical testing as a scientific hypothesis. This uncritical acceptance of a radical theory by mainstream society in itself indicates that gender distortions may be in operation on a large scale. The concept of patriarchy focuses on an elite group of more powerful and wealthy males, whilst minimising the vast majority of men who are working class men, homeless men, parentally alienated men, suicidal men and other relatively disadvantaged male groups. It also minimises the benefits and protections involved in motherhood, family and domestic life for many women including the potential joys and rewards of raising children. Also the concept of patriarchy minimises the hardships of the traditional male role, such as fighting in wars, lower life expectancy, higher risk-taking and working in dangerous occupations.
- Young women in the UK are now in fact earning more on average than their male counterparts (see below), yet the gender pay gap is misunderstood and presented as an example of women's oppression, primarily because of dubious and selective methods of measuring and comparing pay. Even when men are earning more, there are other "trade-offs" and risks that men choose to take on that confer counterbalancing disadvantages (Farrell 2005). However, the public perception and emotional outrage on gender pay are out of proportion to the actual differences that emerge if the matter is analysed more scientifically.

Female Minimisation

- As we saw above, there is evidence that women receive less severe sentences for the same crimes (e.g. Starr 2012; Mustard 2001). Women also enjoy better health and living conditions than men (Carcedo et al. 2008).

Mothers who are prisoners also enjoy better access to their children than fathers who are prisoners (Collins et al. 2011). And yet in terms of public perception there is an image of women being "oppressed in a male-centric prison system" (e.g. Baroness Corston in *The Guardian* 2018).

- In OECD countries at the present time significantly more young women than young men graduate from school and college. According to figures supplied by the Guardian newspaper (2017), for every 13 girls who entered university, only 10 boys did so. The education gap has seen boys fall behind girls in the UK since the 1980s, and 30 years later it has become usual for women in their 20s to be earning more than their male peers, and has been for some years (Guardian 2015). There are still more male senior academics and professors than female in academia, but apart from this 0.3% of jobs at the top of the educational hierarchy, the rest of the hierarchy—from primary school onwards—favours females (Brown 2016).
- Parental privilege—it is a widespread practice in many countries that in legal cases of parental dispute over child custody, sole custody is awarded to mothers rather than fathers almost by default.
- Maternity privilege—when children are born, antenatal, perinatal and postnatal services are highly female-centric and the role of the father is generally not thought about or included. The assumption is that fathers are not as important to children as mothers.
- Protection—we have seen (above) that both in times of war and peace women enjoy the protection of men at times of great threat.
- Elsewhere in this volume (Chapter 10) Belinda Brown presents evidence indicating that females enjoy power and privileges within the domestic and household domain.

Receive Bad (Passive Mode) (or Victimhood)

Male Minimisation

- Men across the globe have a significantly lower average life expectancy than women. As we have also seen (above) men account for almost all deaths at work both in the UK and other nations. However, in terms of public attitudes and beliefs, these facts are relatively invisible. Certainly, no concept of a "gender death gap" has been proposed.

- Although there are signs of this changing, for years there has been less investment in prostate cancer than breast cancer, even though the rates of death caused by each are similar (around 10,000 per year for each in the UK).
- The vast majority of rough sleepers (85% in the UK) are male but there are no gender policies to address this.
- Boys have been falling behind girls in education since the 1980s. Boys are now in the UK around a third less likely to attend university than girls. This however has met with no political action and has never been referred to as the "gender education gap".
- In almost every country across the world men kill themselves at a higher rate than women do. This is now starting to be recognised, but research into suicide and services for those at risk have remained relatively "gender-blind" (Seager, in this volume Chapter 12).
- When in distress, women tend to want to talk about their feelings whereas men tend to want to fix whatever is causing the distress (Holloway et al. 2018). However our mental health services are delivered in a "gender blind" way, so that treatment options that might suit men better are rarely considered (Liddon et al. 2017).
- Issues that impact males more than females such as colour blindness (in 8% of boys and 0.5% girls), tend to be overlooked, despite the significant impact on QoL (Barry et al. 2017). For example, although coloured graphs are difficult for colour blind students to read, a large educational board in the UK recently declined to make graphs in exam papers more colour blind friendly.
- Bedi et al. (2016) found that there are significantly more psychology papers dedicated to women and women's issues compared to men and men's issues.
- Field experiments of domestic violence show that bystanders intervene if the victim is a woman, but keep walking—or even laugh—when the victim is male and the perpetrator female (e.g. ABC News 2010).
- In Nigeria in 2014, 300 female students were kidnapped by the terror group Boko Haram, prompting an international outcry. At the same time, however, and in the same country, as many as 10,000 boys were abducted and many even murdered. However, this even greater outrage went almost completely unnoticed in the media.
- Whilst female genital mutilation (FGM) has rightly received widespread condemnation, male genital mutilation (MGM) has been relatively ignored, despite evidence of harm caused to those who are circumcised.

Female Magnification

- We have already seen (above) that in the field of domestic violence and IPV, the emphasis is largely on female victims and treatments for male perpetrators, when the reality is that both genders are equally capable of such abuses (Archer 2000; Fiebert 2010).
- We have also seen (above) that the concept of "rape culture" exaggerates the perception of men as potential rapists and creates a climate of fear for women. Campaigns such as "#MeToo" can also play into a sense of fear that is based on distorted generalisations from small samples of damaged men to the whole male population.
- The Boko Haram example (above) provides strong evidence that there are much greater empathy levels for females than for males. Correspondingly, our sense of female victimhood is magnified and our sense of outrage is increased by virtue of the gender of the victim rather than the crime.

Why Do These Gender Distortions Exist?

It is challenging to think about the possible adaptive function of biases and errors, but an adaptive value helps us to understand their existence, as well as absolving people of blame for holding them. Haselton et al. (2015) highlight some of the adaptive functions of cognitive biases, and suggest that our evolved adaptive responses can sometimes act against our self-interest when faced with novel modern rules.

Why We Favour Women

The "women are wonderful" effect (Eagly et al. 1991) predicts a type of "halo effect" for women. This effect means that we magnify women in the *Do/Good* cell. This might involve a certain amount of what Beck (1979) call *emotional reasoning*, where one's emotional state guides conclusions about self and others. Such views would be expected if the effect is the result of positive views about women being created from positive early experiences with mothers and other female caregivers.

It also makes sense that women are more valuable than men, because of their importance in reproduction. A very basic way of understanding this is to think about the question of which hypothetical village would have the better chance of survival: the one with 100 women and one man or the

village with 100 men and one woman? The answer to the question demonstrates the unquestionable value of women to human survival.

Why We Disfavour Men

On an evolutionary level, males can be seen as the providers of protection, not the recipients of protection (Seager et al. 2016). It makes sense that someone should have the role of protecting offspring, and also protect those who give birth to and nurture the offspring. Thus social attitudes would have been calibrated accordingly over many thousands of years to associate femininity with nurturing and vulnerability and masculinity with protection and strength. Because of this, it would be more difficult—both unconsciously and consciously—to feel the same level of emotional sympathy for a male than a female. For the man, it might also therefore be difficult to deviate from the script of the protector and seek help. By the same token, it might also be difficult for society to see men as victims rather than protectors.

Another explanation, which is probably an extension to the previous rather than an alternative explanation, is derived from research in social psychology. The phenomenon of ingroup favouritism and outgroup bias is a cornerstone of social psychology. The strength of such biases vary by group e.g. it is well-established that higher-status groups invoke more ingroup bias (e.g. Nosek et al. 2002). Men in general (historically and cross-culturally) have had higher status than women in the public realm (politics, finance etc.), so one might expect that male identity invokes a high level of ingroup bias. However research shows that—uniquely in social identity theory—male identity, unlike female identity, invokes no significant ingroup bias (e.g. Richeson and Ambady 2001).

Men support each other effectively when the identity is based on something other than being male (e.g. football teams), but how do we explain the incohesive effect of male identity? There are several possibilities. For example, it could be that because infant attachment mostly happens with mothers, this programmes for greater bias towards women in later life (Rudman 2004). Similarly, it could be that men are stereotypically more associated with violence and aggression and thus invoke less sympathy even from each other (Rudman and Goodwin 2004).

It is likely that seeing men as protectors rather than receivers of protection leads to a lack of sympathetic bias in their favour, and leads to male gender blindness (Seager et al. 2014), the phenomenon where men's problems go

relatively unseen. This in turn facilitates the gender empathy gap, the phenomenon where males receive less empathy than females, even when in a similar predicament (Barry 2016).

Intersectionality as Male Gender Blindness

According to a much-cited paper by Professor of Psychology and Women's Studies, Stephanie Shields, "Intersectionality, the mutually constitutive relations amongst social identities, is a central tenet of feminist thinking and has transformed how gender is conceptualised in research" (Shields 2008, p. 301). According to this view, men are historically privileged and therefore don't generally deserve help or attention unless they are also members of another historically oppressed, disempowered and marginalised group (e.g. gay, BAME or disabled men). Intersectionality is therefore sometimes used as a way of criticising or devaluing efforts to understand issues facing men in general by deflecting attention exclusively onto specific marginalised sub-groups of men, and so minimising the importance of universal issues facing men.

On one level, the idea of intersectionality has merit in the same way that interactions in ANOVA help identify interesting differences between subgroups of the main variable. But there is one major flaw with the intersectional level of analysis when it comes to understanding male psychology: there is a main effect of being male that runs through all levels of the variable. For example, when it comes to suicide, not only do men in general kill themselves more frequently than women, but BAME men kill themselves more frequently than BAME women (Oquendo et al. 2001), and gay men attempt to kill themselves more frequently than gay women (Bagley and Tremblay 2000). Similarly, the academic underperformance of boys cuts across all social strata and geographies (Curnock-Cook 2016). We should note that firm statistics are not always available related to demographic groups, but what evidence there is tends to support the idea that men in general, not just specific demographics of men, need our help. "Drilling down" into data can be enlightening, but focusing on a single tree might not tell us much about the forest. Focusing on specific issues facing subgroups is of value to the individuals in these groups, but should not be used to distract attention when we are trying to understand wider issues in male psychology.

There are various ways in which male gender blindness is both a cause and effect of the ways we study gender. For example, it can be argued that the concept of "masculinities" is largely based on subjective judgements by

theorists trying to make the case for alternatives 'hegemonic' masculinity. Interestingly, at the same time as magnifying different varieties of masculinity, these theorists tend to minimize difference between men and women, an approach which is a type of *gamma bias* (see chapter on gamma bias by Seager and Barry). Moreover, in attempting to identify multiple versions of masculinity, theorists run the risk of obscuring masculinity as a unitary phenomenon. This means that focusing only on a plurality of "masculinities" doesn't help us address more general issues related to masculinity and may even distract us from doing so.

By looking at men only in terms of the other sub-groups that their gender intersects with, there is in truth the great danger that we will miss the wider gender issues altogether. By defining men only in terms of their subgroup identities (e.g. by race or sexuality) without honouring their collective group identity as a gender, the needs of men of all kinds are likely to be overlooked. If men across various demographic groups, for example, appear to respond in a similar way to therapy (as suggested by Groth in his chapter on existential therapy), then it is likely that the concept of intersectionality is of much less practical or clinical value than the underlying concept of gender itself.

Like the blind man who touches the elephant's tail and then thinks an elephant is like a snake, those who dismiss the idea that men in general need help are committing the cognitive bias of selective abstraction: instead of appreciating the whole picture, they focus on just one part of it. If science is to understand the problems facing men, scientific investigation needs to examine how some discussions about gender tend to distort the issues, making some parts of the picture invisible and magnifying others as if they were the whole picture.

Unconscious Bias Revisited

Some or all of the phenomena described in the cells of the matrix can be considered types of unconscious bias. Distorted narratives that put men perpetually in the role of toxic abuser, risk alienating men from themselves and others, leading to what might be called a state of *gender alienation*. As pointed out by Damien Ridge in his chapter in this book: "the disconnection between theoretical discussions and the daily reality of men promotes a poverty of understanding of male subjectivity… Masculinity has essentially become what different theorists and their followers say it is", and something that probably means little to the average man.

The Patriarchy Revisited

Essentially, patriarchy theory (Walby 1990) is a distorted and untested way of explaining the differences we observe in the reproduction-based division of labour. For example, women are seen as oppressed by the role of "housewife", and men are seen as liberated in the role of "breadwinner". However this is not the only way of viewing traditional gender roles. For example, Dench (1996) suggests that women can have a much more rewarding role in the private realm, and men can have a much harder time in the dangerous, dirty and soulless world of the workplace. Dench also suggests that the idea of the traditional male role as desirable rather than a burden was a way to encourage men to accept a supporting role in society, one that is ultimately of lesser value. Similarly, Van Creveld in his book *The Privileged Sex* (van Creveld 2013) hypothesises that women have always had privileges (e.g. 'women and children first', less dangerous jobs) and that this is something that most people unquestioningly accept as a good thing.

Nobody's life is without suffering, but the suggestion that women have been oppressed by the patriarchy is at best an untested theory and at worst a damaging distortion. At best, it is like looking at the famous rabbit/duck illusion and claiming that there is only a rabbit and no duck, or that the rabbit is being oppressed by the duck. Once evolutionary biology is honoured rather than dismissed, it can be seen that the traditional family structure is based primarily on reciprocal and evolved reproductive roles. Thus the greatest influence on the balance of gender relations, is perhaps none other than the great matriarch herself, "mother nature".

Criticism of the Preliminary Evidence of Gamma Bias

The evidence that we have presented above might be criticised on the grounds of confirmatory bias i.e. the tendency to select only information that supports your view. At the time of writing (August 2018), gamma bias is being presented as a hypothesis that promises to explain broad patterns of data in relation to how issues of gender are perceived, expressed and responded to both in academia and elsewhere in life. The examples we have provided are incomplete and inevitably selective, but we are confident that they offer preliminary support for the existence of gamma bias.

Future Research

The *gender distortion matrix* offers many examples of how the gamma bias hypothesis can be tested. As we write, a new research programme is being organised by the Male Psychology Network, and no doubt our hypothesis will be modified in light of the findings. To enhance ecological validity, real-world examples might be found in newspapers (e.g. the Boka Haram comparison) or the cinema, and assessed. The same principle might be expanded to academic writing and work. It might even be possible to quantify the degree of distortion within a given news article or academic paper. These are just some very basic ideas which we are happy to see others elaborate upon.

Conclusions

In academia, beta-bias and the gender similarities hypothesis are encouraged to such a degree that the term "sex differences" now has an air of controversy, and to point out differences between men and women is considered somewhat distasteful. Perhaps a more acceptable term than "sex differences" is "gender distinctions" (Lemkey et al. 2016) with its connotations that both genders have attributes that are unique and positive.

There is a serious risk arising from using terms such as "toxic masculinity". Unlike "male depression", which helps identify a set of symptoms that can be alleviated with therapy, the term "toxic masculinity" has no clinical value. In fact it is an example of another cognitive distortion called *labelling* (Yurica et al. 2005). Negative labelling and terminology usually have a negative impact, including self-fulfilling prophecies and alienation of the groups who are being labelled. We wouldn't use the term "toxic" to describe any other human demographic. Such a term would be unthinkable with reference to age, disability, ethnicity or religion. The same principle of respect must surely apply to the male gender. It is likely therefore that developing a more realistic and positive narrative about masculinity in our culture will be a good thing for everyone.

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Positive Masculinity: Including Masculinity as a Valued Aspect of Humanity

Martin Seager and John A. Barry

Negative Models of Masculinity—Why Has a Social Deconstructionist Position Become Mainstream?

The study of gender in Western academia has inevitably been influenced by feminist and post-feminist thinking, so predominantly takes a sociological, socio-political, social psychological and sometimes anthropological stance towards masculinity. For this reason, perhaps it is inevitable that our current gender narrative emphasises the influence of social and cultural factors on masculinity. Because of the absence of sound integrated biological and evolutionary data (e.g. Schmitt 2015), discussions about the forces that shape masculinity have been simplified and narrowed into the language of social determinism, viewing masculinity almost as a collection of outdated stereotypes that can be changed and reconstructed through education. There is in truth no equivalent body of authorship in the field of gender studies that has dared to claim unilaterally that gender is biologically programmed without cultural influences. In essence, the field of gender studies has therefore

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become skewed by default towards social determinism, to the extent that those few authors who do draw attention to the contribution of biology and evolutionary processes to gendered behaviour are at risk of being falsely perceived as biological determinists.

Clearly, both social determinism (nurture over nature) and biological determinism (nature over nurture) are extreme theoretical positions that do not fit the evidence on gender or indeed any other aspect of humanity. It is clear that human beings are subject to interacting biological, psychological and social influences. And it would be strange indeed if human beings were the only mammalian species that had no behavioural instincts, drives or motivational heritage relating to evolved biological sex differences. However, current mainstream thinking on gender has lurched relatively unchallenged towards a social constructionist position that in effect splits mind from body. Value-laden concepts such as "traditional" masculinity, "toxic" masculinity and "hegemonic" masculinity have gradually come to dominate the narrative, making it difficult to conduct balanced research on the biology of gender, on positive aspects of gender difference or on positive approaches to masculinity.

Hegemonic Masculinity

"Hegemonic" masculinity (Connell 1987), even though rooted in Marxist and sociological thinking, has become perhaps the most fashionable all-round definition of masculinity in the West or English speaking world and has received widespread acceptance, despite not being properly tested as a hypothesis. A description of this concept and a critical analysis is outlined in more detail elsewhere in this volume (Brown 2019). The sociopolitical thinking behind the theory of hegemonic masculinity is that males are socialised to compete for power, and to assert their dominance over females, over other males and over their social group. This hierarchical and power-based conception of male behaviour is also linked to similar notions of "male privilege" and "patriarchy". The concept of hegemony has been deployed as a general explanatory framework in which to understand male patterns of violence and aggression, on the assumption that achieving power and domination by definition entails the use of force.

Such a broad hypothesis, however, does not meet standards of empirical science and can be refuted not only with international empirical research (e.g. Stoet and Geary 2019), but with a substantial body of other evidence, much of which is already common knowledge, for example:

1. The existence of poverty, powerlessness, ill health, hardship and high mortality amongst large populations of working-class men cross-culturally

throughout the ages. Even today in the UK, working-class males undertake the vast majority of dangerous, dirty and heavy manual jobs and account for 96% of work-related fatalities (HSE 2018). And even ignoring class differences, men collectively still have a significantly lower average life expectancy (averaging between 5 and 6 years less) across the globe according to all available sources.

2. The denial of suffrage in the UK to 44% of the male population (again the working class) until 1918 following the slaughter of a significant cross-section (men of all classes) of the male population in World War One (1914–1918). The sacrifice of men of fighting age in many other wars and conflicts involving many countries across the globe, most notably during the Second World War (1939–1945).
3. The domestic power of women within households, families and in relation to children (see the chapter in this volume by Brown).
4. The sacrificial, risk-taking and protective behaviour of men towards women and children not just in wars but also during peacetime in life-threatening situations. This is illustrated most powerfully by the Titanic disaster in 1912 where the overall survival rate for females was 73% but for males only 21%. It is clear from these stark figures that the men were trying to protect the women and children. This age-old picture of men risking their lives to save women and children at times of great danger does not fit a theory of masculinity based simply upon power, dominance and aggression towards women. This along with numerous other examples of male heroism, rescuing and protective behaviour, points more towards an archetypal instinct to protect the social group than a socially learned desire to dominate it (see also chapter by Seager). In keeping with this, the male gender is the one group discovered by social psychology research that does not show an in-group bias. Whilst women do identify with and show an in-group bias towards other women, men do not show this bias (e.g. Rudman and Goodwin 2004; see also the chapter by Hook in this volume). In the same way, when men celebrate achievement with other men, for example in sporting or military situations, the focus of this celebration is not their shared *gender* identity but their *team* identity or affiliation.
5. The fact that most young boys are socialised and educated primarily by adult females (Hofferth and Sandberg 2001; Parker and Wang 2013). According to evidence researched by *The Guardian* (2017b), Finland is the *only country in the developed world* where school-aged children spend more time (8 minutes a day) with fathers than mothers. According to Department of Education figures in the UK for 2016, only 15% of primary school teachers were male.

6. The high level of female online emotional abuse (cyber-bullying) (e.g. Marcum et al. 2012) and female physical violence in intimate partner relationships (e.g. Archer 2000; Fiebert 2010).
7. Higher male suicide rates, higher male levels of rough sleeping, higher male rates of addiction, higher male rates of imprisonment and more punitive sentences for the same crime for men compared with women (e.g. Starr 2012).
8. In OECD countries young women collectively receive more schooling hours than young men (OECD 2017). According to figures supplied by *The Guardian* (2017a) women in the UK have now become a third more likely than men to attend university.
9. Widespread evidence suggesting biologically influenced sex differences in human motivation and behaviour (e.g. Baron-Cohen 2002; Brizendine 2010; Todd et al. 2018).
10. The protective role of male risk-taking, emotional detachment and aggression in both military and civilian contexts that involve danger and threat to life.

Taken together, these facts and figures are inconsistent with a hegemonic model of masculinity.

Toxic Masculinity

The term "toxic masculinity" (e.g. Haider 2016) has also now become widespread at least in the West and has gained equally uncritical acceptance as a genuine phenomenon alongside "hegemonic" masculinity with which it is often paired. The evidence-base for this concept is typically anecdotal, focussing on selected statistics relating to incidents of male violence, misogyny, homophobia, male sexual crime, extremism and other criminal acts, e.g. by drunken frat house partygoers (Barry 2016). It should be observed that the term "toxic" is not applied in social science to any other general category of human beings, and would most probably be rightly viewed as discriminatory if applied to women, children, the elderly, LGBTQ people, the disabled or any ethnic or religious group. The fact that the use of this term in relation to the masculine gender is tolerated at all in society, and is even regarded as a viable theory within the formal academic literature, speaks volumes about our less empathic attitudes towards men and is indicative of a gender bias (see chapter on 'gamma bias' by Seager and Barry). It could be argued that it is in these attitudes that any true toxicity lies.

There are two possible levels of interpretation of the concept of toxic masculinity. The stronger interpretation implies that masculinity has become globally toxic for all, including men themselves collectively, and requires a complete overhaul, primarily through better socialisation and education of young males. The weaker interpretation implies that it is only extreme, "macho" or "hyper-" masculine behaviour that becomes toxic, so that only one end of the masculine spectrum requires remediation. However, even the weaker interpretation carries the sinister implication that the more masculine an individual is, the more toxic he will become, purely as the result of gender alone and without any other causative factor being involved.

A test of public (student) opinion on this issue came in the UK in May 2016 when the Cambridge Union (2016) for the first time in its history debated the question of masculinity. Whilst the attention being given to male gender issues was itself welcome, the title of the motion in itself suggested pre-existing prejudices: "This House believes masculinity is *harmful to everyone*". The motion was carried by a significant majority indicating a very negative view of masculinity. A year later at University College London in 2017, however, a similar debate was conducted with a more balanced and humorous title: "Is masculinity toxic or a tonic?" The verdict was much closer this time and those who attended actually voted marginally against the proposition that masculinity is toxic. This result appeared to show an encouraging possibility of attitude change towards masculinity as the result of proper debate and a balanced presentation of evidence.

Again, there are demonstrable flaws with the concept of toxic masculinity as a serious scientific hypothesis given the full spectrum of available evidence. There is inevitably a great deal of overlap with the evidence against the "hegemonic" model of masculinity (above):

1. Most young males are socialised primarily by adult females (see above) and so the theory would have to explain why supposedly non-toxic attitudes in one gender would lead to the transmission of toxic attitudes to the other. The evidence is also clear that father absence has a *negative* impact on the development and mental health of children (see the chapter by Briggs in this volume, and Farrell and Gray (2018).
2. Most males behave in risk-taking and protective ways rather than destructive ways in regard to women and children (see above). The role of protector is more naturally adapted to men, as evidenced also by many physiological differences indicating that men are more adapted to combat than are women (Sell et al. 2012).
3. Abusive and toxic behaviour by criminal males constitutes an extreme and atypical sample that cannot be considered scientifically or

statistically representative of the average male or the total male population. It is bad science to generalise from the extreme to the norm and it therefore makes better scientific sense not to attribute the toxic and harmful behaviour of such men to their gender alone.

4. Masculinity as a concept or entity, whether biological, social or psychological, cannot be separated from the reciprocal concept of femininity—if one is toxic then so must be the other.
5. Females equally exhibit substantial levels of violence and aggression in personal and domestic relationships, as described for example by Fiebert (2010), Archer (2000) and also the chapter in this book by Powney and Graham-Kevan. It would be hard to argue from this evidence therefore that toxicity, as measured by violent behaviour, applies particularly to masculinity and not also to femininity.
6. Masculinity cannot be both *toxic* to all (including men themselves) and at the same time *privileging* for men—this is clearly a complete self-contradiction.
7. Male perpetrators of sexual and physical violence or abuse tend to have a history of abuse, trauma or neglect in their own early histories and can be clearly distinguished from the general population of males who have no such histories and are not abusive (Levenson et al. 2016). This implies that the toxicity is in the history of individual men rather than collectively in their gender.
8. Males who perpetrate sexual and physical violence against women in particular can often be shown collectively to have personality disorders relating to a significant history of early childhood abuse and neglect in relation to their early maternal attachments. In one recent study, 52% of men in a sample of high-security prisoners who had committed serious offences against women had been sexually abused in childhood by *female abusers acting independently of men* (Murphy 2018).
9. Whilst theorists such as Kimmell (2018) have attempted to link extreme terrorism with hypothesised toxic attributes of the masculine gender, hard evidence provided by Hudson (2005) shows that females have always played a major role in terrorist activities, accounting for anything between a third and a half of the membership of terrorist groups across the globe.
10. The concept of toxicity uses a powerful biological metaphor involving the notion of a substance that is poisonous and harmful to the health of an organism. Given that masculinity is an attribute found within at least half of the human population, this theory in effect predicts pathology as norm, involving pervasive levels of toxicity, ill health and damage in human societies. However, these predictions do not fit with actual

> observations of human relationships, family life and community life in which men, women and children across many societies are frequently capable of shared health and happiness. Toxic behaviour, where it does occur, is the exception rather than the rule. The theory cannot predict therefore why good gender and family relations should be possible and why any human relationships involving masculinity should function well or why intimate partner satisfaction is as common as it is.

Given the evidence above, it is better science therefore to conclude that it is not masculinity per se that is toxic but that emotional damage, neglect, alienation and abuse of some boys and teenagers in their developmental years will contribute to masculine types of toxic behaviour later in life. It is highly probable that gender interacts with emotional damage and this would explain why damaged men behave in different ways from damaged women, although there are more similarities between men and women in terms of intimate partner violence (Fiebert 2010; Archer 2000), abuse of children (Murphy 2018) and even in terms of participation in terrorism (Hudson 2005) than was previously supposed.

Most obviously, there are clear gender differences in sexual behaviour. Because most males, unlike females, are primarily attached in infancy to the same sex that they will subsequently bond with sexually, it can be predicted that those males whose early emotional attachments to female caregivers have been damaging will resort subsequently to greater levels of sexual violence (including rape) against women than vice versa. In the domain of rape and sexual violence this difference is clearly shown by global statistics. However, the vast majority (perhaps 99.4%, see below) of males cannot reasonably be classified as sexually violent, a fact which strongly supports the conclusion that sexual violence does indeed arise only in a significant minority of men whose relationships to women have already been seriously damaged. Moreover, rates of sexual victimisation perpetrated by women on men and on other women are significantly higher than previously believed (Stemple et al. 2017; Murphy 2018).

"Hyper"—Masculinity

"Hyper-masculinity" or "machismo" (e.g. Mosher and Serkin 1984) was the term used for problematic male behaviour (including sexual aggression, extreme risk-taking and sexist attitudes towards females) before "toxic masculinity" became fashionable. This term is less problematic than

"toxic masculinity" because it does not automatically confer stigma upon the whole masculine gender. Instead, the term implies that such behaviour is more exceptional, an extreme version of masculinity and not inherent to masculinity as a whole. We know that extremes of anything can potentially become harmful. Even Buddhism, for example, can be taken to extremes, as demonstrated by the sarin gas attacks on the Tokyo underground by the "Aum Shinrikyo" Buddhist cult in 1995. Thus it is important that terminology has some sense of boundary that reflects reality, and is not just a blanket generalisation.

Another term which appears to be problematically lacking in boundaries is the concept of "rape culture" that emerged from the 1970s in the US "second wave" feminist movement. The hypotheses behind the concept of "rape culture" (excluding male rape victims and female perpetrators for the purposes of argument) are that (1) the rape of women has been "normalised" and "made acceptable" in many social settings (2) rape is not a rare event and (3) rape reflects the dangers of masculinity generally and not the actions of a damaged minority of men. When compared to the actual statistics, however, these claims are demonstrably inaccurate. In 2012, out of a population of approximately 119 million adult males (aged over 15 years) in the USA, there were 747,748 registered sex offenders (including rapists). Of course, even one sex offender is one too many. However, even assuming all offenders on this list were male, this equates to a prevalence of approximately 0.6% which means that over 99.4% of adult American males in 2012 were not in the sex offender category. Even allowing for some under-representation, sex offending is statistically a rare behaviour amongst the general population of adult males, so any theory postulating a causal link between the normative culture of masculinity and sexual violence would have to explain why the prevalence of sex offending is not greater than it is. It makes much better sense scientifically to hypothesise that sexual offending by males is an interaction between gender and other non-gender-related vulnerability factors. Murphy (2018) reported on findings from her clinical work and research in a high-security prison with men with a history of serious offences involving violence, particularly sexual violence. These were men who would typically attract the labels "personality disorder" and "psychopath". She found clear links between their adult offending behaviours and extremely damaging childhood histories, including severe "parental antipathy", rejection, abuse (physical, sexual and emotional), trauma and neglect. Most significantly, in relation to the fact that these men had often offended against women, she found that: "… of those who had been sexually abused during childhood, 52% had been abused on at least one occasion

by a woman (acting independently of any men)" (Murphy 2018). Murphy reported high levels of prejudice initially, even amongst professional prison staff, that men could really be victims in this way. There were also high levels of scepticism that therapeutic change could or should be achieved with such a population. However, she found that by offering personalised approaches, building trust over time and treating these men as deeply damaged people who had built up extreme emotional defences against their vulnerability, she and colleagues were able to achieve significant therapeutic change in many cases. These findings make sense in terms of psychodynamic theories of attachment, infant development and personality development. Unlike for most females, the first love attachment for most male infants is with the gender that they will subsequently bond with sexually in adulthood. This means that for males their initial dependency on a female adult, if it goes wrong, contaminates their subsequent adult sexual behaviour and relationships.

Summing Up: What if Masculinity Is Neither Toxic nor a Social Construct? The Dangers of a Falsely Negative Construction of Masculinity

It has been demonstrated here and elsewhere (e.g. the chapter by Barry and Owens) that a social constructionist model of the male gender, as exemplified by popular notions of "hegemonic" and "toxic" masculinity, does not fit a large body of evidence and cannot be considered to meet standards of empirical science. It is never good science or philosophy to split mind from body. Without sex there could be no gender. Given that human beings are a mammalian species, it should not be surprising that biological sex differences make a significant contribution to masculine identity and male psychology. If this were not the case, it would be impossible to explain why transgender people, who have been socialised from early childhood congruently with their outward physical appearance, still come to feel an overpowering gender dysphoria, an *essential* internal sense of being in the wrong body. Clearly, this proves that a person's gender is not entirely the result of learning and acculturation. The dysphoria of transgender people is therefore better explained by sex differences in their brain development than by social factors.

However, this equally does *not* mean that gender is determined solely by nature. Scientific evidence indicates that social factors shape the *expression* of gender identity rather than creating gender itself. But although the social expression of masculinity may in part be learned and adapted, masculinity

is clearly neither a set of stereotypical roles that humans play (as hinted at in another fashionable term, "masculinit***ies***") nor is it something that can be chosen. Masculinity, just like femininity, is an embodied and evolved part of our species.

Although we celebrate many other identities (e.g. LGBTQ, women, disabled, ethnicity and religious faiths) we do not currently celebrate or even value men and masculinity. By only seeing negative aspects of men and masculinity and by continuing to address the problems of men and boys as if these reflect mere stereotypes, there are three serious ongoing risks to society:

1. *Stigma*—if the underlying assumption in public messages about masculinity in our culture, politics and media is that masculinity is toxic, this will inevitably have a corrosive and stigmatising impact on the self-image and self-esteem of boys. The danger of boys internalising this stigma is a classic "unintended consequence," and research into self-fulfilling prophecy suggests that "giving a dog a bad name" tends to make behaviour worse (Sharma and Sharma 2015).
2. *Prejudice and bias*—in an age of intense focus on gender equality, the failure to recognise areas of male victimhood and disadvantage constitutes a double standard that breaches standards of ethics, science and humanity, and is not good for the health of society as a whole.
3. *Misguided and Damaging Social Engineering*—without empathic, gender-specific and male-friendly services, based on research and understanding of the male experience (see chapter by Liddon et al.), the continued provision of gender-blind, feminised (Morison et al. 2014) social constructionist (or, more aptly, "social destructionist") services to men can only fail to address—or even further undermine—the health of men, their families and their communities. Only therapeutic failure can result from blaming men for their differences in help-seeking behaviour (e.g. Yousaf et al. 2015) rather than honouring and respecting those differences. Taken to extremes, the thinking behind the concepts of hegemonic and toxic masculinity has resulted in approaches to therapy for men that have the aim of reconstructing or detoxifying their masculine characteristics; these amount, in effect, to social engineering. Various forms of feminist therapies exist that are said to be applicable to male clients, for example "Feminist multicultural therapy" (FMCT) (Wolf et al. 2018) and the "Duluth Domestic Abuse Intervention Project" (DAIP) (Pence and Paymar 1993). Perhaps not surprisingly, the empirical evidence for the effectiveness of these approaches is underwhelming (e.g. see chapter by Powney and Graham-Kevan). Even for very widespread interventions such as Duluth, it seems unlikely that such approaches meet professional

standards of ethics in terms of being judgmental, unempathic and non-collaborative when it comes to male clients (see Corvo et al. 2009). It might be thought that a reassessment is needed, but the chronic issues with interventions based on this negative approach to masculinity don't appear to have been noticed in mainstream psychology. Indeed a recent initiative within the UK Division of Clinical Psychology called the "Power Threat Meaning Framework" (Johnstone et al. 2018) suggests that power imbalances, such as "patriarchy and masculinity" contribute to the creation of mental health problems (see pp. 124–8 of the long version), especially in women. The PTM Framework has subsequently been criticised as "a hybrid social constructionist, anti-psychiatry, anti-science and political agenda… more manifesto than scholarly document" (Salkovskis and Sutcliffe 2018). The blindness to this crusade to reform masculine identity is very ironic, however, at a time when the British Psychological Society has worked so hard to outlaw "conversion therapy" for homosexuality (BPS 2017).

Towards Positive Models of Masculinity

From Stereotypical to Archetypal Masculinity

Given age-old universal and cross-cultural patterns of male behaviour, particularly in relation to play, fighting, protecting, risk-taking, help-seeking and even suicide, it perhaps constitutes better science to conclude that masculinity is closer to an archetypal (embodied) phenomenon than a stereotypical (learned) phenomenon. This means that gender is intimately connected with biological sex and with our human evolution as a mammalian species, and that whilst the expression of gender can and does adapt to social and cultural changes, gender itself is an instinctive and natural part of the human condition.

The idea of masculinity as archetypal rather than stereotypical offers a much more positive, clear and hopeful approach than the one popularised today, yet it is certainly not a new idea. In ancient China, Taoist philosophy conceptualised the duality of femininity and masculinity as reciprocal and universal aspects of life, being aspects of "Yin" and "Yang", respectively. Carl Jung took a similar view that masculinity and femininity were universal and archetypal aspects of human nature that, whilst they could be expressed differently within individual personalities, transcended the individual and were embedded at a deeper level in what he called the *collective unconscious*. For Jung, this also meant that all men contained a universal feminine element

which he called "anima" and all women contained a corresponding masculine element called "animus". The implication of this is that there are universal and archetypal scripts for gender difference that we all recognise implicitly as human beings, regardless of our own personal place as an individual within the gender spectrum.

More recently, the idea of archetypal gender scripts has been further explored as a way of trying to explain major gender differences in suicidal behaviour. Our own research team has hypothesised that men on average have a greater archetypal drive or instinct to:

1. "Fight/win"
2. "Provide/protect"
3. "Retain self-mastery/control of emotions".

In a survey (Seager et al. 2014) of 518 men and women, higher scores on the Fight/win scale were predictive of higher suicidality scores, suggesting that reworking *overly-rigid* interpretations of these embedded ideals could be a way forward (see Seager 2019 in this volume for further details). Whilst further research is required, the initial findings support the theory that whilst such archetypal gender scripts do not define or constrain individual men and women, they do begin to explain *average* gender differences in drives, motivations and life choices. These findings also take us closer to developing more positive and gender-specific ways of reaching and helping potentially suicidal men collectively. For example, the use of male-friendly language that *honours* and goes *with the grain* of the male archetype (e.g. "if you seek help you're taking action and taking control") is much more likely to encourage men to seek help in the real world than language that violates the archetype (e.g. "don't be so macho—go ahead and show your feelings!") (see chapter by Seager).

The Positive Impact of Fathering

Elsewhere in this volume Briggs (2019) details the seriously negative impact of father absence in three cases that presented to him in his work as a consultant child psychotherapist in the UK. This experience is echoed in a recent book by Farrell and Gray (2018), illustrating the very different outcomes for "dad-deprived" versus "dad-enriched" boys. These authors point out the evidence that "dad deprived" boys are much more likely to go on to fill the "dad void" in negative ways, often involving a cycle of criminal behaviour and further deprivation. Similarly, Hill et al. (2016) point out the

value of fathers for daughters too, providing evidence within an evolutionary-based framework that shows that the regulation of sexual development and the quality of subsequent reproductive decision-making in girls without good fathering is, on average, significantly less healthy than in those with good fathering. Again, this kind of evidence about the value of masculine parenting can get lost because of the inevitable publicity that surrounds the minority of fathers and other male adults who are abusive.

If the evidence is clear that children without fathering are likely to have poorer health and social outcomes, then it makes sense to suggest that the masculinity inherent in fathering is positive. Farrell and Gray (2018) count several ways in which dads are important to their children of both sexes and illustrate numerous key domains of life where father absence is detrimental, for example: education, employment, suicide, drugs, homelessness, bullying, poverty, social mobility, crime (including rape), trust and empathy. These authors also list numerous positive things that dads on average do differently that are vital to the healthy development of children including: boundary enforcement, exploring nature, taking risks, roughhousing, hangout time, teasing and humour.

The Positive Psychology/Positive Masculinity Framework for Psychotherapy with Boys and Men

The question of male-friendly therapy will be dealt with in more detail in another chapter in this volume (by Liddon et al.). However, it is worth noting in general that new therapy approaches that take a positive view of masculinity are at last beginning to emerge. One notable example is the "Positive Psychology/Positive Masculinity Framework" (PP/PM) developed in the USA by Kiselica and Englar-Carlson. These authors have in essence taken the ethos of "positive psychology"—a humanistic term coined originally by Maslow and expanded by Seligman (2002) into a comprehensive approach—and applied it inclusively to psychotherapy with men and boys. In practice this has meant recognising that "traditional" masculinity has many positive features and strengths and that building on these is a much better way of connecting with individual men and boys than focussing on their deficiencies. Kiselica and Englar-Carlson (2010) outline ten domains of positive masculinity where such therapeutic connections can be made with men and boys either individually or in groups:

1. Male relational styles
2. Male ways of caring

3. Generative fatherhood
4. Male self-reliance
5. The worker/provider tradition of men
6. Male courage, daring and risk-taking
7. The group orientation of boys and men
8. The humanitarian service of fraternal organisations
9. Men's use of humour
10. Male heroism.

They richly illustrate their approach with a moving case study of a man ('Clifford') who had experienced previous therapy as overly critical and undermining, but who was able to turn his life around through experiencing this new PP/PM approach. The authors conclude that "positive masculinity should be the central focus, rather than an afterthought, of clinical practice and psychological research pertaining to boys and men. Much more attention should be focused on studying those aspects of masculinity that are worthy of emulation …" (Kiselica and Englar-Carlson 2010, p. 283).

"Traditional" Masculinity Can Have a Positive Side

Along very similar lines, a meta-analysis and meta-synthesis of 34 studies concluded that traditional masculine virtues can in fact become healthy resources for men coping with depression (Krumm et al. 2017). These resources were, in brief: taking control through information gathered and relying on one's own resources; beating depression and regaining control by becoming independent from medication; physical activities such as chopping wood, playing in a rock band, and motor biking; reframing depression as a heroic struggle from which they emerged a stronger person; reframing help-seeking as active, rational, responsible and independent action. We should not be surprised that masculinity has a positive side—there is a sound evidence base that testosterone itself has many psychological and health benefits (see chapter by Barry and Owens).

Conclusion

It has been shown that contemporary mainstream approaches to masculinity have tended to be rooted in social constructionist assumptions and, although perhaps with good intentions, have taken a judgmental stance towards the male gender. Evidence has been presented in this chapter

showing that such an approach to gender leaves room for improvement in terms of ethical and scientific standards. Generalisations about masculinity as a whole appear to have been made on the basis of small, unrepresentative and extreme samples of damaged men. Ideas such as "hegemonic" and "toxic" masculinity have grown in acceptance without being subjected to proper debate or empirical testing.

It has been argued that whilst masculinity, as a natural part of the human spectrum, cannot be toxic, social attitudes to the male gender as exemplified by the concept of "toxic masculinity" *have* become toxic. Masculinity is better understood as an archetypal part of the human condition rather than as a collection of stereotypes that can be altered through treatment or education. Whilst gender itself is not alterable through therapy, individual men and boys with problems can be helped to change their feelings, attitudes and behaviours if male-friendly and gender-specific approaches are adopted. It has been shown that when a positive, inclusive, empathic and respectful approach to men and boys is offered, much better results can be obtained, as would be expected with any other category of human beings.

It is not so much masculinity therefore that needs to change as our collective social attitudes towards it. If masculinity is afforded equal respect as a natural part of human diversity along with other identities, a great deal of progress can be achieved in making society better for all of us.

Aspects of the male archetype itself, particularly the drive to take risks, to protect others and not to seek help, combined with the absence of an "in-group" bias, have also contributed to the relative invisibility of male victimhood and a resultant "empathy gap" (e.g. Seager et al. 2016) towards men and boys. It is hoped that this chapter, along with the other chapters in this collection, will serve to raise awareness of the issues and problems facing the male gender, and encourage others to find effective ways to address them.

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Male Victims of Intimate Partner Violence: A Challenge to the Gendered Paradigm

Deborah Powney and Nicola Graham-Kevan

Intimate Partner Violence (IPV) is defined as any behaviour within a current or previous intimate relationship that causes physical, psychological or sexual harm (WHO 2005). IPV is a global social health issue (Dutton and Corvo 2006; WHO 2005), resulting in negative physical effects such as injury; negative health-related behaviours such as substance misuse, psychological effects that include PTSD and depression (Lawrence et al. 2012), and economic effects such as homelessness (Roberts et al. 2017). Traditionally, this matter has been framed as violence against women, or 'gendered violence,' which the Home Office (2016) posits 'should be understood as *a cause and consequence of gender inequality*, and as a result, impacts disproportionately on women and girls' (Home Office 2016, 7). Despite evidence to the contrary (see below), two core assumptions here are: (1) violence towards women is gender based violence, i.e., it is because the victim is a woman that she is targeted; and (2) women are subject to 'structural inequality' in England and Wales, which in some unspecified way motivates men to use violence to women and girls.

The first assumption is that violence towards women is because they are women. As Felson and Lane (2010) explain, this translates to the idea that

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misogynist men assault their female partners to maintain their dominance, in contrast to violence committed by women which is understood as a reaction to the violent behaviour of their partner, and so is motivated by self-defence. The problem with this assumption is that empirically it is not supported. Not only is the majority of IPV bilateral (see below) but evidence indicates IPV is not gender driven. Evidence shows that typical motives; are: to get the partner's attention, expression of negative emotions, jealousy and communication difficulties, and that these motives are reported equally by both male and female perpetrators (Elmquist et al. 2014; Langhinrichsen-Rohling and McCullars 2012). Additionally, contrary to the assumption, men typically inhibit their violence towards a female partner due to normative constraints against harming women (Felson et al. 2015).

The second assumption is that women are subject to structural inequality. No concrete examples are given to support this or any indication what may count as measurable evidence for evaluation. In England and Wales there is little evidence of structural inequality favouring men over women, indeed within family court and the criminal justice system (CJS) women are generally treated more favourably than men (MoJ 2014). In spite of this, the government and charities are very concerned about women within the CJS and are calling for a reduction in women's imprisonment, even though it is acknowledged by the Ministry of Justice (MoJ) that females are underrepresented as offenders across all crimes (MoJ 2015, 10). It seems that women are treated more leniently than men throughout the CJS, enjoying a confluence of unequal relations in roles, functions, decisions, rights and opportunities within the CJS compared with men. This sexism is not only approved of, but also criticised for not going far enough.

The Development of the Gendered Paradigm

In the UK IPV is prevalent, with these types of crimes accounting for almost 16% of the caseload of the Crown Prosecution Service (CPS 2016), with an estimated 1.6 million incidents per year (ONS 2017). It is often reported by action groups and the media that over 4 million women experience IPV each year, accounting for 7.7% or 1 in 4 women. However, what is rarely discussed are the statistics from the same reports that estimate 4.4% of men in the UK were victims of IPV in that year (ONS 2016; Mankind Initiative Brooks 2016). This equates to one in three victims being male, with the Office of National Statistics (2016) estimating that 1 in 6 men will be a victim of IPV in their lifetime. Additionally, as men are three times less

likely to report incidents than women, in this already under-reported area (Mankind Initiative Brooks 2016), the estimate for male victims is probably conservative. Despite the evidence, victimisation of this type has been framed a characteristic of being female, with perpetrator programmes (Bates et al. 2017b), victim support (Mankind Initiative Brooks 2016), and political policy (Women's Aid 2018) being led by the patriarchal narrative, leaving male victims very much under supported.

Since the 1970s, there has been debate between theoretical and scientific communities regarding the causes of IPV (Graham-Kevan 2011; Straus 2009a; Whitaker and Lutzker 2009). Although evidence-based theories have been put forward, feminist ideology has dominated the field. This is due in part to sustained feminist campaigning bringing domestic violence against women into the public domain (Straus 2009b), thereby securing public and institutional support to help female victims and stop heterosexual male perpetrators (Graham-Kevan 2011). From this feminist stance, 'patriarchy' is viewed as the single, direct cause of IPV (Bell and Naugle 2008; Dixon and Graham-Kevan 2011) (see Chapter 5 by Seager and Barry for a description of patriarchy theory). While this theoretical principle has been heavily criticised (Cook 1997; Dutton et al. 2009; Dutton 2011; Straus et al. 1988; Straus 2009b), it has been instrumental in shaping the responses of law enforcement, public offices and societal opinion and is clearly the foundation for the government's approach to intervention.

The most prolific and influential programme developed to counter IPV is the feminist-centric Duluth Domestic Abuse Intervention Project (Bates et al. 2017b; Graham-Kevan 2017), colloquially known as the Duluth model. Although commonly understood as a male perpetrator educational course, the main aim of the project was to develop a wide-reaching strategy of synchronised policies and practices that integrated law enforcement, the judiciary and service providers (Graham-Kevan 2007). The programme curriculum was developed in conjunction with female victims, shelter workers and activists from the battered women's movement with the purpose of using community institutions to diminish the believed power batterers had over their victims (Pence and Paymar 1993). It is therefore unsurprising that the premise of the programme is that of a gendered perspective, grounded in patriarchal feminist theory (Graham-Kevan 2017; Dobash and Dobash 1979; Pence and Paymar 1993). With the primary or even exclusive cause of IPV believed to be the 'Power and Control' of women by men; instigated, developed and supported by the patriarchy. No other explanation of the cause of IPV is acknowledged and any other possible cause, such as psychological issues and emotional dysregulation, is admonished and attributed to the patriarchy (Dutton and Corvo 2006).

As a core belief of the Duluth model, this stance is monolithic and unwavering (Dutton and Corvo 2006, 2007; Dutton 2006, 2012; Dutton and Nicholls 2005), and forms the absolute centre of the Duluth Model. Based on theory, Duluth is a psychoeducational (Dutton 2006) perpetrator programme intended to ensure the safety of women by holding men accountable for the abuse they have committed (Shepard and Pence 1999). The model is a court mandated 26-week group programme that aims to educate men to change their behaviour from those represented on a 'power and control' wheel to those which are described on an 'equality' wheel, terms which have become synonymous with the Duluth model. These behaviours were defined by female victims of IPV and are split into eight themes, each being explored over a 3-week period. It is believed that this process will move relationships from authoritarian and destructive to egalitarian (Pence and Paymar 1993).

Key to the implementation of the Duluth plan is the requirement for all agencies that are involved in IPV cases to be fully coordinated in the Duluth philosophy. As well as providing sanctions and rehabilitation for abusers via probation services, strategies are developed and implemented to coordinate action by the police, the court, child protection services and shelters, thereby, covering all possible contact points. A tracking system is applied with the intention of '*preventing community collusion with abusers*'… Ensuring '*that individual police officers, probation officers, therapists, prosecutors, judges, advocates, and jailers are not screening cases out of the systems based on misinformation*' (Pence and Paymar 1993, 19). Information is gathered at each stage of the process in a prescribed manner in order to guarantee that the different agencies adhere to the Duluth way of reading and interpreting, and those individuals within the institutions involved that fail to meet the required standards are held personally accountable. Controlling all elements of the process (including: beliefs regarding domestic abuse, agency responses, information processing and overall compliance) ensures that everyone involved is obedient to the philosophy of the Duluth model. This level of integration and control has ripple effects throughout the system (Dutton and Corvo 2006). Men who are experiencing abuse from a female partner may not perceive themselves to be a victim of abuse, as the establishment normalises the Duluth patriarchal concept. Shelters will be set up for female victims, and law enforcement may not take men's victimisation seriously (Douglas and Hines 2011).

Those that present challenges to the Duluth model are seen as detractors (Shepard and Pence 1999), dismissed as anti-feminist (DeKeseredy and Dragieicz 2007; Gondolf 2007) or accused of endangering the lives of women (Campbell 1997 in Shepard and Pence 1999). The main challenge

to the Duluth philosophy is the growing body of evidence regarding female perpetrators and male victims, which is dismissed as 'backlash'. Robust scientific method is criticised on the grounds that the context of the violence is not considered when examining female perpetrators. Although for male perpetrators one of the core requirements is to agree that the '*act of violence must be made the sole responsibility of the person using it*' (Pence and Paymar 1993, 17), it is asserted that female perpetrated violence is committed in self-defence or retaliation for abuse by a male partner. Additionally, it is claimed that female abuse is less serious than male violence and does not cause fear in the male victims. These conclusions are based on research carried out by the originators of the Duluth model, with women who had either self-referred, been arrested or court-ordered to an abuser programme for acts of IPV against a male partner (Shepard and Pence 1999). In some cases, self-defence and retaliation were given as the motivation behind the violence. However, other reasons given include: *I wanted him to pay attention to me, I wanted to get some control over the situation, I wanted him to take responsibility,* and *I wanted him to respect me.* Furthermore, it was reported that the female perpetrators did not feel that their male victims were fearful of the violence inflicted on them, regardless of the degree of force the women used, unless she used weapons such as knives or guns, in which case it was felt that the male victim may have felt fear but only temporarily. For each and every reason given by these female perpetrators the creators of the Duluth model not only continually dismissed female perpetrated violence, but attributed the abuse to the behaviour of the male victim. It would seem that the standards and expectations of ownership of violent acts, and cessation of victim blaming, only apply if those involved fit with the prescribed template of feminist theory.

The Duluth model was created over three decades ago. Since that time numerous studies have shown gender symmetry regarding perpetration of IPV (Archer 2000, 2006; Langhinrichsen-Rohling et al. 2012; Straus et al. 1980; Straus 1979, 2009b; Straus and Ramirez 2007; Whitaker et al. 2007). These studies also demonstrate evidence against adopting a single cause, gendered perspective approach to domestic violence (Bates 2016; Bates et al. 2014; Dutton 2006; Dutton and Corvo 2006; Dutton and Nicholls 2005; Graham-Kevan 2017). Despite this, development of perpetrator programmes have been heavily influenced by the Duluth model (Bates et al. 2017b). The UK's government funded charity Respect, which accredits domestic violence prevention programmes, mirrors the feminist beliefs enshrined in the Duluth model, with the accreditation framework based on the premise that domestic violence is a gendered issue (Dixon and Graham-Kevan 2011).

To attain accreditation, prospective members must demonstrate that the survivor experience is placed at the centre of all work carried out with perpetrators (Sarah Newton MP in The Respect Standards 2017), in the same manner as the Duluth model. Furthermore, the Respect standards call for an integrated agency approach and national strategies to address Violence Against Women and Girls (VAWG), which could be compared to the coordinated agency response within the Duluth model. In order to retain accreditation, organisations are subject to a 'robust and thorough full scrutiny audit, carried out by expert assessors', and includes desktop reviews, site visits, sampling of client videos and interviews with staff (Respect 2017). This tracking and monitoring ensures that all services meet or exceed the quality standards. In the same vein as the Duluth model, prescribed procedures, polices and ways of working are closely controlled to ensure that each accredited organisation follows the feminist doctrine of Respects' standards.

It is informative that there are a number of professional endorsements published along with the 3rd (latest) edition of the Respect accreditation standards. Here we see key influencers such as the Minister for Crime, Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) lead on domestic abuse, various prominent academics whose research is gender focused, and even the Children and Family Court Advisory Support Service (CAFCASS), paying homage to the standards introduced. Women's Aid praised Respect for recognising that domestic abuse is far from gender neutral and that women's inequality is both a root cause and consequence of domestic abuse (Katie Ghose in The Respect Standards 2017). From government departments, police forces, academia, through to children's social workers, these testimonials demonstrate the institutional pervasiveness of feminist theory, that requires strict adherence to the principles of patriarchy as the exclusive reason for IPV. Evidently, Respect not only has the same ethos as the Duluth model, but has an almost identical framework. Based on what academics call 'feminist dogma' (Dutton and Corvo 2006; Dutton et al. 2009), both organisations believe the single issue of patriarchy as the cause of IPV.

When examining the gendered theoretical stance of IPV prevention in the UK, it would be remiss not to consider Women's Aid, the charity widely acknowledged for raising awareness, and heralded by feminists as the experts within the field of IPV (Eadie and Knight 2002). Women's Aid is a federation of women's aid support groups that coordinates local services to support women and children that are victims of domestic violence. However, like the Duluth model proponents, they lobby government, consult with social agencies and campaign for changes within the police and the judiciary to bring

about changes in policies and procedures. As expected Women's Aid is a support group for women, helping thousands of women each year; this in itself is to be praised but does not qualify them to dictate interventions (Graham-Kevan 2017). The reach achieved by Women's Aid is problematic when we consider the impact the views of such an influential organisation have on wider perceptions of IPV (e.g. in the courts, media, general public etc).

In line with both Duluth and Respect, Women's Aid perpetuate the claim that 'domestic abuse is a gendered crime which is deeply rooted in the societal inequalities between women and men' (Women's Aid 2018). Women's Aid also affirms that women are the 'overwhelming majority of victims of domestic abuse' and that 'domestic abuse is a violation of women and their children's human rights'. Any reference to female perpetrated violence is moderated as not as harmful or frequent as male violence, and claims not to cause fear in male victims (Hester 2013). The avoidance of acknowledging male victimisation is common in all communication from Women's Aid. It has been suggested that the type of social marketing utilised by some charities to gain funding and disseminate their message could be described as propaganda, defined as 'the deliberate and systematic attempt to shape perceptions, manipulate cognitions, and direct behaviour to achieve a response that furthers the desired intent of the propagandist' (Shaughnessy 1996). Data regarding female victims appears to be repeatedly stated as a method of propaganda (Gambrill 2010) to support the extent to which women are affected, while data regarding male victimisation is completely ignored even when its reported from the same sources (Cook 1997). In addition to using externally sourced data from academics who specialise in researching IPV from a gendered perspective, Women's Aid carry out internal research involving women in their shelters that is used to inform external agency policy and practice. This poses methodological issues that are typical for organisations with a vested interest in finding high rates of male to female violence only (Dixon and Graham-Kevan 2011; Dutton 2011). Most obvious among these issues, using a sample recruited from Women's Aid shelters will undoubtedly show high levels of male to female perpetrated violence, but such levels cannot be applied to the general population (Cook 1997; Dutton 2006).

A tactic of the Duluth model is to work with influential agencies to ensure interventions conform to the Duluth philosophy (Graham-Kevan 2007), and the same strategy is being applied by Women's Aid. Section 2 of Women's Aid's latest Trustees' Report sets out the strategy for influencing legislation and policy to protect survivors and their children, including a list of the groups Women's Aid was involved with in the past year.

These include: the Inter-Ministerial Group on VAWG, the Home Office Stakeholder group which is responsible for the way domestic abuse is handled as a crime, The Crown Prosecution Service (CPS) VAWG consultation group, the National Oversight Group on police response to domestic violence, Police Regional Leads and Stakeholders for domestic abuse group, and the Domestic Abuse Statistics Steering Group set up by the Office for National Statistic. As a key stakeholder in each of these groups, Women's Aid can influence every agency that sets national policy and procedure for dealing with IPV. The government and CPS now refer to violence against women and children when debating decisions regarding IPV. Women's Aid even has influence over the way in which national statistics are being reported; being a member of the steering group set up by the Office of National Statistics to review the way domestic abuse statistics are produced and published. Additionally, Women's Aid collaborated with CAFCASS to produce a report into family cases in the courts, claiming that in 62% of child contact cases the father was accused of domestic abuse. Following widespread criticism (Men's Aid 2017) regarding a government agency being influenced by a politically driven feminist group, CAFCASS removed the report and it is no longer available (contact Author for a copy). Once again, the Duluth model is echoed in the strategy of a highly influential feminist group, meaning national decisions and policies will be led by the belief that the patriarchy is the singular cause of IPV, where exclusively men are the perpetrators and women are the victims.

From the Duluth perspective, preventing IPV would require overturning the deep entrenched social structure of patriarchy, which many feminists believe is the root cause not just of IPV but of the inequality of women across the whole of society (Dutton 2006). It has been suggested that for feminists, IPV represents a visible example or 'poster child' of the harm caused to women by a patriarchal system (Straus 2009b), making IPV a tool for propaganda that could potentially distort our perceptions (Gambrill 2010). Consequently, the existence of male victims of IPV represent a threat towards the central philosophy of feminism (Whitaker and Lutzker 2009). As well as concerns that acknowledgment of male victims impact the judiciaries view of IPV (Bates 2016), anxieties are exacerbated by the fear that recognition of male victims would result in cuts to funding for female-focused support (Cook 1997). For these reasons, information regarding male victimisation is routinely ignored or removed from the public eye and met persistently with unsubstantiated claims regarding female victims (Straus 2010). Moreover, feminist supporters typically become combative (Cook 1997)

when presented with research findings that don't fit the Duluth view, including smear campaigns and punishment of well-respected researchers who had previously been heralded by the feminist movement, to the point where in the US tenure has been denied (Straus 2010).

These politically persuasive organisations appear to be motivated to ensure that their message is dominant, not only inside government and community agencies but also for the general public. As governmental and public funding will be acquired on the basis of the message provided, the very existence of these organisations is dependent on wholesale belief in feminist view of IPV. Gambrill (2010) investigated the concern that propaganda is affecting the quality of practices and policies in the helping professions. Gambrill posits that the use of propaganda, using theory rather than evidence-based practice, may lead to the helping professions inflicting harm upon those they are claiming to support, because a categorical commitment to dogma prevents in-depth investigation and a full view of the available data, thereby preventing development of a robust and effective approach (Dixon and Graham-Kevan 2011; Dutton and Nicholls 2005; Graham-Kevan 2017; Straus 2009a).

Gender Symmetry and Male Victims of Female Perpetrated IPV

Within a feminist paradigm, acknowledgement of the male IPV victim is a direct threat as this also requires recognition that women can be perpetrators. From the gendered perspective, this acceptance removes women from the carefully choreographed stereotype of victim, and catapults them into the area exclusively reserved for men. It is also at odds with feminist-informed research using selected samples that are so often used to investigate IPV (Archer 2000; Cook 1997; Graham-Kevan 2007; Straus 2010). However, there are hundreds of gender-inclusive studies that show the symmetry of aggression across the genders. Martin Fiebert began collating references for peer-reviewed research and as of 2012 lists a bibliography examining 286 scholarly investigations, 221 empirical studies and 65 reviews and/or analyses, which demonstrate that women are as physically aggressive, or more aggressive, than men in their relationships with their spouses or male partners. The aggregate sample size in the reviewed studies exceeds 371,600. As mentioned previously, awareness of a lack of sex-differences in men's and women's use of IPV in western nations began in the

1970s (Straus 2009a; Graham-Kevan 2017), from research led by academics that were respected by feminist activists, but who were consequently excommunicated (Cook 1997). Straus et al. (1980), in the first ever population IPV survey in the world, reporting on findings from a community study of 2143 husbands and wives, found that of those who reported incidents of violence, 49% reported bilateral violence (violence by both partners), 27% reported that only the husband was violent, and 24% reporting that only the wife was violent.

This finding was repeated with a similar, though larger ($N = 5531$) sample (Stets and Straus 1989). Of this sample, 825 respondents reported experiencing one or more incidents of IPV, with again 49% of the abuse being bilateral, 23% with the only the husband being abusive towards the wife, and 28% where only the wife was the perpetrator of IPV. Thus the most common type of violence is bilateral IPV engaged in by both men and women. The second most common type of violence was by women, perpetrated against men that either use minor or no violence. The least common type was male perpetrated violence, against a female who engages in minimal or no violence. This directly challenged the stereotypical understanding of IPV presented by the feminist ideology (Dutton and Corvo 2006). The findings were consistent with a systematic review (Langhinrichsen-Rohling et al. 2012), which also found the same pattern for lesbian and gay couples, and further undermines the typical gendered understanding of IPV.

Stets and Straus (1989) also found that women reported they were more likely than their male partner to instigate violence by striking the first blow (52.7% vs 42.6%). As it has been shown that women are more likely to get injured by physical conflict, it would appear that by not addressing the overall issue of IPV, including treatment for female perpetrated violence, the gender paradigm is inadvertently contributing to the harm experienced by women (Archer 2000; Bates et al. 2017b; Felson 1996; Gelles and Straus 1992; Graham-Kevan 2017; Straus et al. 1988; Straus and Ramirez 2007). It is of note that this data has been available for as long as the women's movement has been actively promoting the gender paradigm, yet due to concealment and denial, most organisations and individuals are unaware of these findings (Graham-Kevan 2007; Straus 2009a).

Considered to be of 'gold standard' in studies of gender violence (Dutton 2006), Archer (2000) carried out a meta-analysis of 82 independent studies, resulting in a combined sample of size of 64,487 (men $n = 30{,}434$, women $n = 34{,}053$). The study aimed to investigate rates of perpetration and the physical consequences of physical aggression between heterosexual partners. Results showed that women were slightly more likely to be

injured by men ($d = +0.15$), which can be explained by differences in size and strength (Felson 1996). Crucially, it was found that women are slightly more likely than men to use physical violence against a partner. In a similar vein, Whitaker et al. (2007) analysed data regarding partner violence and injury in heterosexual relationships ($n = 18{,}761$) of adults aged 18–28 ($n = 11{,}370$). The data was taken from a National Longitudinal Study where IPV was reported in 23.9% of relationships, with women reporting more violent relationships than men (28.4% vs 19.3%). Among relationships that engaged in IPV, 49.7% were bidirectional, with incidents of injury that were more frequent within this type of violent relationship, than unilateral (only one violent partner). In relationships where the violence was unilateral, women were reported by both women (67.7%) and men (74.9%) to be the perpetrator in most cases. Whitaker et al. (2007) concluded they were not surprised that reciprocal violence was at such a high level, as previous studies had indicated this pattern, but they were surprised that women were the primary perpetrator in the majority of cases. They conclude that reciprocal violence is injurious regardless of gender, although women tend to be injured more severely. These findings support those reported by Stets and Straus (1992), that women are equally engaged in IPV, but are directly opposed to the claims held by those supporting the gender paradigm, who have ignored such results.

Despite belief to the contrary, the research evidence showing bilateral and female-only IPV is large, and the number of studies and participants involved have compelled a response from the feminist community (Graham-Kevan 2007). Unsurprisingly responses attempt to explain women's use of violence as self-defence against the control motivated abuse from men (Pence and Paymar 1993; Dobash and Dobash 2004; Walker 1980). Even when female perpetrators quite clearly state that they have used violence against their male partners, feminist theorists appear unable to accept any reason other than self-defence (Shepard and Pence 1999).

A systematic review of literature by Langhinrichsen-Rohling and McCullars (2012) found little support for a self-defence motive. They found that men's and women's IPV was perpetrated for similar motives, which were primarily: to get back at their partner for emotional hurt, due to perpetrators' feelings of stress or jealousy, in order to express anger and other negative emotions that they found hard to articulate and/or communicate to their partners, or to get their partner's attention. Within their review, eight studies directly compared men's and women's power/control motivations and largely found no significant gender differences. There were ten papers that allow analysis of self-defence motivations. Half found women more

likely to give this as a reason, four found no statistically significant difference between men and women and one paper found men more likely to report this motive than women. Authors point out however that self-defence is rarely endorsed for men and women. More frequently endorsed were the motivations of anger and/or retaliation, and jealousy, which were equally likely to be motivating IPV for men and women. Again, these findings present a challenge to the gender paradigm. More importantly, interventions need to consider the motivations that are specific to the individual, and not based on gender stereotypes (Carney et al. 2007; Dixon et al. 2012; O'leary et al. 2007).

The gendered view of IPV insists that where men are abused by women, there is no fear, or any immediate or long-lasting negative effects, and only minor injury. For women, not only is there expectation of serious injury, but also there is a large body of evidence that shows life altering psychological effects including PTSD, depression, anxiety, substance dependency and suicide ideation (Campbell 2002; Gelles and Straus 1988; Golding 1999; Goodman et al. 1993). However, despite being subjected to the same actions as female victims, the same consequences are deemed not pertinent for men, with the connotation that men need not have access to the support services or treatment they need (Douglas and Hines 2011). Nevertheless, although relatively under-researched, there is evidence showing that consequences for men are almost identical (Dutton 2011).

Hines et al. (2007) examined the experience of domestic violence of men ($n=190$) who had contacted the first helpline dedicated for men in the US. The men ranged in age from 19 to 64 years, with a third of the victims between 40 and 49 years. Female perpetrators ranged in age from 17 to 59, with a third falling into the 30 to 39 years bracket. The men had a variety of professions including frontline services such as police, firemen and military (13.7%), construction (4.2%), manual labour (11.6%), doctors, lawyers or professionals, or engineers or architects (3.25%). Others were either unemployed (9.5%) or disabled (17.9%). This shows that men from any background, including those that are stereotypically tough men, can be victims of abuse by a woman. Minor violence such as slapping and grabbing had been experienced along with more serious assaults such as choking and stabbing. Additionally, almost 95% of the men said that their female partner had tried to control them via threats, emotional abuse, intimidation and isolation. Many (64.5%) disclosed that often children were used to control them, and 50% said that their partner used manipulation of the system, such as obtain a restraining order or sole custody of the children. 52.4% of the men were fearful of their partner and believed that she would harm them if they found

out the man had contacted the helpline. This was echoed in a subsequent study by Hines and Douglas (2010), who examined why men stay in abusive relationships: almost 25% of the male victims said they feared their partner would kill them or someone they loved. The most common reasons for not leaving were: concerns about the safety of the children, commitment to marriage and love, and fear that he may never see his children again.

Hines et al. (2007) also examined the types of physical violence men endured. The acts most reported were being slapped or hit, pushed, grabbed or punched. However, some men described severe IPV such as attack to the groin area, having a knife held against their genitals and threatened with castration, having knives pulled on them, and being raped. Similar experiences were found by Mechem et al. (1999), who investigated male injuries as a result of female perpetrated IPV over a 13-week period, in an Emergency Department of the Hospital of the University of Pennsylvania. A previous study (Dearwater et al. 1998) had shown that 14.4% of women that used community emergency rooms had been abused by their partner within the preceding 12 months. Mechem et al. (1999) found that of the 866 male patients interviewed, 12.6% (109) had been abused by a female partner in the same time frame. Comparable to Douglas and Hines (2011), the most common forms of abuse included slapping, shoving and grabbing (60.6%), followed by choking, kicking, biting and punching (48.6%). However, 37% of cases involved the use of a weapon and 7% of victims were forced to have sex. Despite this, only 16 victims (14%) had contacted the police.

In a re-examination of the data from the National Violence Against Women telephone survey, conducted by Tjaden and Thoennes (2000), Coker et al. (2002) investigated the physical and mental health effects of experiencing IPV, including depressive symptoms, substance abuse, chronic disease and chronic mental illness. They found that physical and psychological violence affected the mental health of female and male victims, with 14% of women and 18% of men reporting that they were victims of psychological abuse alone, during their lifetime. Psychological abuse includes behaviours now recognised as coercive control in Section 76 of the Serious Crimes Act 2015, such as bullying, intimidation, isolation, humiliation and monitoring activities (CPS 2015). Within the feminist paradigm, control has historically been associated with male perpetrated abuse (Dobash and Dobash 1979; Pence and Paymar 1993; Respect 2018; Women's Aid 2018), yet in this study 78% of that experienced by men was psychological abuse, which was associated with chronic illness, depression and substance abuse. Despite the limitation that the original survey was framed as a gendered issue, results showed that both types of IPV were associated with significant

physical and mental health consequences in both female and male victims. In a subsequent study from the same data, Coker et al. (2005) reported that 24% of women and 20% of men who had suffered IPV had moderate to severe PTSD symptoms.

Implications for Male Victims and Female Perpetrators

The above evidence suggests that the need of support in male victims of IPV is equal to that required by female victims. However, due to the gendered view of IPV, men may not recognise that they are being abused (Dutton 2011; Dutton and White 2013; Gelles and Straus 1992), or they may feel shame due to societal stigma and fear of ridicule (Steinmetz 1977). This means that men may not reach out to formal support organisations (Barber 2008; Drijber et al. 2013) without campaigns similar to that which have been used for decades to encourage women to recognise their partners' IPV, and more recently coercive control, as problematic and criminal. Truthful campaigns are now needed to raise awareness among male victims so that men can (a) identify that they are being criminally victimised, (b) that society can understand that there should be no stigma attached to being a victim of this crime, and (c) that law enforcement and support agencies are ready and willing to provide support for male victims and their children. Currently there has been no such campaign in any nation in the world. Indeed men are worse than invisible, in that they are actually regarded with scorn (George 2016) and/or suspicion (Dixon and Graham-Kevan 2011) by the very agencies that should be there to help them. Not surprisingly therefore, in their study of US help-seeking male victims, Douglas and Hines (2011), found that men tended to use informal types of support such as friends, neighbours and family. Frontline services that are instrumental to the domestic violence support system such as the police, hotlines and domestic violence agencies were reported as being not helpful to male victims. Men accessing these services were told that they only helped women, and 95% of men felt that the agencies were biased against them, with some men being accused of being the perpetrator rather than victim. Additionally, 16% of men contacting a hotline and 15% of men that contacted domestic violence agencies had been ridiculed. For those men who contacted the police, 21% said the police refused to arrest the female partner and 38.7% reported that the police said there was nothing they could do. The social support that victims receive after sustaining IPV has been shown to be

negatively correlated with post-traumatic stressors and positively correlated with adaption (Anderson et al. 2012; Canady and Babcock 2009; Cobb et al. 2006; Jose and Novaco 2016). Conversely, if victims are subjected to secondary victimisation, for example victim blaming, ridicule and dismissal, and not given the support they require, male victims are at increased risk of anxiety, depression and PTSD (Campbell and Raja 1999, 2005).

Evidently, the feminist assertions that women do not perpetrate violence at the same rate as men, that when they do it is in self-defence, and that men are not fearful or harmed by female perpetrated violence, do not hold. Men are abused at similar rates as women (Archer 2000, 2006; Stets and Straus 1989), they feel fear (Hines et al. 2007), they sustain physical injuries and experience psychological effects that have devastating consequences (Coker et al. 2005), in the same way as female victims. In addition, there is a substantial lack of support available which may result in under-reporting or secondary victimisation leading to an increase in mental health issues (Campbell and Raja 1999). Unfortunately, the actions of the women's movement, intended to provide safety and freedom for female victims, appear to have become a justification for biased social control (Dutton and Corvo 2006) and the dismissal of male victims. Likewise, focusing on a small area of IPV, unilaterally male-on-female, not only means that male victims are ignored, but that the overall issue of IPV is not addressed. Evidence shows that women engage in the same—or slightly higher—levels of IPV, are more likely to instigate violence, and more likely to be physically injured. Having a singular theory of patriarchy as the cause of IPV means that feminist theorists may actually be putting women at risk of harm. Appropriate prevention programmes and treatment will not be available for women who abuse, preventing them from gaining the skills they require to enable effective conflict management without violence. Current policies are putting women at greater risk of being physically harmed (Archer 2000; Swan et al. 2008) and re-victimisation (Kuijpers et al. 2012) that may lead to increased negative outcomes such as injuries, fear, mental health issues and PTSD (Caldwell et al. 2012; Zacarias 2012), demonstrating that feminist theory is contributing to the harm it proposes to combat.

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Men's Health and Cancer—The Case of Prostate Cancer

Kenneth Gannon

Prostate Cancer: The Disease, Gender and Inequality

The prostate is a small gland situated immediately under the bladder, in front of the rectum, and surrounding the urethra (see Fig. 1). It's function is to produce some of the fluid that nourishes and supports sperm following ejaculation. It grows throughout the lifespan post-puberty due to testosterone, and most men as they age will experience lower urinary tract symptoms (LUTS) due to this benign enlargement of the prostate, known as benign prostatic hyperplasia (BPH). These symptoms include frequency, urgency and, in extreme circumstances, acute retention of urine (Gannon et al. 2005). However, the enlargement may also be the result of a cancerous tumour.

Prostate cancer is the most common cancer in men in the UK. A quarter of all new cases of cancer diagnosed in men are prostate cancers. In 2014, around 46,690 men were diagnosed with prostate cancer in the UK. Incidence increases with age. It is uncommon in men before the age of 50 but rapidly increases in successive years. For men aged 55–59 the incidence rate per 100,000 is 181.4; for the range 65–69 it is 585.7/100,000 and for 85–89 the rate is 786.6/100,000 (CRUK 2017).

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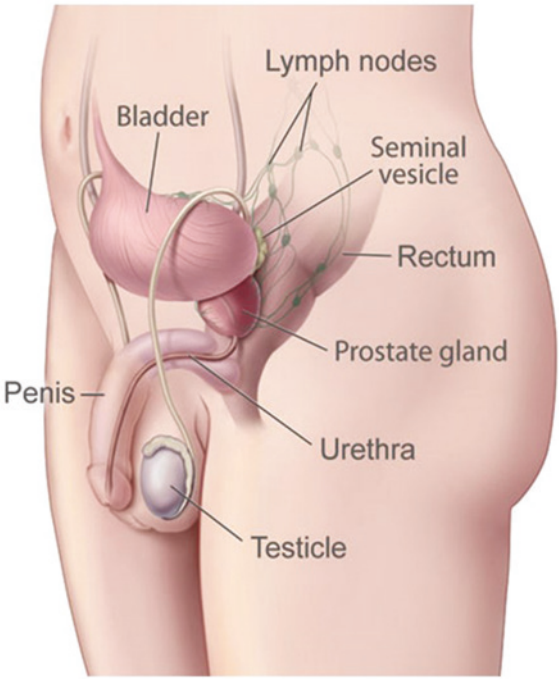

Fig. 1 Illustration showing the location of the prostate in relation to the genito-urinary system and the rectum (*Source* National Cancer Institute; Creator: NIH Medical Arts)

In 2014, there were 11,287 deaths in the UK from prostate cancer. Prostate cancer accounts for around 12% of male deaths from cancer in the UK and is the second most common cause of cancer death in men, after lung cancer. Approximately 92,300 men in Europe (EU-27) died from prostate cancer in 2012 and worldwide around 307,000 men died from the disease in 2012. Black, Asian and Minority Ethnic status (BAME) is related to mortality rates, which are generally high in predominantly black populations (Caribbean and sub-Saharan Africa), and very low in Asia. For example, African American men have an age adjusted incidence rate 1.6 times that of white American men and a UK study found that black men were three times more likely to be diagnosed with prostate cancer than white men. Subgroup analyses revealed that while the age-adjusted incidence rate for white men was 56.4/100,000 it was 173/100,000 for Afro-Caribbean men and 139/100,000 for black African men (Chinegwundoh et al. 2006). Like many cancers, the rates of PCa increase with age and more than 80% of prostate cancer deaths occur in men of 70 and over.

Diagnosis Symptoms of prostate cancer, including poor urine stream, hesitancy, terminal dribbling, retention and uraemia, usually start to develop once the tumour is large enough to press on the urethra and are very similar to those of BPH. The non-specificity of symptoms and their absence in some cases of cancer makes it difficult to identify the disease in its early stages, which is crucial for effective treatment. The situation is particularly challenging because at present there are no effective screening tests. Detection of PCa is usually on a case-finding basis whereby men that consider themselves at risk, because of family history, ethnicity or both, seek testing. Initial testing is generally by means of blood tests for Prostate Specific Antigen (PSA) accompanied by Digital Rectal Examination (DRE) of the prostate. If these tests indicate possible malignancy then the next stage is biopsy of the prostate. Unfortunately the PSA lacks specificity and sensitivity while the DRE can also fail to detect abnormalities in the prostate. Hence, there are no national screening programmes for PCa in either the UK or the US, although there are disagreements as to whether these should be introduced (Barry 2009).

An additional complicating factor is that men are frequently poorly informed about the nature and symptoms of PCa and their risk of developing the disease, with some evidence of ethnic variations (Prostate Cancer UK 2014). Studies of African-American and African men have found that both groups were unaware of the symptoms of the disease and of issues related to testing, early detection and treatment (Allen et al. 2007). Factors associated with low levels of knowledge included level of income and educational level, with some authors suggesting that when income levels are controlled the effect of ethnicity disappears (Winterich et al. 2009). For African-American men lack of knowledge was also associated with lack of medical insurance, indicating that issues of social disadvantage are important in addition to increased biological vulnerability (Allen et al. 2007). All of these may contribute to the poorer outcomes that have been reported for black men treated for prostate cancer (Allen et al. 2007). There have been several attempts to address these issues among African-American men, for example by educational and intervention programmes targeted specifically at this population. These interventions have been shown to improve knowledge of prostate cancer and uptake of screening programmes (Allen et al. 2007).

The fact that the symptoms involve potentially embarrassing urological problems may act as an additional cause of delay in addition to men's unwillingness to consult doctors. Such barriers to consultation may be greater in some cultural/ethnic groups because of culturally mediated understandings

of masculinity that increase resistance to help-seeking in general and investigations such as DREs in particular (Seymour-Smith et al. 2016).

The fact that the PSA test is widely recognised to be unreliable gives rise to challenges for GPs and Primary Care Physicians, in terms of providing guidance to men and enabling informed decision-making, and for men themselves in terms of deciding how they might wish to proceed in the face of uncertainty. There are concerns that testing can result in heightened anxiety in men even when the tests are negative (Macefield et al. 2010) and an elevated PSA can trigger additional more invasive investigations. From the few studies that have been carried out with GPs in relation to this issue there is evidence of considerable ambivalence concerning the PSA test and how best to raise the issue with men that may be at elevated risk and how to advise them about proceeding thereafter (Hale et al. 2010).

Treatment

Treatment depends on the stage of the disease. Castration (surgical or chemical) is often the treatment of choice for advanced cancer because it virtually eliminates testosterone, thereby slowing or stopping the growth of the tumour. Surgical removal of the prostate (radical prostatectomy or RP), external beam radiation therapy, brachytherapy (the implantation of radioactive beads in the prostate) and, in the case of slow-growing tumours, active surveillance may be selected for a localised tumour. All forms of treatment, apart from active surveillance, have been reported to cause temporary or permanent erectile dysfunction (Lavery and Cooperberg 2017). Other side effects include:

- Urinary incontinence
- Reduction in the length of the penis
- Retrograde ejaculation
- Faecal incontinence (following radiotherapy).

All have been found to have a substantial impact on men's sense of masculine identity, which for some men results in social withdrawal and isolation (Gannon et al. 2010). The side effects impinge on and compromise characteristics that are associated with the concept of hegemonic masculinity, such as sexual potency, physical strength and emotional resilience.

Treating localised disease Although there are many treatments available for localised PCa surgical removal of the prostate followed by chemotherapy

and/or radiation therapy remains the most common intervention and one that is the treatment of choice of many men (Lavery and Cooperberg 2017). Because of the proximity of nerves that control erection and ejaculation to the prostate and effects on the urinary sphincter RP can result in long-lasting or permanent erectile dysfunction and some degree of urinary incontinence, which can also be long-lasting or permanent (Frey et al. 2014). The severity and duration of these side-effects of treatment have been reduced through the development of nerve-sparing surgical techniques and robotic surgery but they are nonetheless experienced to some degree by most men that undergo RP. The psychological and psychosocial impact depend to some extent on their severity, the age of the man concerned and cultural factors, but studies over the years have demonstrated that it is considerable (e.g. Chapple and Ziebland 2002; Eton and Lepore 2002; Fergus et al. 2002).

Although both ED and urinary incontinence can be distressing the evidence indicates that it is ED that has the most significant impact on men (Stanford et al. 2000). Studies have documented the way in which men's sense of masculine identity can be challenged and compromised by a complete inability to achieve an erection or by an inability to achieve an erection sufficiently firm to permit intercourse (Grey et al. 2002). Men have described feeling less of a man and, particularly in the case of single men, avoiding social contexts in which the possibility of a sexual relationship might arise. For example, men in a study by Gannon et al. (2010) made comments such as

> I am not the same I used to be. I can't perform so I don't go to places where I may meet people…
> … but as a sexual partner I have no function now.

Even when there is no possibility of a sexual encounter men report distress due to the lack of a physical response to the sight of an attractive woman

> let's say if I see a pretty woman or a pretty girl on TV or something, it is nice but… I just think that is nice. Before probably could feel it was nice. At the moment it is purely in the mind.

Although aids to achieving an erection, such as vacuum pumps, viagra and injections, are available many men prefer not to use them. For some it is because the planning required to use the aids removes the spontaneity that is an important part of a sexual relationship and for others it relates to beliefs

that erections should be "natural" and spontaneous. Men that are willing to consider using aids have reported a lack of information from GPs and healthcare professionals (Gannon et al. 2010).

Men adopt a range of strategies to adapt to and manage the distress related to ED. Some simply withdraw from sexual activity, some attempt to normalise this by framing it as something that is inappropriate for people of their age or as something that becomes less possible in a busy life. Others adapt their sexual behaviour to focus less on penetrative sex and more on providing sexual gratification to their partner by other means (Gannon et al. 2010).

Some groups of men may be particularly affected by ED. Black men often develop the disease at a much younger age than white men, which means that they may have a greater desire to continue to be sexually active. In fact there is evidence that some Black men may be put off being investigated and treated for PCa because of a fear of ED (Weinrich et al. 1998). Gay men and men that have sex with men (MSM) can also suffer a particular impact because of the fact that greater rigidity is required for anal than vaginal intercourse. In addition, the retrograde ejaculation that is a consequence of RP means a loss of what for many gay and MSM is an important element of the sexual act (Filiault et al. 2008).

In general, the physical side effects of treatment can have a marked psycho-social impact on men although they tend not to report these kind of worries to other people, even to their partners and physicians.

Given the severity of the side effects and the absence of a "gold standard" of treatment men are faced with a difficult choice between a range of options, each of which has serious and unpleasant side effects. There has been little systematic investigation of how such decisions are made, but there is evidence that up to 53% of men subsequently regret them (Steer et al. 2013).

Treating advanced and metastatic disease Tumour growth and development in prostate cancer, like some other cancers including types of breast cancer, is hormone-dependent. Androgens, principally testosterone, are closely implicated in the development, growth and maintenance of the disease and removal of androgens by means of surgical castration has been shown to result in dramatic regression of disease (Huggins and Hodges 1941).

Although surgical castration is still sometimes employed in the treatment of metastatic prostate cancer a range of hormonally-based treatments (sometimes referred to as "chemical castration") have been developed over the past 30–40 years. These Androgen Deprivation Therapies (ADT) are widely

used in the treatment of locally spread (close to the prostate) and metastatic disease, although studies have found that significant numbers of men with non-metastatic disease receive hormonal intervention at some point (e.g. Cetin et al. 2013). Studies in the 1990s showed benefits of ADT in treating disease that recurred following local treatment (e.g. Messing et al. 1999). Almost half of all men treated for prostate cancer will be offered ADT if men with localised disease are included (Casey et al. 2012).

ADT is a collective term for hormone therapy, which can take a number of forms. Luteinizing hormone-releasing hormone (LHRH) agonists (also called LHRH analogs or GnRH agonists) act by reducing testosterone production in the testicles, though additional drugs are required to stop production at other sites in the body (including the prostate itself). Anti-androgens act by preferentially binding to the sites at which androgens act and thereby blocking them. GnRH antagonists (gonadotrophin-releasing hormone antagonists) are generally used when cancer has spread to the bones of the pelvis and spine.

ADT is widely considered as an effective treatment for prostate cancer (Bolla et al. 2008). It has been demonstrated to increase survival times for men with clinically localised or locally advanced disease and to provide improved symptom control, particularly pain relief, for men with advanced disease (Connolly et al. 2012). However it is associated with significant side effects, including hot flashes, osteoporosis, loss of muscle mass, breast enlargement, anaemia, fatigue, erectile dysfunction, loss of libido, risk of diabetes, risk of cardiovascular disease and, potentially fatal, cardiac events (Holzbeierlein et al. 2004). In addition to these physical effects, many of which parallel those of the menopause in women, there are growing concerns about the cognitive impact of ADT. Of particular concern is evidence implicating it in the development of dementia, including Alzheimer's disease. A recent US study (Nead et al. 2017) collected data on 9272 men with prostate cancer and the analysis indicated a statistically significant ($P < 0.001$) association between use of ADT and risk of dementia. The increased risk of developing dementia was 4.4% for men who had received ADT compared with a group that had not.

There is also evidence that ADT can be associated with more subtle cognitive impairments, particularly in relation to executive functioning, which is involved in planning, initiating and sequencing complex goal-directed behaviours. The evidence for a relationship is not clear and studies are not all in agreement. Green et al. (2002) concluded that ADT may be associated with impairments to executive function as well as to memory and attention while other authors such as Joly et al. (2006) and Salminen et al. (2003)

found no such association. However, subsequent studies by Salminen et al. (2004, 2005) indicated an association between falling levels of testosterone and a decline in cognitive performance. More recent work by Alibhai et al. (2010) and Wiechno et al. (2013) concluded that ADT had no or a negligible effect on cognitive function. One explanation for the differences in findings is that some tests are insufficiently sensitive to detect impairments and small sample sizes may also be an issue.

While the evidence at present is inconclusive there are reports from men receiving ADT of cognitive difficulties, which they attribute to ADT (Cherrier et al. 2009). This is clearly an area in which further research and the development of sufficiently sensitive neuropsychological measures of executive function are required. Given the substantial number of men receiving some form of ADT it is undoubtedly of considerable clinical and social significance.

The feminising effects of ADT, such as breast enlargement, genital shrinkage, hot flushes, loss of muscle and weight gain can also have a significant impact on men's sense of masculinity (Oliffe 2006). Another contributor to this sense of diminished masculinity is increased emotional lability and mood swings (Cary et al. 2014), particularly a greater proneness to tearfulness (Ng et al. 2012). There is also evidence that ADT is associated with depression, probably as a consequence of the reduction in testosterone levels (Lee et al. 2015). It is important to bear in mind that the experience of prostate cancer and the impact of the side-effects of treatment may well contribute to depression and there is evidence that a significant minority of patients not undergoing ADT also experience symptoms (Bennett and Badger 2005).

Prostate Cancer and the Heterosexual Couple

The partners of men with prostate cancer are a crucial source of support throughout the trajectory of the disease from diagnosis, through treatment-related decision-making, treatment and beyond to the transition to survivorship. Indeed, prostate cancer has been described as a couple's disease because of the way in which both partners are so intimately involved at all stages and each is affected by the experiences they encounter (Harden et al. 2013; Williams et al. 2014). Men clearly benefit from having a supportive partner, for example in terms of improved quality of Life (Gore et al. 2005; Soloway et al. 2005) and better physical and mental health (Krongrad et al. 1996) compared with patients without a partner. The duration of survivorship is greater for married men (Banthia et al. 2003) and partner

involvement in care is associated with improved adjustment and emotional health for the patients (Riechers 2004).

It has been recognised for some time now that men often require encouragement from their partner to seek medical advice in relation to symptoms of illness (Norcross et al. 1996) and this is also the case in prostate cancer (Seymour-Smith et al. 2002). Their partner will frequently accompany men to these initial and subsequent appointments and are closely involved in making decisions concerning treatment (Jacobs et al. 2002; Malcarne et al. 2002; Davison et al. 2002). While, as noted above, men are sometimes concerned about the potential impact of side effects erectile dysfunction, women are generally more concerned about survival (Badr and Carmack Taylor 2009). Nevertheless, the side-effects associated with treatment, including both the physical and emotional aspects, do have an emotional impact on the partner. In addition, women frequently express frustration and distress about the unwillingness of their partner to openly share their feelings and they can feel emotionally cut-off from them (Badr and Carmack Taylor 2009). As a result of this range of challenging and distressing experiences female partners of men with prostate cancer report levels of psychological distress that are in general higher than those of their partners (Herr 1997).

Prostate Cancer and Gay Men/Men That Have Sex with Men

There are good reasons for thinking that sexual orientation is an important factor in people's experiences of the healthcare system. Studies have documented accounts from lesbian, gay, bisexual and trans (LGBT) people of experiences of both heteronormativity and homophobia in the healthcare system (e.g. Dean et al. 2000) while others have found that LGBT individuals were reluctant to disclose their sexual orientation to healthcare professionals for fear of homophobia (e.g. Klitzman and Greenberg 2002) or because of concerns about confidentiality (e.g. Cant and Taket 2006). Even in the absence of homophobia LGBT people report experiencing a system in which heterosexuality is assumed to be the norm (e.g. Heaphy et al. 2003) and in which questions about partners or sexual practices are grounded in this assumption (e.g. Neville and Henrickson 2006). Such research suggests that gay men and men that have sex with men (MSM) may well experience challenges and difficulties in the course of receiving a diagnosis of and undergoing treatment for prostate cancer.

Men in general know very little about the location and function of their prostate and of their risk of developing prostate cancer (e.g. Baker et al. 2007). There is almost no research that has specifically addressed this issue in relation to gay men/MSM, but a focus group study (Asencio et al. 2009) found that a group of self-identified gay men had little or no knowledge of the prostate and the potential consequences of the treatment of prostate cancer for sexual activity and performance. Additionally, a study of the relationship between sexual orientation and screening for prostate cancer conducted in California (Heslin et al. 2008) found that gay men/MSM were less likely to have been screened than exclusively heterosexual men.

We know that female partners of heterosexual men appear to play a significant role in caring for their health and prompting them to seek medical advice but almost nothing about the role played by the partner or friends of gay men/MSM in their healthcare. Similarly, while female partners play a very significant role in treatment-related decision-making (e.g. Sinfield et al. 2009; Boehmer and Clark 2001) information about the experiences of gay men/MSM in this regard is lacking.

As described above, it is well established that all forms of treatment for prostate cancer result in a range of unpleasant and distressing side-effects and that such side-effects have a significant impact on quality of life (e.g. Sanda et al. 2008) and on the man's sense of masculinity (e.g. Stansbury et al. 2005). Experiences of the side effects of treatment for prostate cancer in gay/MSM are likely to be shaped both by prevalent norms within the gay/MSM community and the forms of sexual activity engaged in by individual men. The common side effects, such as erectile dysfunction, urinary incontinence and retrograde ejaculation, are likely to have somewhat different significance for gay compared to straight men (Blank 2005). For example, the degree of rigidity required for anal penetration is greater than that required for vaginal penetration; semen can have non-reproductive significance in the context of gay/MSM sexual activity and the prostate itself is the site of erotic stimulation (Blank 2005; Filiault et al. 2008).

Unlike the situation of female partners of heterosexual men we know nothing about the psychological effects on the partners of gay men and very little about how gay men/MSM with prostate cancer and their partners access and make use of support.

Some helpful light can be shed on possible issues facing gay men living as survivors of prostate cancer by considering the findings of a study of chronic illness in non-heterosexuals (Jowett and Peel 2009). These authors employed an online survey aimed at the LGBT community in the UK and internationally and received responses from 190 self-identified LGBT individuals

who were living with a chronic illness. They identified a number of themes in the responses that are relevant to gay men surviving prostate cancer. One issue was that respondents often experienced the LGBT community as being unsupportive of people with chronic illnesses other than HIV/AIDS. A related point was that a perceived culture that emphasises bodily perfection within the gay community could present the chronically ill with difficulties. This might be particularly relevant to gay men who have scars and reduced penile length due to radical prostatectomy or who are experiencing bodily changes as a consequence of hormone therapy. A second theme was one of feeling isolated from the LGBT community and the difficulties of identifying others within the LGBT community with the same difficulties, describing themselves as a "minority within a minority". They also identified themes relating to issues identified above, such as fear of homophobia in the healthcare system and lack of information and support tailored to their particular needs.

Overall, the experiences and needs of gay men/MSM and the LGBT community more generally have largely been overlooked in research into cancers of all kinds. There is undoubtedly a need for more research to focus on the relationship between sexual orientation and cancer detection, treatment and survivorship generally as well as for prostate cancer in particular (Boehmer et al. 2012).

Surviving Prostate Cancer

In the period 2010–2011, in England and Wales the one-year survival rate for prostate cancer was 94% and the five-year rate was 85%. These survival rates were the highest among the 21 most common cancers in the UK (CRUK 2018). Prostate cancer patients can be characterised as long-term survivors with a high probability of being alive 5 years after the initial diagnosis. While this is excellent news it raises issues about how to support men in living with the side effects described above and dealing with the ongoing uncertainty concerning recurrence that all cancer survivors must contend with. In the case of men this is likely to be exacerbated by their demonstrated difficulties in accessing and making use of social and medical support compared with women in general and women cancer survivors in particular. The participation of patients in treatment-related decision-making and acknowledgement of side effects has been shown to influence their adjustment to their post-treatment life and treatment side effects are also important. The majority of studies have not found significant differences in general health-related quality of life (HRQoL) scores but

they have identified differences in disease-specific HRQoL scores. Bacon and his colleagues (2001) examined PCa patients who had received radiotherapy and brachytherapy (the implantation of radioactive beads directly into the prostate) and they reported more bowel dysfunction than those with prostatectomy. Patients treated with radiotherapy and hormones had better or the same sexual and urinary function but lower QoL scores in many domains compared to the prostatectomy patients. Patients who underwent brachytherapy and those who had prostatectomy had similar QoL scores. Patients that had radical prostatectomy had higher HRQoL scores compared to those who did not have treatment and those who had a radiotherapy. Patients who chose therapy with hormones had the lowest HRQoL scores among the other treatment groups.

Typically, once men have been successfully treated for prostate cancer they are discharged back to primary care. There is very little research on transfer from hospital-based care to primary care for disease monitoring after primary treatment has been delivered, and most of this has focused on discharge from intensive and acute care. There are a small number of studies that have addressed the ongoing needs of cancer survivors in relation to primary care. Harrison et al. (2012) studied cancer survivors' experiences of discharge from hospital follow-up. Survivors of breast, colorectal and prostate cancer ($n = 1275$), 5–16 years post diagnosis were recruited for a questionnaire survey. Approximately one-third of respondents were not discharged from follow-up 5–16 years post diagnosis. Of those who were discharged, a substantial minority reported insufficient time (27.9%), information (24.5–45.0%) or adverse emotions (30.9%) at the time of discharge. However, 90.6% of respondents reported satisfaction with how discharge from hospital follow-up was managed. As part of the same study the researchers (Harrison et al. 2012) also examined the primary health and supportive care needs of the survivors. The most frequently endorsed unmet need was for help to manage concerns about cancer recurrence. Trait anxiety, non-discharged status, dissatisfaction with discharge and receipt of hormonal therapy were predictive of unmet supportive care needs. The most frequently reported unmet needs were "help to manage my concerns about the cancer coming back" and "I need to know that all my doctors talk to each other to coordinate my care".

Hudson et al. (2012) reported the findings of a US-based study. They conducted in-depth interviews with a purposive sample of early-stage breast and prostate cancer survivors ($N = 42$) aged from 47 to 80 years, stratified by age, race, and length of time from and location of cancer treatment all of whom had completed treatment at least two years previously. Survivors were at least 2 years beyond completion of their active cancer treatment.

Most participants expressed strong preferences to receive follow-up care from their cancer specialists (52%). They described the following barriers to the primary care physician's engagement in follow-up care: (1) lack of cancer expertise, (2) limited or no involvement with original cancer care, and (3) lack of care continuity. Only one-third of participants (38%) believed there was a role for primary care in cancer follow-up care. While it is important to acknowledge the differences in the way healthcare is delivered in the UK and the US the findings of this study are broadly consistent with the findings of Harrison et al.

These studies raise important questions and some concerns about the way in which the transition to primary care is managed. The focus of survivorship research has been on the patients but the fact that men's partners are very important in providing support and contributing to decision-making but also experience emotional distress means that it is also important to consider their needs for information and support. Again, very little research or intervention work has been done in this area.

The fact that African-Caribbean and African-American men are at greater risk of developing prostate cancer and also tend to develop it at a younger age than white men means that their experiences and needs as survivors of the disease are likely to be different. This is an area that requires more research attention than it has so far received, but issues relating to sexual performance, fertility and communication of risk to close male relatives are likely to be salient. There are reports that at least some GPs are lacking in awareness of the elevated risk of African-Caribbean men (Thompson 2014) and this may have consequences once these men are discharged back to primary care following treatment in terms of trust in the relationship.

Conclusions and Recommendations

Prostate cancer is virtually a paradigmatic exemplar of the need to adopt a gendered approach to understanding men's health-related behaviours. Each stage of the journey through prostate cancer, from noticing and acting on symptoms via treatment-related decision-making to being a survivor raises issues and challenges that are grounded in personally and socially constructed understandings of what it is to be a man. The concept of hegemonic masculinity is one way of framing these issues and has been much used in terms of directing and interpreting the findings of research, but it ignores structural inequalities grounded in race and social status that are demonstrably important in the case of prostate cancer in particular, and of men's

health more generally. A gendered understanding of men's health that is also cognizant of the importance of such structural inequalities is a key underpinning for research, practice and social policy in the arena of men's health.

Implications for Practice and Research

Men's management of their health and their responses to illness and to treatment are influenced by prevailing conceptions and constructions of masculinity. Structural inequalities also play a significant part. Each type of health problem will raise specific issues, but it is possible to identify some broad guiding principles and make suggestions informed by theory and research:

Healthcare professionals of all types need to take gender into account in working with men in both physical and mental health contexts.

Social constructionist, narrative and systemic approaches may be helpful to men in terms of examining and challenging dominant constructions.

Men in minority groups, such as ethnic and sexual minorities, and lower income groups are likely to suffer particular disadvantages, which intersect with issues related to gender.

In terms of research we need to develop a better understanding of how these gendered and structural issues interact and determine outcomes and processes in relation to particular health conditions. In the case of prostate cancer there is a particular need to understand treatment-related decision-making, survivorship and the experiences of men from ethnic and sexual minorities.

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May the force of gender be with you: Identity, Identification and "Own-Gender Bias"

Describing a New Experimental Method and New Findings

Nathan Hook

In 1890 one of the founders of experimental psychology William James referred to 'multiple selves,' meaning that the 'self' contains multiple identities. In simple terms an identity is an answer to the question 'who am I?' All of us have many ways to answer that question in different times and contexts. Identity is an under-researched topic primarily because it is difficult to access and hard to measure in quantifiable terms, yet at the same time identity goes to the very heart of what psychology is about, being literally the study of the 'psyche' or 'mind'.

For a more formal definition of identity, Stryker (1980) refers to an 'internalised positional designation' for each of the roles one plays in society; someone 'is a student', not 'playing the role of a student.' More recently Burke and Stets (2009) suggest that an identity could either relate to a role in society (as Stryker describes), group membership (as Social Identity Theory (SIT) presents) or particular identifying characteristics. Burke and Stets also note that this third category of identity, based on particular characteristics, is a particularly under-researched area.

Identity theory is a generic term that encompasses a range of specific theories that seek to explain the mechanisms of identities, how identities relate to each other and how they influence behaviour, thoughts and emotions along with their wider social impact. Successfully fulfilling a sense of identity generates self-esteem, while a lack of self-esteem creates vulnerability to mental health conditions such as depression—a failure to satisfactorily

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answer the question 'who am I?' and thus a failure to construct oneself or one's possible future. However, because identity theory consists of ideas developed across different disciplines, it does not yield a coherent unified model. Furthermore, because different disciplines use the same terms to mean different things, there is also a lack of consistent terminology.

Identity theory recognises that identities do change, but usually over time in a gradual and developmental sense. This fits with our everyday experience that a person is unlikely to say that they are a different person from a week ago, but more likely to perceive a change over a decade or more. Identity theory generally recognises gender as a core aspect of identity for most human beings. It is accepted that gender identity is usually formed very early and usually remains in place for life. While other identities such as an occupational role identity can depend on physical resources and/or social position, gender identity is broadly much less dependent on context.

Experimental Approaches to Identity

Psychology is not the only discipline interested in identity, but unlike other disciplines it has sought to apply the experimental method. One strand of this has been a series of experiments that led to SIT developed by Tajfel (1970). By assigning participants to random groups and asking them to assign points to other participants, it was found that people demonstrated a bias in favour of their own group over another group, implying that group identity is very easily formed and that group conflict is inevitable. There is now a large body of research on SIT and while there is still much debate about what conclusions can be drawn, this is perhaps the most well-established way of applying the experimental method to researching identity based on group membership.

However, gender is not merely a group identity. An individual cut off from other people would still retain some sense of their gender. Gender can also be considered to be an embodied and personal characteristic, and yet previously there have been few attempts to explore gender identity in this holistic way experimentally.

This chapter describes a new approach developed by the author to tackle this issue by using identification as a proxy for identity. Rather than testing how strongly a person self-identifies, this method tests how strongly a person identifies with a fictional character in a game or story. This lends itself to the experimental method because a controlled stimulus consisting of a fictional character can be presented precisely and consistently. This then allows

participants to report on the strength of identification with characters in a concise and highly measurable fashion.

This methodology based upon identification with fictional characters in a game or story can therefore help to expand the findings, value and scope of identity theory by offering insight into the mechanisms by which identities connect or detach. The methodology offers an opportunity to measure the divergence and the boundary between possible mechanisms of identification and dis-identification:

- One possibility is that identifying with a character who shares one or more identities with the player globally activates these shared identities, generating a sense of connection and self-esteem. In this first model, a character activating shared identities would generate stronger identification than one that does not.
- A second possibility is that although there are some shared identities, the character is construed as a separate identity with its own set of sub-identities. In the second model any shared identities would be much less likely to lead to identification.

This chapter describes an experiment using this new methodology to examine gender identity and to explore potential gender differences in how players/readers identify with characters of a particular gender, both in their own right and as a proxy for their own sense of self-identity. The initial hypothesis under investigation was that both (self-identifying) men and women would identify more strongly with characters of their own gender than those of the other gender. The null hypothesis correspondingly was that the strength with which players identify with characters is unaffected by the gender of the character.

A Brief Review of Literature on Identification in Science and the Humanities

For the purposes of this review, the Oxford dictionary definition of identification as 'a person's sense of identity with someone or something' is being followed.

In the field of sociology, the concept of identification has been used to refer to identifying with a group (Holt 1950) while in the field of psychoanalytic theory Freud (2010) discusses identification with a real person or object. Neither theorist however addresses identification with fictional characters in stories, even though fiction is a substantial part of human life and culture.

In the humanities, Igartua (2010) found that strong identification with film characters is associated with enjoyment, cognitive elaboration, dramatic impact and attitude change. Identification is also a core topic within literary and film studies (Oatley 1994) and McCloud (1993) writing about characters in comics suggests that shallow iconic characters pull readers in. Cohen (2001) discusses the lack of empirical testing or conceptualisation in these fields. At an applied level, a better understanding of this topic would be useful to inform science, media and the arts in terms of how best to communicate and connect with fellow human beings.

From the turn of the millennium, a new academic discipline called Game Studies has emerged. Game studies draws on both humanities and social sciences and involves studying games as text, gaming as an activity and gamer culture. This relatively new discipline inevitably focuses on computer games but is not limited to these. Within the field of game studies, Klimmt et al. (2009) argue that identification with a character occurs when the player self-perceives some of the character's attributes as part of themselves. These authors also claim that everyday life self-perception can be altered by this fictional identification process. Follow-up empirical research by Blake et al. (2012) does provide some support for this theory although because of some design flaws, alternative explanations of these results may be possible. Shaw (2011) interviewed players qualitatively and found that greater control over a character's actions increases identification.

There is a reasonable body of research within game studies on identification with an avatar, including Martin (2005), Bessiere et al. (2007), and Kafai et al. (2007), Kujanpää et al. (2007), Ducheneaut et al. (2009), Jorgensen (2009) and Shaw (2011). Kromand (2007) offers an axis model for categorising the design of avatars involving "archetypes". However avatar play differs from playing a character in the literary sense. An avatar is a digital object manipulated by the player like a chess piece rather than a character-person treated as having their own agency and an internal mind.

In summary, identification with fictional characters is an under-researched topic in psychology and sociology, and lacks robust empirical investigation within the field of literary, media and film studies. Game studies has focused on exploring avatar play and not investigated identifying with an active character in the literary sense. The present study described here therefore may be said to address all of these gaps in the literature by using an experimental methodology rooted in the social psychology tradition using technology to precisely measure identification with fictional characters.

A Brief Review of the Literature on "Own-Gender Bias"

Since the focus of the present study was not just identification in general but gender identification in particular, it is also important to summarise briefly the literature on own-gender bias.

Wright and Sladden (2003) investigated gender differences in face recognition and found an own-gender bias for both genders: males are better at recognising male faces and females are better at identifying female faces. In contrast, Herlitz and Loven (2013) used a meta-analysis to review research on the same topic and found that females remember more faces generally and remember more female faces than male faces but that males do not remember more faces of one gender than the other. In other words, they found a female own-gender bias but not a male own-gender bias. These researchers explain their findings in terms of facial and visual processes with the implication that this gender difference would not necessarily generalise to other situations.

In relation to SIT, Rudman and Goodwin (2004) report four experiments relating to gender differences in in-group bias and found that women's automatic in-group bias was stronger than men's. However they did not use gender itself as the basis of group membership in this research.

In game studies Yee's (2017) quantitative research reported that 75% of female gamers rated the presence of female protagonists as 'very or extremely important,' three times higher than the male gamers who tended to rate the presence of female protagonists as 'somewhat important.'

Methodology

My own experiment used as a stimulus a *Hypertext Fiction* (HF) story-game, a type of *Interactive Fiction* (IF), as discussed in Montfort (2005). HF might be more commonly referred to in everyday language as a 'choose-your-own-adventure' story. Such texts are intended to be read in a non-linear sequence (Aarseth 1997). When reading a HF the reader-player reads a passage of text (usually written in the second person) and selects from a number of options to continue. This decision points the reader to the next passage to read until the next decision point. The term HF refers to this hyperlink mechanism which might be implemented as a physical page number in a hardcopy book

to turn to or as a digital link. *Interactive Fiction* can also use other interfaces such as free text entry. Famous HF texts include the computer game *Depression Quest* (Quinn 2013) and the *Fighting Fantasy* physical book series that started with *The Warlock of Firetop Mountain* (Jackson and Livingstone 1982). Aarseth (1997) has claimed that the reader of an IF is a player in a game-world whereas the reader of a traditional linear text is a spectator.

HF is used as a form of minimal role-playing game with a single player-participant thus enabling strong experimental controls. A game with more players would have been too unpredictable and varied to serve as a controlled stimulus. For a further discussion of digital games as experimental stimulus, see Järvelä et al. (2012). At a higher conceptual level this 'minimal ludic roleplay experiment' was inspired in part by the 'minimal group experiments' of Tajfel (1970).

One design challenge was the need to avoid identification based on other shared player-character traits, such as a student player identifying with a student character. For this reason a modern day setting was avoided and the diegetic setting of Star Wars was used, since it was unlikely that players would share other identities such as occupation roles with such characters. It also provided an easily relatable fictional world that many participants would have some level of awareness of, while it could still be understood as a generic space adventure setting. Use of this setting also could be said to increase ecological validity because it is already used for many commercial games and other texts in different media. At a practical level this popular setting also helped attract participants to take part in the research, making the pool of participants larger.

Original characters previously unknown to the participants were used as protagonists in the HF to avoid any bias for pre-existing characters. The text of the game was also original, being developed by the research team whose qualifications include creative writing. This ensured that no player had any prior exposure to the narrative stimulus. While the use of original material as opposed to a published game is unusual in game studies and literary research, it is not unusual practice in psychology to create the experimental stimulus.

The stimulus was a short HF with two separate stories each about a different character, referred to here as J (in the Star Wars setting, a Jedi) and S (in the Star Wars setting, a Sith). After reading an introduction screen, the participant would be presented with a character briefing screen followed by the first page of the story, ending with a binary decision point as hypertext links. These links would then lead to the next page depending on which option was chosen, which then would in turn link to the next page with another binary

decision point. In total each story was made up of five binary decision points for each participant playing each character. After this the character briefing screen for the next character would be presented and a different story with another five binary decision points would be presented. The sequence of the two stories/characters was randomised independently of group allocation to counteract any influence this might have.

The participants were blindly and randomly split by the software into one of two groups, referred to here as JMSF and JFSM. The stimulus for each group differs in that:

- For group JMSF, character J is male and character S is female.
- For group JFSM, character J is female and character S is male.

Every text page in the game included one reference to the character's gender, such as another character addressing them in dialogue with a gendered term. Aside from these minor text changes and the randomised sequence of characters the story-game itself was exactly the same for all participants. The experiment could have functioned with a single character and story, but this double design enabled a built in replication to be conducted at the same time.

In practical terms the HF was developed with the free development software Twine version 2.1.3 (http://twinery.org/) and uploaded to the web. It could be played on any web browser and the participants used their own devices in their natural surroundings. While this varied between participants this was controlled for by the independent group randomisation. This unusual experimental design makes the hardware and physical surroundings the same as when the participants play digital games or read web-based texts in everyday life.

Data Collection

Twine does not record user inputs and so a link to an online form for data collection was shown after the participants played both stories, with the data downloaded after the experiment was completed. After playing through the HF for each character, participants are asked two questions for each character:

- 'How strongly did you identify with < character name > ?'
- 'How strongly were you able to take on the role of < character name > ?'

Responses were recorded on a scale from 1 to 7, and the pair of responses for each character then averaged. This use of two questions with combined results was intended to lessen any quirk of the particular wording or the participant's understanding. Together this produced quantitative data for appropriate statistical analysis.

The three dimensions were:

- The player's gender (M or F). Participants could also state their own gender as either 'other/non-binary' or 'prefer not to say', but their data was then excluded from the primary analysis.
- The character's gender (M or F).
- The character (J or S).

All participants provided two data points: how strongly they identified with character J and character S, in the dimensions for their own gender and the character's gender (which depended on their assigned group).

Information about the participant's age bracket, gender identity, national identity, educational background, familiarity with the setting, level of HF and roleplay experience, device used, whether the surroundings were distracting and self-declared play-style was also gathered for secondary analysis. Participant names and other identifying data were not requested so data was automatically anonymous.

Participants

Participants were recruited by posting a request to take part with a link to various Star Wars, gaming and roleplay social media communities online. The first page explained that the game was for academic research and that their consent for their data to be used could be given by taking part, filling in the form and clicking "submit". No reward was offered for taking part and participants had the option to leave the page or to play the game but then not complete the research questions at the end. It is unknown how many potential participants opted out in this way.

The experiment ran online for two weeks during May 2017. In total 386 responses were received. Based on the responses to secondary questions, it is possible to make some descriptive statements about the participant pool:

- 73% identified as male, 24% identified as female, 2% as other/non-binary, 1% declined to answer.

- 47% identified with a European nationality, 45% with North American nationality, 2% with an Asian nationality, 1% with a Middle East nationality and 1% with a South American nationality. 4% identified with an 'other' nationality, and 1 single participant left this blank.
- 45% completed the experiment on a computer, 47% on a phone, and 8% on a tablet. Two participants used an 'other' device.
- 30% of participants had no degree, 33% had one or more science degrees and 30% had one or more arts/humanities degrees, 7% had degrees in both sciences and arts/humanities. Three participants left this blank.
- 2% had no knowledge of the Star Wars setting, 34% knew only the main films and 65% reported that they knew the wider expanded universe from other media.
- 15% reporting their surroundings were distracting while playing the game. Two participants left this blank.

Some questions were asked for the participant's role-play game experience:

- 5% had no experience with IF games, 18% had played less than three games, 25% had played between three and ten games, 51% had played more than ten games. Two participants left this question blank.
- 21% had 'none / very little' experience of tabletop RPGs, 18% had 'some, up to a year' of experience, 61% had 'many years' of experience. One participant left this question blank.
- 72% had 'none / very little' experience of 'larps' (live action role-play games), 12% had 'some, up to a year' of experience, 16% had 'many years' of experience.

Participants were asked a single question about their play-style/creative agenda, based on the GNS model from Forge theory (Boss 2008). A full discussion of this theory is beyond the scope of this chapter. The question was 'When role-playing, which of these is most important to you?' The possible answers were:

- 'Your character achieving their goals / winning' (gamism),
- 'Experiencing a good story with strong narrative / drama' (narrativism)
- 'Becoming the character, feeling their emotions and acting accurately for the character' (simulationism).

The results were 8% gamist, 61% narrativist and 30% simulationist for these participants. Three participants left this blank.

Analysis

Once the data was gathered, it was analysed using paired T tests which reveal whether two groups of data are significantly different or not. There were four T tests for participants of the same gender playing the same character, between those who played the character as male and those who played the character as female. There were a further four T tests comparing participants of different genders playing the same character with the same gender. Hence all tests were between different participants. It would have been possible to compare the two data points from the same participants but this would be data from different characters and different stories so any differences this might produce could be due to these differences in stimulus.

The eight mean identification scores are shown in Table 1.

The range of possible scores is from 1 to 7 and the means fall roughly in the middle of that range.

For the four comparisons between those who played the character as male and those who played the character as female (for each character and each player gender group) the results for the male participants showed no significant differences for either character. However for female participants a

Table 1 Mean identification scores, split by participant group and character

Male participants		
	Character	
Character gender	J	S
M	4.725352	4.431655
F	4.776978	4.31338
Female participants		
	Character	
Character gender	J	S
M	4.117021	4.095745
F	4.787234	4.361702
Jedi character		
	Participant	
Character gender	M	F
M	4.725352	4.117021
F	4.776978	4.787234
Sith character		
	Participant	
Character gender	M	F
M	4.431655	4.095745
F	4.31338	4.361702

highly statistically significant difference was found. Female participants more strongly identified with character J if that character were female ($p = 0.005$). While not quite significant with this sample size, results for female participants with character S were also in support of this trend ($p = 0.1655$). This provides some evidence that the gender of a character does not affect how strongly males identify with the character, but that females do identify more strongly with female character than a male character.

For the comparisons between male and female participants (for the same character with the same character gender) these results give one strongly significant result ($p = 0.0035$) that women identify less strongly than men with character J as male. The result for character S as male was also in this direction and approaching significance ($p = 0.074$). For either character as female there was no significant difference for how strongly male or female participants identified with them. Putting this all together, it seems that males and females identify equally with a female character, but that females identify less strongly than males with a male character.

The pattern generated by all of these results is presented visually in Table 2.

Looking at the results together, this experiment has found significant evidence that character gender has no significant effect on how strongly males identify with a character, but that female players identify more strongly with female characters than male characters and also identify less strongly than male players with male characters. This means that this experiment has found clear evidence of a female own-gender bias alongside clear evidence that males lack an own-gender bias.

Six responses from participants who identified either as 'other / non-binary' and five who replied 'prefer not to say' (including one who left this blank) were not included in the primary analysis. No other data were excluded. The data from the six 'other / non-binary' participants (3 from each group) indicated that they identified much more strongly with characters as male rather than as female, implying that there may be a distinct

Table 2 Significant differences, shown visually

	Player M	Is there evidence of significant differences?	Player F
Character M		Significant Differences	
Is there evidence of significant differences?	No evidence		Significant Differences
Character F		No evidence	

third group. While constituting too small a sample for statistical analysis, this does add an interesting additional twist to these findings.

Secondary Analysis

Beyond testing the primary hypothesis some observations can also be made from the responses to the secondary questions. These may provide additional insights for planning future experiments.

- Participants using a phone device generally reported lower identification (mean 4.41) than tablet users (4.58) and computer users (4.61). This might reflect the comfort of the surroundings, ease of use and lack of distraction. Two participants used an 'other' device and reported much lower identification (3.75).
- Participants who knew the wider expanded Star Wars universe from other media reported higher identification (4.62) than those who knew only the main films (4.30).
- Simulationists reported stronger identification (4.77) than narrativists (4.44) and gamists (4.26) This may reflect aiming for and mentally seeking stronger character identification, an underlying personality difference or a positive reporting bias (participants reporting they do well at something they consider important).

Group assignment was random and independent of these other factors, so these should not have impacted on the primary analysis. These are included as an additional insight unrelated to the hypothesis to raise further questions and suggest areas for further research. While it would be technically possible to carry out further statistical tests with this data, testing every possible combination after the fact would dramatically increase the possibility of false positive "type I" errors.

Relating Back to Theory

The initial hypothesis being tested was that both males and females would identify more strongly with characters of their own gender. However the results instead provide evidence for a more nuanced two-fold finding:

- Males identify equally strongly with characters regardless of their gender.
- Females identify more strongly with a female character than a male character.

If we accept the validity of these findings this may be new evidence of an important gender difference that males lack an own-gender bias, at least in certain domains. The statistics strongly indicate that this gender difference is present but they cannot tell us the reason for it, whether it has an underlying biological cause or results from life experience or cultural exposure. However it is possible to speculate in an educated way on the reasons for this gender difference based on existing theories.

Considering these results through the lens of SIT, these findings might be understood as providing insight into the implicit construction of 'in-groups' and 'out-groups.' Women see gender as a characteristic to determine group membership, which leads to displaying in-group bias. Men are more 'gender blind' and tend not to construct in- and out-groups by gender and so don't display this form of in-group bias. This is a feature that would likely not have been captured by traditional experiments in the SIT tradition where the relevant group membership would be implicitly or explicitly stated to the participants.

As noted in the literature review (above), Herlitz and Loven (2013) and Rudman and Goodwin (2004) who researched very different topics did similarly find a female only own-gender bias. These authors had suggested domain-specific explanations, but taking their work and the findings of this experiment together implies that a cross-domain generalised mechanism may be the source of a much broader gender difference.

The literature review noted two possible ways of adapting identity theory to the topic of identification and the results of this experiment can perhaps help determine which model best fits reality: either playing a character activates the player's own gender identity (and other identities shared by both player and character) or the character is related to as a separate and distinct identity. One way to interpret these more nuanced results is to conclude that the first approach is a better model for understanding typical female character role-playing and the second approach is a better model for understanding typical male character role-playing. Further research could explore this by looking at other identities that a player and character share and investigating if sharing more identities increases identification. For example, would a male player and a female player identify more strongly with a character that shares

the same occupation or national identity as them? Given the findings of this experiment, it might be predicted that generally male players will not but female players will. An alternative hypothesis would be that there is something inherently special about gender identity, being stable for most people, that functions differently from other identities.

In this experiment the story-game was exactly the same for participants apart from the minor text change on every page to indicate the character's gender, to maintain strong experimental controls. It might be speculated that the results would have been even more pronounced if the fictional characters had engaged in behaviour appropriate to their gender (either as defined by the reader-player's worldview or by the character's diegetic culture). This may be more relevant if the diegesis (the fictional world) has strongly defined gender roles. The Star Wars setting lacks strongly differentiated gender roles which made it easier to write a consistent story regardless of character gender. We might also reflect on how players would have responded to a gender neutral character such as a droid or an alien species without gendered biology or culture.

Reflection on the Method

Aside from the particular hypothesis tested by this experiment, it is also worth reflecting on the method. The experimental approach is unusual in both the topic of identity and the varied disciplines of literary studies and game studies. This experiment demonstrates how by using identification as a proxy for identity it is possible to construct and administer an experiment in the psychological tradition within this field of enquiry. The digital nature of many ludic media lends itself to the experimental method and freely available tools make it practical to create or modify games to produce stimulus material for experimental purposes. There may well be other topics in psychology where games offer a way to conduct experiments.

Applying the self-reflexivity of the British critical psychology tradition, it occurs to me that had the results supported the original hypothesis of an own-gender bias for *both* genders, speculation would have followed that this would be likely to generalise to other identities that a reader/player shares with their character, an example of over-generalisation of findings. This was the primary reason why the design used a fictional setting as a precaution against such global self-reference. As it turned out the findings obtained are counter-intuitive to simple generalisations, and therefore more robust and more striking.

Practical Implications and Applications

One direct implication of this finding is that it can inform artistic creation, potentially across a wide range of media. Given that strong identification increases reader-players' involvement, it suggests a game or other work of fiction intended for a mixed audience would be better received with a female protagonist since it would increase identification for female players and not affect male players. This might also generalise to other fields seeking to build popular identification with someone, such as a brand choosing a celebrity to promote itself.

The mirror side of this is that when creating art to appeal to men, depicting a male protagonist does not in itself build identification. Other identities and techniques need to be used in artistic creation to achieve this. For example, previous experiments that used a similar design to the one described here found that richly defined characters with many identities build stronger identification than one-dimensional characters.

On a wider scale, these results might suggest one possible and important explanation for why men are more prone to suicide. Identity theory suggests that people have many identities and that fulfilling those identities produces self-esteem. For most people gender might be thought of as a core identity that can usually be fulfilled for self-esteem. However, if men do not as strongly invest in their gender identity, they have one less easy source of self-esteem than women, which leaves them more vulnerable when other identities (e.g. occupational) are not able to be fulfilled. For example, a female teacher who loses their job can still derive self-esteem from their gender during a difficult time of unemployment, but a male teacher could be less equipped to do so.

One way to tackle this at a personal level might be to encourage men at risk of depression to cultivate a richer and more varied set of identities, to have many ways of defining who they are, so that if some become blocked they still have others. This is healthy for everyone but may be particularly important to males. Practically speaking, identities that are less dependent upon physical resources or social position are also less likely to be disrupted.

At a wider social level, challenging negative constructions of males and masculinity and recognising the positive contributions that exceptional men and men collectively make to the world may help to support boys and young men in viewing their gender in a more positive way that could boost self-esteem. Celebrating masculine psychology as having the clarity and strength to avoid own-gender bias and to display less in-group bias generally could form one facet of that.

From a wider social justice perspective, assuming the validity of these findings, the presence of greater in-group bias in one gender has potential implications for social policy. Making this issue more explicit could help prevent unnecessary bias or inequality in hitherto hidden contexts.

Conclusion

This experiment has produced strong evidence (with extremely low *p* values) that females have an own-gender bias in character identification but males do not. We might explain this finding using several different theories, but the strong implication is that gender is a less important group identity for men than it is for women. This has implications for how we communicate with men and women across varied domains of life such as health, politics and culture. It also has implications for how we might need to design differently nuanced health messages and approaches to connect with and help vulnerable men in comparison with vulnerable women. These findings also raise the question as to whether this is a universal finding or culture-dependent. Further research will be required to answer these important questions more fully. Whatever the reason for the difference and however global it might be, it is hoped that this chapter has revealed important evidence of potentially critical gender differences, along with an important new experimental method for researching identity.

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From Hegemonic to Responsive Masculinity: The Transformative Power of the Provider Role

Belinda Brown

Introduction

In recent decades the concept of hegemonic masculinity has developed as a theoretical umbrella to explain negative aspects of masculinity, for example, higher levels of male violence and the processes through which men are believed to maintain power and dominance over women. This was theorised by Connell in his book *Masculinities* (1995). More recently Kimmel, abandoning the language of toxic masculinity and replacing it with the concept of "aggrieved entitlement", has done much to keep the idea of masculinity as potentially damaging to "women, children, men, and all other living things" alive (Kimmel and Wade 2018).

The breadwinner or provider role is central to the concept of hegemonic masculinity providing a link through which the male's privileged position in relation to the means of production enables men to maintain control over women. The provider role is understood to have placed women in a particularly vulnerable position, depriving them of opportunities to develop strength and competence and productive skills. It is seen as equally detrimental to men, removing them from the family into the workplace, thereby damaging the possibility of developing intimate relationships and hindering male emotional expression, as a man is valued only for what he can provide (Bernard 1981).

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Qualitative research on low income male providers finds that having to fulfil the provider role prevents fathers from being emotionally and physically present for their children because of the time they have to spend at work. They are marginalised as fathers and stigmatized by the courts, the mother and society when they can't provide (Bryan 2013).

My goal in this chapter is not to deny these arguments, which contain much that is valid. Rather I would like to demonstrate that the provider role is a product of male responsiveness. This responsiveness is an evolved trait which is reflected in gender differences in empathy and emotion. As such the provider role gives men a crucial place in family life from which the pairbond can strengthen and attachment to offspring develop. This is facilitated by the male neuroendocrine system which appears to be designed to encourage male responsiveness to cues from partner and children. By playing a role within the family men's testosterone driven impulses towards status seeking and male competition are transformed into responsive nurturing behaviour. Securing themselves a place in family life through this process allows the real fathering work to be done. The importance of the breadwinner role to the development of fatherly work is demonstrated by the greater parental involvement of fathers who have traditional values than fathers who don't. It is vital that these processes are thoroughly analysed and understood before the provider role is further undermined.

Evolutionary psychology will be used to show the desire to provide is both a product of male responsiveness and facilitates male responsiveness and nurturing behaviour. According to evolutionary theory, homo sapiens evolved in an extremely different environment about 150,000 years ago. The humans who had the most offspring surviving into future generations were the humans whose genes we carry today. These genes not only shape basic biological processes like eating and sleeping but influence our behaviours, emotions and cognitive processes in ways which facilitate our survival. The full range of behavioural, psychological and social mechanisms are constrained by the basic facts of human reproduction which are that women are biologically compelled, through a nine months pregnancy and until recently several years of breastfeeding, to invest a great deal more into their offspring than men. There are a number of competing interpretations about *how* this has shaped who we are (Geary 1998).

In early evolutionary theory, as it has developed from Darwin's writings, men competed with each other to mate with as many women as possible (Darwin 1888). Those who were successful had more offspring than other males. Thus these trends became embedded in the male genome. Men evolved to pursue short-term sexual relationships while women sought

quality of mates and favoured long-term pair bonds. While this is an enormously simplified version of evolutionary theory, it fits in with contemporary ideas about male competitiveness and dominance and can be harnessed to support 'hegemonic' masculinity (Fessler 2010). However it leaves much of male behaviour unexplained, as we will go on to see.

The Practical Significance of Male Providing

A glance at consumer spending suggests the provider role is alive and well. Evidence shows that women are responsible for 83% of all consumer purchases—health care spending, choice of bank account, home furnishings—the decision making power belongs to them (Barletta 2003). In 2008 women controlled 60% of all wealth in the United States (Gunelius 2010).

At the wider state level men in the UK men provide over 71% of income tax which funds the benefits system (HMRC 2016). Since the benefits system is in large part designed to protect and support women and children this suggests that the provider role functions indirectly as well.

Research reveals that women have significant influence over the spending of money which men earned. Jan Pahl (1995) showed that despite women earning significantly less than men 42% of women were in overall charge of money compared to 35% of men. She also showed that although men made more money than women 93% of men regarded this income as belonging to the couple or the family with only 7% regarding it as belonging to themselves. Research conducted in household spending today shows that women play the 'alpha role' when deciding how money is spent (Wood et al. 2012).

It would appear that men are producing resources for women. Furthermore, throughout history they have taken the least pleasant, most dangerous, hard physical labour, sometimes even taking the place of beasts of burden (Van Creveld 2013). By exploring male social and psychological behaviour, and the role of biology in this, the aim here is to find out why this was done.

The Social Stimulus to the Provider Role

First of all, it appears that having a partner spurs men into productive activity and this is particularly important for men who have menial or poorly paid work. Geoff Dench explains how these are the men who are most likely to need a 'family role' to motivate them as their work is not rewarding in

itself: “Knowing that there are people whose wellbeing depends on them can dignify and make bearable even the most tedious or unpleasant work”.

He explores the impact of simply having a partner on men at different ages and with different levels of qualification. He finds at all levels of qualification and in all the different age groups having a partner impacts positively on the likelihood of being in employment. Among the least qualified the impact of having a partner on employment, is most significant of all (Dench 2017).

We can understand why this should be so by looking at Ryan and Deci’s study on intrinsic motivation. A great deal of work which needs to be performed is not interesting, creative, or engaging. Therefore external pressure is required to perform the work. However tasks which are boring, repetitive or monotonous will be more effectively performed where the drive to do so is internalised, where the person acts autonomously out of his independent free will. Such motivation is most likely to emerge where doing the work will be valued and recognised by significant others. They explain: ‘Because extrinsically motivated behaviours are not typically interesting, the primary reason people initially perform such actions is because the behaviours are prompted modelled or valued by significant others to whom they feel (or want to feel) attached or related. This suggests that relatedness, the need to feel belongingness and connectedness with others is centrally important to internalisation’ (Ryan and Deci 2000).

The idea that men may be working to strengthen attachments, build relationships and increase belonging to others is conceptually new.

Other research shows that marriage, particularly marriage to the mother or your child, increases the male wage premium suggesting that marriage and reproduction impact further on male motivation (Lerman and Wilcox 2014). A study on a US-based nationally representative sample of men which explored how marriage and fatherhood impacted on the wage premium found that among men without children, married men earned on average 7.3% more than single men, while men in cohabiting relationships earned 5.4% more. Divorced men’s wages did not appear to differ significantly from those of single childless men (Killewald and Gough 2013).

Fatherhood added to this marriage premium. Married fathers of two or more children averaged 4.8% higher wages than married men without children but only if they were married to the child’s mother; this wage premium did not apply to stepfathers, nor to fathers who lived with but were not married to their child’s mother. This combination of marriage and biological fatherhood maximises the wage premium and this occurred regardless of race, ethnicity or level of education. Killewald suggests that the married

fathers' clear commitment to their families as husbands and fathers and their perceived role as providers may have contributed to their higher wages (Killewald 2013).

De Linde Leonard and Stanley conducted a meta-analysis of the data on the marriage premium. After looking at more than 661 estimates of the male marriage premium they settled on a marriage premium of between 9 and 13%—similar to those of Killewald. They too cast doubt on selection as an explanation and argue that marriage may cause men to become more stable and committed workers (de Linde Leonard and Stanley 2015).

Social Costs and Benefits of the Provider Role

There is also ample evidence the women respond positively to male earning and where men struggle in this area it has a negative effect. For example, a Finnish study found that the unemployment and low income of the male in particular increased rates of dissolution for marriages and cohabitation. The employment and income of the male had a particularly positive affect on marriage (Jalovaara 2013). Kanji and Schober (2014) found that married couples in which the mother is the only earner face more than twice the risk of divorce faced by other couples in the early years of a child's life. Sayer et al. (2011) found that a wife was more likely to initiate divorce if her husband was not employed. Charles and Stephens also found that layoffs precipitate divorce (Charles and Stephens 2004). Henau and Himmelweit (2013) found full-time male employment produces more satisfaction with household income for couples than full-time female employment.

Even Kimmel who sees the provider role as a product of 'aggrieved entitlement', repeatedly acknowledges that the women he interviewed wanted men to earn: "I discounted the sentiments of their wives, for whom the traditional patriarchal bargain - he works and supports the family, she stays home and raises the children-was still a desire, if no longer a safe bet" (Kimmel 2017).

What we are seeing is that men go out to earn money, increasing the amount of effort they put into this as the reproductive bonds deepen. And they do this even when the work is mindnumbingly dull. Women appear to have considerable leeway in how this money is spent. Not surprisingly women respond well to this and are more likely to be happy with the household income when the man is earning it. When the man fails in this enterprise he may lose his place in the home.

None of this fits in with the ideas of hegemonic masculinity. Rather I would suggest that the provider role is an *altruistic* mechanism. In order to understand this we need to look at the deeper architecture of human behaviours and motivations and evolutionary psychology provides a useful lens.

The Origins of Paternal Investment

While basic evolutionary theory fits in with contemporary ideas of male competitiveness and dominance, it does not explain the fact that the vast majority of children are born within monogamous relationships where the father does not just disappear but invests in and remains part of the child's life. Therefore evolutionary psychology began exploring the development of paternal investment and how this supported reproductive success. Paternal investment is extremely rare in mammals and other primates but strongly present among human beings. It was a mystery why this should be so (Geary 2000).

The most convincing explanations suggest that paternal investment goes back to the dawn of our human existence approximately 150,000 years ago. Paternal investment coincided with the period when the enormous increases in brain size meant the baby's head began to exceed the capacity limits of the birth canal. This was related to the bipedalism which made the birth canal narrower. Human physiology accommodated this problem by timing childbirth earlier in our development. According to Finkel and Eastwick (2015), compared to other primates humans are born 12 months premature. This means that human infants are completely dependent on an adult carer for a much longer period of time than other primates or animals and during this time the caregiver's capacity to seek resources is significantly compromised. These large brains also require copious amounts of fat which human mothers need to provide through their milk which adds to the burden of care (Lieberman 2014). Human mothers require significant levels of support to be able to feed both their offspring and themselves and are particularly dependent on help from those around them. Anthropologists have coined the term 'alloparent' for those who help provide this care (Hrdy 1999). While there has been extensive discussion about who these alloparents are and it is accepted that other women and children play a significant role, various lines of analysis have converged on the view that paternal investment was crucial to infant survival. Paternal investment was secured through pairbonding and the emotional bond between the mother and father of the young children (Geary 2000). There are various suggestions about how this pairbonding occurred.

Pairbonding and the Development of Male Responsiveness

Various social and physical adaptations are believed to have evolved in order to facilitate pairbonding as a way of ensuring paternal investment. These adaptations include hidden ovulation (only males who stay with their mates for an extended period will be able to ensure that they have sex with them when they are fertile), mateguarding (only men who stay with their mates will be able to protect their reproductive resources against other predatory males), constant sexual receptivity (human females are constantly sexually receptive unlike females in many other species who are only receptive during their fertile period)—and so on (Geary 1998).

However the theory I would like to develop here is that male responsiveness and male nurturing have been a crucial evolutionary adaptation. And it is this which has facilitated firstly pairbonding and secondly paternal attachment. Those males who responded to female need were more likely to keep their mate and their children close to them and by doing so they helped to support their reproductive fitness to the degree that a high level of responsiveness to female need became embedded in the male population.

Evidence for this will be drawn from what we know about male sensitivity, differences in male and female emotional expressiveness, the empathy gap, male hormones and an exploration of male responsive behaviours.

Male Sensitivity

Males appear to start out in life as more responsive than little girls. Psychologist Terry Real (1998) finds that "If any differences exist, little boys are, in fact, slightly more sensitive and expressive than little girls. They cry more easily, seem more easily frustrated, appear more upset when a caregiver leaves the room". Weinberg and Tronick (1997) state that "infant boys are more emotionally reactive than girls. They display more positive as well as negative affect, focus more on their mother and display more….distress and demands for contact than to girls". Interestingly a study which looked at the differences between six-year-old boy's and girl's responses to the sound of a crying baby actually suggested that the boys were more distressed by the sound than the girls were. This was reflected by their heart rate (Fabes et al. 1994).

Gender Differences in Emotional Expression

Despite this higher level of sensitivity at earlier ages it is argued that men are less emotionally literate than women (Levant 1996).

However research exploring sex differences in emotion found unambiguously that there were no significant differences in male and female *experience* of emotion (Kring and Gordon 1998). Lennon and Eisenberg concluded in a review of the subject that females scored higher than males where participants had conscious control over their responses, for example in self reports. When physiological responses or facial and gestural measures were used as indicators for emotional state little or no sex difference was demonstrated.

The key difference between men and women did not lie in their experience of emotion but rather in the expression of it. Men tended to be internalizers with their display of emotion being in the psychophysiological domain. They were also more likely to mask their feelings. Women were in contrast much more expressive of most emotions than men for example sadness, disgust, fear, happiness and anger. Emotional expressivity is more influenced by cultural context than emotional experience. For example, women would be more likely to express their emotions in the presence of familiar others and inhibit expression in the presence of unfamiliar others. The presence of another person tended to act as an eliciting stimulus (Lennon and Eisenberg 1987).

In order to understand why women are more emotionally expressive than men we can borrow from Scarantino's Theory of Affective Pragmatics and her distinction between the *sender* and the individual who is the *recipient* (Scarantino 2017). This distinction between the *sender* and the *recipient* provides a framework onto which we can map the emotionally expressive female who thereby transmits her needs to the 'receiver', who acts to deliver them, very often a man.

Studies of emotion have suggested that they help individuals deal with survival issues posed by the environment—for example finding food, avoiding injury and reproducing. They do this by the rapid translation of information gathered through unconscious cognitive processes into the intense feelings we know as emotions. These then produce behaviours which cause either ourselves or others to act—hopefully in ways which serve our interests (Matsumoto 2009).

It is this relationship between the female 'sender' and the male 'recipient', which is key in translating the emotion into a behaviour which will ensure the survival of the gene line of the participants.[1] Emotions are vital because

[1]This theory has been developed in detail by William Collins in his online article on emotion and the pairbond: http://empathygap.uk/?p=1396.

as well as enabling the rapid translation of cognitive information into a form of behaviour which will spur others into action, emotions can also lead to 'altruistic' behaviours in others i.e. behaviours which do not appear to have immediate benefits to the actor but which will facilitate the perpetuation of genes. Emotions have a particularly important role in spurring on altruistic behaviours because they are less likely to be mediated by rational thought processes which might calculate costs and benefits to the self.

There is evidence to show that males are more likely to engage in costly altruism—i.e. altruism which will actually incur a disbenefit to themselves, when the beneficiary of the altruistic behaviour is a female. In a study conducted by FeldmanHall et al. (2016) where electric shocks could be reduced at financial cost to the participant it was found that males were significantly more likely to engage in costly altruism i.e. reduce the electric shocks at a financial cost to themselves if the target was a female. Looking from an evolutionary standpoint one can see that if women are the limiting resource to further reproduction taking extra care not to harm women would make evolutionary sense.

Gender Differences in Empathic Responsiveness

Olweus and Endresen (1998) describe *empathic concern* or *empathic distress* as being an example of a tendency to experience strong emotional responses. Studies of empathy which demonstrate that males have greater empathy for females than they do for other males supports the idea that female emotional expressiveness serves to provoke an empathic response in the recipient. Studies of empathy thus complement studies of emotional behaviour.

What is particularly interesting about the studies of empathy is the way in which the very particular patterns which emerge are predictable from the standpoint of evolutionary theory. For example results derived from research with questionnaires indicate that empathic responsiveness tends to increase with age, at least up to the mid-elementary school level, and in general, girls seem to be more empathic than boys. (Stuijfzand et al. 2016)

This would make sense. During the time that homo sapiens was undergoing the most significant periods of evolutionary change females would have been highly burdened by childcare. Feeding and carrying a child would have precluded much activity and therefore they would have required others to act on their behalf. Mothers would have acted to support the needs of their children while others—siblings, female relatives and men would have acted to support the needs of mothers.

Bryant (1982) found that during childhood empathic sadness for same-sex others was stronger than for other-sex others but patterns changed in adolescence particularly for males. Whereas girls showed more empathic sadness towards other girls at all ages, boys showed increasing empathic sadness towards the other sex from the ages of 12 to 13 years old. These results were subsequently confirmed by Endresen and Olweaus (2001) for a slightly older adolescent cohort (13–16 years). While girls showed more empathic sadness towards both genders than males regardless of age boys showed decreasing empathy for boys and increasing empathic concern towards girls. This is unexpected as people usually respond more empathically to others who are similar to themselves.

Using evolutionary psychology Olweus and Endresen explain how, this type of attitude or behaviour could have evolved from intermale competition which would have made it necessary for men to avoid signs of vulnerability in a masculine competitive environment. They suggest that a more circumscribed mechanism of '*male emotional inexpressiveness in relation to other males*' evolved over very long periods of time and this may explain the decreasing levels of empathic concern in boys (Olweus and Endresen 1998).

This is predictable from the earlier evolutionary understanding that males compete with each other for access to females and it also supports portrayals of hegemonic masculinity. However this is the state of maleness *before* finding a mate and pairbonding. This is the point at which the hegemonic male is transformed into a responsive and potentially nurturing male. And being able to provide is the first and most essential step for bringing about this transformation.

Male Responsiveness and the Provider Role

If male empathic responsiveness is particularly honed to female need males are likely to be more vulnerable to female emotional expressiveness in ways which could result in altruistic behaviour even if this is at a cost to themselves.

From the perspective of responsive masculinity what underlies male providing is not so much the desire for status, or dominance or achieving competence. What really underlies male providing is the demand from women themselves.

For example, in a sixty year study of mating preferences authors found that in every decade studied women ranked "good financial prospect" as

more important in a mate than men did for every decade studied (Buss et al. 2001). In a cross-cultural sample of mating preferences women were more likely than men to value partners who were a "good financial prospect" and showed "good earning capacity" in thirty-six out of thirty-seven countries (Buss 1989). For the same reasons women prefer slightly older men as husbands because this provides the time frame necessary for them to acquire the physical and social skills and capital for them to be good and consistent providers (Ellis 2011).

There were similar findings for cohabiting couples. Research which examined whether cohabiting couples marry was reviewed. In every study which included men male income was a significant predictor of marriage and qualitative studies found that both men and women stressed the importance of men's economic situation rather than women's. The couples were generally unwilling to marry until the man had a stable and reliable source of sufficient income regardless of the woman's financial status (Smock et al. 2005). Similar patterns are found even in Sweden with its highly egalitarian reputation (Bernardt and Goldscheider 2001).

That women attach so much importance to provisioning could be an evolved trait. The importance attached to male providing would have made enormous sense in an evolutionary context where resources were scarce. We can get some sense of the value of men's role from Frank Marlowe's (2001) study of the relationship between male provisioning and female fertility among 161 subsistence-level societies. Those societies in which more of the diet was contributed by men have shorter interbirth intervals, lower juvenile mortality and higher female fertility than societies in which men contribute a lower proportion. Through this provision men increased their fertility and the survival of their offspring which resulted in increased fitness for both men and women. In many forager societies children without an investing father have lower survival rates than those with one (Dwyer and Minegal 1993).

However there is also much evidence to suggest huge variability in male provisioning with some societies managing with low levels (Marlowe 2000). Other research has shown the loss of a father does not have such a severe impact on a young child as the loss of a mother (Sear and Mace 2008). And while there are strong correlations between male provisioning and child mortality causality cannot be established (Geary 1998).

This is because what is essential is not so much the provisioning but the *indirect* consequences of the provider role.

The Provider Role as a Cornerstone to Greater Paternal Involvement

What is being suggested here is that while the provider role is often important for its role in provisioning the family its real importance extends well beyond that. What the provider role does is help keep men within families and foster male attachment and it is through this that the real fathering work begins. We know from pre-industrial societies that provisioning a family is a first step in developing other forms of paternal care.

For example we find that men's contribution to subsistence is greatest in monogamous societies. These also appear to be the societies in which men are engaged in higher levels of paternal care. His contribution to subsistence decreases the greater the number of wives he has and these patterns appear to be echoed in the provision of direct paternal care. In an analysis of the Standard Cross-Cultural Sample of 186 societies Marlowe (2000) documented that the greater the proportion of men who have multiple wives the less direct paternal care is provided. All this suggests a link between provisioning, the pairbond and paternal care.

Where opportunities for mating are increased provisioning activities appear to reduce. Gray and Anderson (2010) explain how the greater the levels of polygyny the more men might be putting their energy into seeking additional mates rather than investing in current ones. Waynforth (1999) shows how men invest less in their immediate families where their facial attractiveness and therefore their ability to attract mates, is high. While provisioning can act to increase mating opportunities, where mating opportunities are more available provisioning activities will be reduced. By contrast where males feel obliged to provide for their children their opportunities for mating elsewhere are reduced. In this way it may be that paternal provisioning works to keep men within the family.

Generative of Paternal Attachment

The theory proposed here is that paternal attachment which shapes the nature of fatherhood emerges in the same way as maternal attachment—it is in part a response to the experience of having an infant dependent on you. The point of the provider role is that it gives men the experience of having

others dependent on them[2]. This experience of being needed stimulates attachment to those the male must provide for in the same way that infant dependency stimulates attachment in a mother. The experience of being needed ties men into families where they play an active role beyond that of material provisioning.

If the link between experiencing dependent others and the development of attachment towards those others is in some way correct it would help to explain the persistent behavioural differences between mothers and fathers. As an infant has a prior and more direct attachment to the mother (as a result of parturition and breast feeding) paternal attachment is moderated by the mother's response. The more directly dependent a child is on the father the more nurturant and responsive the father will be. It is because of the accepted and mediating role of the mother that when both parents are around the father always engages less with the child than the mother (Belsky et al. 1984). When mothers assert their position of primary carer the father's nurturant response is tempered; if the mother abandons the child the father will step up to the plate.

The Biological Impact of Men's Family Role

The idea underlying evolutionary psychology is that behaviours which further reproduction will become embodied in some form. This can happen for example at a genetic level or through the neuroendocrine system Ellis (2011).

Gray and Anderson (2010) outline some of the ways in which the neuroendocrine system complements some of the psychological changes which take place during men's transition to fatherhood. They explain how the neuroendocrine system functions to integrate information both within and outside the organism and then uses that information to guide behavioural responses to the environment:

> Effectively, the neuroendocrine systems serves as the body's primary means of engaging sensory, cognitive, emotional and motor mechanisms to enable the kinds of behaviour, such as childcare or mating, that enhances an organism's survival and reproductive success. (p. 208)

[2]This idea is further developed in Dench (2011), Transforming Men, Transaction.

They show the body is primed to physiologically respond to changes in the environment and this can happen in ways which will further reproduction. Various studies have shown how men in long-term relationships or with children have lower average testosterone levels than do single men and that this has been confirmed by various research groups using a range of methods and in both industrialised and non-industrialised societies (Stewart-Williams and Thomas 2013). A study among 624 Filipino men shows that this is not simply that men with lower testosterone levels are more likely to pairbond and have children. Rather they found that men who got married and had children during the course of a five-year study experienced a larger reduction in testosterone than single, childless men (Gettler et al. 2011). The relationships are highly complex and beyond the scope of this paper but it may be that hormonal changes bring about behaviour which helps men adapt to fatherhood.

Research on *Couvade*, a French word meaning brooding or hatching suggests that men are also primed to be responsive to the pregnancy of their partner. A number of pieces of research have shown that during the first and third trimester of their partner's pregnancy men experience more pregnancy symptoms for example weight gain, restlessness, insomnia, appetite changes and so forth than men whose partners are not pregnant.

Men also appear to be primed to respond to infants. Touch has a powerful impact on cortisol levels and fathers could recognise their infants simply by touch suggesting that doing so had left a powerful learning imprint on their mind enabling them to recognise their infant without actually being able to see them. Gray and Anderson also discuss how facial resemblance matters more to men than women with greater resemblance leading to more anticipated paternal investment. MRI scanning demonstrated the neural substrates of this suggesting that what some might interpret as a form of cultural conditioning actually has a physiological root. Men listening to the cries from their own infants experienced increased activation in several brain areas. One of the areas activated was the hypothalamus which can affect the release of hormones throughout the body (Gray and Anderson 2010).

Some of these responses, for example the testosterone lowering effects of pairbonding, or couvade do not occur in all cultural contexts suggesting that the hormonal and psychological response is influenced by the cultural context. If some of these responses are more desirable than others (for example it is known that lower testosterone levels prime a man for childcare) the question then becomes what are the social and cultural formations which are most conducive to these socially useful responses in men.

This raises the possibility that the provider role could in some way prime men for an appropriate familial response. One hint comes from the animal kingdom. Research among birds has shown that intermale competition and courtship may lead to increases in testosterone levels while the formation of long terms bonds and the raising of chicks causes the testosterone levels to drop. Injecting birds with artificial testosterone was found to lead to reductions in provisioning behaviours but increases in the courtship of extra-pair mates (Ketterson and Nolan 1999). This points to a link between provisioning behaviours and testosterone levels. And while we can see that testosterone impacts on provisioning behaviours it also seems possible that these behaviours could be impacting on testosterone levels, helping to bring them down.

This is extremely tentative but if similar relationships between provisioning and testosterone levels were found among humans this could have some very interesting implications. It would provide evidence that the provider role by reducing testosterone levels could potentially be reducing some behaviours such as competitiveness and status seeking, which are not valued in the male by contemporary society.

How the Provider Role Facilitates Other Paternal Behaviour

While the provider role may be valuable in itself its greatest value lies in the way in which it provides the cornerstone for other forms of male nurturant response. This is not only because male provisioning helps the father to secure a place in his child's home. I submit that the act of providing elicits a more nurturing and caring response from men.

This is a challenge to those theories which argue that working in order to provide for the family necessarily gets in the way of more direct forms of fathering. While it seems obvious that a man who is out of the house all day earning a living is less likely to be engaged in more direct forms of fatherhood, as long as the work is not too consuming and is rewarding enough to enable him to spend time at home, the overall effect of the provider role is to shore up rather than challenge a father's more directly nurturing roles.

Hints that this might be the case are emerging. Firstly, although research suggested no significant differences in infant caregiving between traditional and non-traditional fathers interestingly it turned out that it was the traditional fathers who were more likely to play with their children (Lamb et al. 1982).

A more recent study suggested that it was not the amount the father worked which determined how much a father played with his child but the *mother's* work schedules which determined paternal involvement (Norman and Elliot 2015). This reminds us that fathers appear to be responsive to what the mother wants them to do.

A study based on Swedish panel survey data examined, among other things how traditional or egalitarian gender roles influenced attitudes towards parenting and the transition towards parenting. Men with traditional (i.e. breadwinner) views about men's and women's roles actually perceived higher costs of parenting than men with egalitarian roles and this was not related to economic concerns. Rather it was related to the concern that children would limit their personal freedom and reduce time with friends (Bernardt and Goldscheider 2006). This suggests that those who expect to provide for their children are expecting to also invest heavily in their children in other ways. It was also the traditional fathers who had children sooner suggesting that the providing role is still furthering reproductive fitness today.

Traditional fathers have been found to be more likely than non-traditional fathers to be engaged with their children regardless of whether they worked more or whether their partner worked more. Hofferth and Goldsheider (2010) found that even when neither of them worked the traditional fathers would be more actively involved with their children. By contrast when fathers did not hold traditional gender roles they were less involved with their children than was predicted based on their own and their partner's work commitments. The authors point out that as today's young fathers are more likely to fall on the non-traditional gender role end of the continuum, they may be less able to reach an appropriate compromise regarding work and family when faced with unemployment than were earlier generations of young men with traditional gender role attitudes.

Male employment has been found to contribute to father involvement even where he is not living with the mother. Mincy et al. (2005) found that pre-birth employment tends to increase all forms of father involvement: non-residential visitation, non-marital cohabitation, and marriage.

The generative potential of the provider role takes shape when we look at Cazenave's study of black fathers who were letter carriers in New Orleans. Although the study was published in 1979 it is notable that over half the men had employed wives rendering their situation comparable to the current day. Choosing fathers from a reasonably paid non-professional job meant that potentially confounding variables were not allowed to get in the way. Cazenave chose a job which enabled men to support their families

without providing a too salient competing source of identity while at the same time ensuring that they had time available to spend with the family at home.

For the men in his sample the provider role was also the most salient role identity to being a father and was likely to be seen as the most important thing these men did for their children. Cazenave examined the possibility that being able to provide for your family made other modalities of fathering possible. The fathers felt that their own greater ability to provide for their families had fed directly into playing with their babies more, helping with homework more and a greater emphasis on companionship and education than had been possible for their own fathers (Cazenave 1979).

Dench too found in his research on fathering in minority cultures in the UK that men who spent more time doing domestic work tended to be men who had fairly traditional ideas about the sexual division of labour. They put their own careers first, and saw this as the economic mainstay and foundation for the family. However furnishing the basic family income gave these men the confidence to take on domestic work as well. The men who had accepted the equal importance of women's work often appeared to have opted out of both financial contributions and domestic work (Dench 2011).

Although I have tried to demonstrate that the provider role has leverage on other forms of nurturing this is only part of the story. A father who is so poorly paid that he spends the vast majority of his waking life working is likely to feel alienated from the means of reproduction, his family. The fruits of his labour are so paltry and his absence from the family so palpable that any link between parenting and providing becomes too tenuous for the generativity of the provider role to evolve. It is also likely to be the case that work stress which a father experiences can get in the way of effective direct nurturing. The breadwinning role can have negative consequences for men's mental health when they perceive themselves to have failed in it while fathers can be excluded from fathering simply because they failed to provide (Oliffe et al. 2011; Bryan 2013).

However in these examples it is not the provider role itself which has failed in its potential to generate nurturing behaviour. Problems have arisen because of difficulties in performing the provider role.

Nonetheless the provider role can get in the way of paternal direct nurturing. Working will get in the way of the direct care of children no matter who performs it and negotiating the balance between these two activities causes tensions between parents up and down the country day and night. But the provider role is not only about bringing home the bread, or the bacon, but about something more.

A recognition of the importance of the provider role emerges in Farrell and Gray's book (2018) where they suggest that if being the primary parent is viewed by men *as employment* this will make for a happier life. However I would suggest that employment derives its value from provisioning and simply viewing childcare as employment will not have a beneficial effect. Rather if the primary parent is a male, a better outcome would be achieved by finding some form of provisioning activity such as home improvement, excellent shopping or cooking skills or even the provision of status or social networks.

Conclusion

The provider or breadwinner role has been seen as belonging to the constellation of masculine characteristics which are broadly conceptualised as 'hegemonic'. What I have tried to demonstrate here is that the provider role may in fact be an expression of a responsive masculinity and provisioning behaviour actually serves to develop male nurturing instincts further.

If we explore evolutionary psychology the idea of 'hegemonic' masculinity roughly corresponds with the adolescent, pre-reproductive phase of development when more competitive status seeking practices are ascendant perhaps partly because of higher testosterone levels. During this phase responsive masculinity lies dormant but is activated in response to male female interaction (what happens with homosexual relations would be an extremely interesting area of exploration and may shed light on heterosexual relations too). Once a pairbond forms male responsiveness causes males to participate more in provisioning activity as this appears to be highly valued by females, even in contemporary industrial societies. Men who provision are more likely to reproduce due to female demand for male providers. Fatherhood itself stimulates further nurturing behaviour and processes of attachment. The tendencies to nurturing, attachment and responsiveness are strongly supported by a whole range of neuroendocrinological processes.

The aim of the paper is to show that even where the nutritional or financial value of what is provided is not essential, the provider role *is* because it provides the foundation on which the real and most valuable and essential work of fatherhood is done. These other paternal roles have been extensively elaborated elsewhere. This suggests a link between provisioning, the pairbond and paternal care. The provider role by giving men a place in the family may act as a cornerstone for the full range of paternal engagement.

The hope of the article is to stimulate more research into the relationship between paternal provisioning, attachment and nurturing before the

provider role is dismantled further. Research should also be conducted into the range of forms which provisioning can take in contemporary society and developing models of provisioning which do not depend on employment.

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Games People Play: The Collapse of "Masculinities" and the Rise of Masculinity as Spectacle

Damien Ridge

Introduction

While many feminist scholars—for good historical reasons—want to focus our attention on patriarchy, the power of men over women (and subordinated men), the everyday lived reality for men can seem at odds with this discourse on masculinity. As was demonstrated by the election of Donald Trump, it appeared that many deprived white heterosexual men did not consider themselves to have power, they were living in a hopeless place, and rejected the world order as espoused by elites. With little comprehension of the kind of patriarchal power middle-class feminists discuss (Lamont et al. 2017), less affluent men (and women)—long forgotten by mainstream elites—registered their anger and frustration with the status quo by electing a controversial figure who used "calculated chaos" to defeat liberals (Steinberg et al. 2018). Long before the Brexit and Trump political eruptions of 2016, there were men involved in the men's movement (Farrell 1993), or those who had experienced sexual assault (Stemple 2008), for example, who felt frustrated and left out by prevailing liberal discourses. Additionally, in a lived way, men subjectively experience their masculinity in ways which do not always resonate with feminist discourses. For instance, in everyday life, men are more likely to locate their masculinity in their body,

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particularly in their penis (Potts 2000), and may fail to recognise a competitive social-wide system that dominates women as outlined by hegemonic masculinity (Connell 1995). Given the perilous state of the world, it is more urgent than ever to understand how differing vantage points on the public spectacle of masculinity can be better understood.

Taking into account the disparate views of masculinity in the literature (as outlined below), an alternative approach is to take as a starting point that masculinity is *meant* to be interpreted in different ways. For instance, men themselves frequently have a deep understanding of the game-like nature of masculinity as intimated above, i.e. the idea of realities existing behind gendered performances, and the use of "masculinity" to achieve some kind of purpose socially. Thus masculine-based charisma, for instance, might be used by gang leaders to attract members and build a power base (Kadir 2012). Or particular zones of the masculinised body (Graham 1998), or motions of the male body, could be used to convey something about masculinity, like power and sex (McClelland 2002). But it is a game, not all audience members will notice—or be affected by—the erotic dimensions of masculinity. It is entirely possible that some observers might not consciously register masculinity at all in certain situations. The important point here is that to a large extent, masculinity is in the eye of the beholder, and it needs to be activated at some level, consciously or less consciously.

In this chapter, I will outline the roots of this masculine "gaming" approach. Here, I argue that gender has elements of spectacle, of "virtual reality," in that it is conjured up in the minds of social participants, it is not just an interior quality, nor a social system. Masculinity is not a thing that will resonate with people in the same way, the influence of gender has to compete with other social things happening at any given time. Thus, masculinity could be understood as something that emerges in social participation, through varying interpretations, and in competition with other dimensions like ethnicity, social class and so, i.e. it is grounded in intersectionality.

As in any virtual reality game, there is a biological substrate from which the reality (masculinity) arises: You cannot have a reality without bodies engaged. Men, for example, know that it helps to have the right kind of body for conveying masculinity, where muscular endomorphic bodies are generally at an advantage over ectomorphic ones (Wienke 1998). It is not just the male body, but the ways in which it is deployed, as well as the use of objects, that are important. Men "use their bodies as emotional and sensual instruments" (Gorman-Murray 2013, p. 137). For example, bodies are used as a way of striking a work/life balance, where home can provide a refuge from the

exhaustion of public performance. As one man put it (p. 141), "*It is important for me to get changed as soon as I get home*" so as to put away the costume and become a "homebody". Boys are acutely aware of gendered games from an early age, and they know something about the superficiality of masculinity (Chu 2005). There are aware of more authentic feelings lurking behind the game playing, for example, they are aware of their insecurities and anxieties behind the facade. But similarly, men playing the masculinity game can easily become divorced from their authenticity, finding it difficult to know what they feel (Levant et al. 2003). Playing the game without insight in this way can mean men's feelings become an alien, frightening territory, with temptations to find short-term ways to manage them, like substance use (Lomas et al. 2013). Masculine gaming, as outlined at the end of this chapter, attempts to take into account not only the performative aspect of masculinity, but also the subjectivities of men themselves (frequently neglected in theories of masculinity), not to mention the different readings of masculinity that inevitably emerge in the playing of gendered games.

Historical Gender Theory and Hegemony

Once, masculinity was considered just an inevitable outcome of biology. However, biology did not explain why women were relegated to housekeeping post World War 2 after doing the same jobs as men during the war (Annandale and Clark 1996). In the twentieth century, "sex role theory" was developed to explain expectations on people to play a role, depending on their gender. For example, the traits expected of men (e.g. toughness, independence, rationality) were quite different to those expected of women (e.g. nurturing, emotional) (Harrison and Lynch 2005). But sex role theory failed to explain why society had such expectations about men and women in the first place, and alternative theories were put forward (Connell 1987). Second wave feminism from the 1960s began to tackle social problems facing women, including the need to improve reproductive rights, address domestic violence, as well as wider sexual harassment and violence.

In the early twentieth century, Antonio Gramsci developed the idea of hegemony to describe the wielding of political power by the upper classes, manipulating values and social mores to justify their power and the status quo (Gramsci 1998). Australian sociologist, Raewyn Connell, subsequently transported this idea of cultural hegemony to the area of gender. She developed a social wide concept of gender and used it to make sense of men's life history accounts. She argued that not one kind, but multiple forms of

masculinity existed and competed with each other for dominance (Connell 1995). Connell suggested that different kinds of masculinities emerged in everyday life, and the type of masculinity that prevailed as the current "most honoured way of being a man" in any particular locale was "hegemonic" (Connell and Messerschmidt 2005). Thus, certain men had the power to define what was valued masculinity, and other kinds of masculinity were marginalised. In practice, however, scholars frequently used the theory in unanticipated ways, for example, by invoking the idea of static and toxic traits as making up hegemony e.g. stoicism, risk taking, and violence. But hegemony was never intended to be used thus, and was instead meant to be responsive to social circumstances. Thus, hegemony could potentially appropriate positive values (like emotional intimacy), not just ones considered toxic (Lomas et al. 2015).

Hegemony was envisaged as a powerful ideology shaping men, even if no man could actually live up to its varying (and impossible) expectations (Connell 1995). For example, the instilling of fear in boys (gay or straight) who failed to live up to expectations of heteronormativity (including avoiding "effeminacy" or emotional sensitivity) was thought by Connell to be key to policing masculinity. Certainly, heteronormativity has been a powerful force influencing masculinity. Feminine traits like creativity were not permissible for large swathes of boys in social institutions like schools, lest their heterosexuality be questioned and they risked social marginalisation (Plummer 1999). However, heteronormativity is increasingly challenged. For example, boys in some school settings are beginning to advocate pro-gay attitudes and emotional intimacy as part of their masculinity (McCormack and Anderson 2010), although not by any means overturning homophobia entirely. And as intimated above, localised groups of men (e.g. friendship groups, meditation groups) appear to have created new hegemonic values that prize previously marginalised values, like talking about emotions and expressing vulnerability in the company of other men (Creigton and Oliffe 2010; Lomas et al. 2015). Thus, masculine hegemonies are not uniform, they are local, they do not have to be toxic, they can adapt to local conditions, and challenge heteronormativity.

Nevertheless, commentators in the mass media have promoted the idea of a globalising, "toxic masculinity", despite the lack of scholarly support for the concept. The #MeToo movement has highlighted predatory and abusive behaviours against men, first triggered by the allegations made against movie producer Harvey Weinstein in late 2017. Here many social commentators promote the idea of masculinity turning "toxic", a kind of society-wide pathology that infects masculinity (Syed 2016). Connell (1998) herself once

tried to develop the idea of a "world gender order," arguing for recognition of a "transnational business masculinity" situated in corporations, to describe men especially influenced by neoliberal ideals (e.g. privatisation, deregulation). However, this globalising masculinity concept collapsed for want of evidence (Beasley 2008), and Connell (2014) later abandoned the project, finally concluding it was too simplistic (p. 228) "*we cannot presuppose a consolidated gender order.*" While clearly a different concept to toxicity as argued above, Connell's theory of hegemonic masculinities has proliferated exponentially. So much so that hegemonic masculinities had come to dominate discussions of men and gender. Connell's (1995) book, *Masculinities*, published in 1995 and subsequently updated, had nearly 18,800 Google Scholar citations by late 2018. Clearly, the concept continues to inspire scholarly thinking. Hearn (2004), for example, has argued that Connell's concept of hegemony does not go far enough in describing and then working to dismantle the dominance of men.

But what about the critiques of hegemony? Connell and Messerschmidt (2005) addressed the critiques well over a decade ago, quite rightly pointing out that scholars often misinterpreted the theory. For example, because men frequently seemed to depart from hegemonic ideals in terms of health and help-seeking, some incorrectly saw this as a lack of evidence for hegemony (Reed 2013). Yet the theory specifically allows for such departures: hegemony is not the same thing as traditional masculinity, and it is meant as a yardstick for men to be measured against. And yet, in the fourth decade of its use, cracks in the theory continue. In their "rethinking" piece, they summarised 5 main criticisms of the theory (Connell and Messerschmidt 2005):

1. Flaws in the concept of masculinity, e.g. it is a fuzzy and static concept, fixates on heteronormativity, is too essentialist, and is not needed to understand male power anyway.
2. Difficulties translating the hegemony concept to real life, the ambiguity of which Connell admits to, suggesting hegemonies should be seen as ideals only.
3. Reification—hegemony becomes reduced to toxic traits or simply conflated with patriarchy.
4. Being overly social or structural to the point of neglecting the actual subjectivity as experienced by men, which as outlined in this chapter, is hard to deny.
5. As limiting gender to a "self-contained, self-reproducing system", yet Connell points out how hegemony is open to historical change, such as by appropriating gay styles.

Despite the critiques, Connell has argued that what should be retained is the focus on multiple masculinities and the notion of hierarchies. Connell also noted that research around hegemonic masculinity had become disconnected from femininity, including "emphasised" (hegemonic) femininity, and stated that research "*now needs to give much closer attention to the practices of women, and the historical interplay of femininities and masculinities… acknowledging the possibility of the democratizing gender relations… it is possible to define a hegemonic masculinity that is thoroughly 'positive*". She also noted subsequently that "*…the same masculinities may be simultaneously hegemonic and subordinated…*" (Connell 2014). But the theory itself actually discourages conceptual links to "emphasized" femininity, and it encourages a view of unidirectional power from men towards women, and lesser men. Connell herself acknowledges that one problem with hegemonic masculinities is that it tends to separate out (and turn into binaries) the experiences of men and women (Connell and Messerschmidt 2005). Connell admits a kind of uni-directionality in that the concept of hegemony emerged to describe "the pattern of practice …that allowed men's dominance over women to continue" (Connell and Messerschmidt 2005). However, in an age of intersectionality (see below), unidirectional gendered power on its own cannot fully make sense of contemporary social situations. Research continues to accumulate showing that gendered power flows in different directions, and is mediated by other factors, like ethnicity.

Some authors have pointed out that the concept of hegemony is vague and unhelpful. For example, does hegemony refer to men at a political level, the most powerful "versions" of men, or groups of everyday men (Beasley 2008)? Beasley suggests that the term should be reserved for use in describing a "political ideal," so as to focus on its "legitimating function" (p. 95). Other authors have questioned even the need for the concept of hegemony at all. Schrock and Schwalbe, for example (2009) have argued that concepts of multiple masculinities prevents us from properly considering what it is that masculinity is about. In practice, they also note that plurality in the theory tends to essentialise men into specific categories of masculinity, e.g. as gay or Black masculinities, neglecting in-group variability, which is considerable. The additional problem with the theory is that it draws our attention away from what subjectively is going on for men, because it asks us to filter our answers through a structural theory. One author, for example, has suggested that hegemonic masculinity has tended to obfuscate how men perceive and feel in the world, in favour of more structural and even speculative issues, like globalised masculinity (Whitehead 2002). Other writers like Jefferson (2002) argue that in practice (if not original intent of

hegemony), an "over-socialised" view of male subjectivity emerged. What the masculinities debate does show is that even with a strong theory with one origin, different authors interpret it in different ways, and varying assessments are made of its usefulness. So what about a concept with different origins, such as "doing gender"?

Doing Gender

In more recent decades, the idea of "doing" gender, with similar concepts being "gender performance" or "gender performativity", developed in parallel to masculinities, although again there are divergent interpretations of the concept. The idea that gender is "done" by men and women, rather than being traits that we possess, has been advanced since the 1960s. For instance, Harold Garfinkel (1967) studied a young "trans" woman—Agnes—who performed and achieved status as a woman before being able to access gender-reassignment surgery. Ervin Goffman subsequently (1977) used a dramaturgical metaphor to show how gender has to be (re)produced in everyday life, such as through the way public toilets were designed and segregated, with a public stage for men to urinate, but with much greater privacy and luxury afforded to women. Following on from this early work, Candace West and Don Zimmerman struggled for 10 years to get their now well-regarded 1987 paper on "doing gender" published (it was initially rejected by the top journals). In talking about how they developed their ideas, they acknowledged their debt to Harold Garfinkel but noted that Judith Butler (see below) had not acknowledged their earlier work in developing her notion of gender performativity (West and Zimmerman 2009). They provided a definition of doing gender as "*a routine, methodical, and recurring accomplishment. We contend that the 'doing' of gender is undertaken by women and men whose competence as members of society is hostage to its production*" (1987, p. 126).

In doing gender, men are compelled to become skilled at acting as "masculine" as defined by society, or face (frequently dire) consequences. Differences between the sexes then become rarefied to reinforce the naturalness of the traits that distinguish men and women. But the important point here is that masculinity is policed with a heavy hand. To illustrate by compelling example, in one South African prison, it was shown how men could rapidly shift status from men to women. Specifically, men who had been raped in prison were considered by other inmates to have undergone a kind of feminine transformation (Gear 2007). Rather than being regarded first and foremost as criminally violated: "*In fact, the person who*

has been raped… is regarded as a woman … Prisoners will whistle for him as if whistling for a woman… If he mistakenly step[s] on your feet, you will call him 'bitch'." The "doing gender" framework shows how interpretations of gender are complex, requiring other social actors, audiences, and ongoing "competence" on the part of actors (a requirement they may have no control over). Interestingly, it was also possible in this prison for more dominant men (active in penetration) to take other men as "wives" (receptive in penetration), and such unions could be considered "marriages" by other men. Thus, the wider binaries of male/female, active/passive, and heterosexual/homosexual were superimposed on an exclusively homosocial space. While doing gender is at once fluid and so allows for variation, it is also rigidly reproductive of the social order via heavy policing.

By further example, Pascoe (2005) from the University of California studied one particular high school in the US (fictitiously called "River High"). Boys at River High use the term "fag" as a vantage point to mark "outside masculinity", so as to define what masculinity entails (p. 342). Here, boys had to work at trying to rebut a feared label, and to bolster their own masculinity in the eyes of others. There is fluidity here again in that the "fag" label is usually not permanent, and boys "move in and out of fag positions" (p. 342). Additionally, the tag does not literally mean that the boy is gay, but it does mean the boy has ceased to be considered masculine in a specific situation by particular observers. And here, the way in which masculinity is played out is very much dependent on who is performing. So, while dancing and attention to clothes could attract the label "fag" for white boys, the same behaviour for Black boys might bolster their manhood. Again, what we are seeing here are masculine identities which emerge through carefully "routinised and managed" spectacles in local settings (Brickell 2006).

While "doing gender" was originally intended to mean conforming to—and subverting—the gender expected of social categories like "man" and "woman" (West and Zimmerman 2009), some argue that the exclusion of the concept of "undoing gender" was an omission. In this way of understanding, social life is thought to become "less gendered" at certain times, where masculine gender may even cease to matter as much. For example, Deutsch (2007) noted "*Female interviewers may have to contend with male interviewees' attempts to reassert male power, but in the end, the interviewer writes the article that defines the interaction between them…*" (p. 113). The potential for "undoing" gender happens in unlikely places too, including traditionally male-dominated off-shore oil platforms. Here Ely and Meyerson (2010) discovered how relatively easy it was for men to be "released" from the constraints of masculinity when allowed the opportunity by a powerful institution. With their company heavily involved in promoting collective

goals, men became more emotionally connected to others and felt responsible for others' wellbeing. The authors argued that male identities could become much broader than usually allowed by masculinity (p. 27): "*organisations equip men to undo gender by giving them the motivation, a model, and a margin of safety to deviate from conventional masculine scripts*." Or as one male production operator put it (p. 15), "*[We had to be taught] how to be more lovey-dovey and more friendly with each other and to get in touch with the more tender side of each other type of thing.*"

Once the idea of "doing gender" was established in sociology, Judith Butler's (1990) take on it was that gender was achieved through repetitive and stylised acts that established a fictitiously coherent stable inner "core" of gendered identity. While the male/female binary that results appears "natural", Butler drew attention to its intrinsic instability, and the heavy policing required to achieve it. Following on from Foucault (1986), Butler thought that it was through the language available to us that gender came into being and was regulated and normalised. Gender does not so much express an identity, rather it reinforces prior conventions already established by available discourses. Famously, Foucault had already argued that the binary division of human sexual expression into heterosexual and homosexual identities developed out of specific legal and medical discourses in the nineteenth century. Similarly, Butler was saying that sex (male/female) and gender (men/women) are legitimised by power structures in society, and these are performatively (re)produced. This was a radical (post-structural) position, as she was essentially overturning the idea of a prior gender identity, and instead arguing that gender and sex were "unstable discursive productions" produced through actions (Nayak and Kehily 2006, p. 460). So, there does not have to be an agent behind the deed, as the deed itself in effect produces the doer. Butler thus (p. 460) "*subvert(s) and implodes the very basis of identity itself*". Here, the repetitiveness in performativity is inherently unstable, and so there is always the potential for change to be incorporated into gender (Brickell 2005). The subtle—yet profound—differences in how different theorists understand the doing of gender point to the multiple interpretations of the surface performances that theorists have elaborated.

Manhood Acts

Researchers Douglas Schrock and Michael Schwalbe (2009) in the US did their own stocktake of masculinity, given what they saw as inadequate theorising. They argued that while we know a lot about men in different contexts (e.g. sport, work, health), scholars needed to focus on "manhood acts",

defined as "*cultural practices that construct women and men as different…*" (p. 278). They insisted that manhood acts were about unidirectional power: "*aimed at claiming privilege, eliciting deference, and resisting exploitation.*" Additionally, following on from Goffman, they adopted the dramaturgical idea that the male body itself was important in signifying credible manliness, and so the masculinised identity became a kind of "*virtual reality… a consequence of how an actor's appearance and behaviour are interpreted by others*" (p. 280). This theory is important, because it focuses our attention on the audience, although the theory (similarly to masculinities) advances unidirectionality in terms of power (Ezzell 2012). By way of illustration of manhood acts, Vaccaro et al. (2011) observed power in a mixed martial arts gym, revealing the game like nature of masculinity. They found that although fighters appeared to act with bravery, they were inevitably suppressing their anxieties and fears. Fighters feared injury and the intense shame of losing a fight. So fighters must be strategic, developing well worked out plans including: researching opponents on YouTube for vulnerabilities; talking themselves into seeing themselves as superior to their opponents; and trying to psych out their opponents (e.g. by revealing their muscular bodies before a fight). Thus, masculinity is about managing interior vulnerabilities while trying to project a particular kind of manliness. Sumerau (2012) similarly found that gay Christian men played-up elements of dominant masculinity in certain situations to compensate for their deep sense of lack (compensatory manhood acts). For example, men would present themselves as being rational and in control, e.g. "*The gay Christian men… constructed compensatory manhood acts in ways that explicitly defined women and other sexual minorities (e.g. promiscuous or effeminate gay men) as inferior beings.*" While I caution against the notion of unidirectional power, the game playing involved, and the activation of masculinity according to circumstances, are central to new conceptualisation of masculinity as outlined below.

The concept of "manhood acts" while helpfully refocusing attention on how masculinity is observed, does not discuss the kinds of power that women exercise over men, nor the potential power of marginalised boys and men. For example, in a large mixed-methods study of adolescent romantic relationships in the US, it was found that boys reported less confidence and greater awkwardness than girls in negotiating romantic relations (Giordano et al. 2006). One 17 year old Jake talked about the prelude to being dumped as (p. 273), "*…I like talked to her on the phone, I don't know it was kind of awkward, like long silences… I couldn't like think of anything more to say you know….*" The authors expressed surprise that while boys make more attempts to influence girls, it was the boys who reported greater levels

of actually being influenced by their romantic partners. In terms of perceived power, boys also suggest they have less capability in the face of girls decision-making power. As David, 18, said (p. 281), "*…I guess I wasn't on her level you know because she wanted to do it [have sex] more than I did… I was scared, I didn't know what I was doing…*" Research commonly focuses on how men control condom use and non-use, but in one study, one young man said about condoms, "*I really didn't have much of a say in this anyways, because she said she didn't like condoms period… for the longest time I never used condoms… but I wanted to…*" (Devries and Free 2010). Men may have good reasons to use condoms (e.g. to avoid fatherhood), but can feel pressured to not use them, just like women (Bowleg 2004).

There is also the slow democratision of sexual relations among younger men and women. Here, some—but not all—elements of the double standard (sexually experienced boys as "studs", girls as "sluts") are being challenged. For example, a study of US undergraduate college students presented a scenario of a heterosexual hook-up (casual sex) at a party, followed by a date. Students generally were relaxed about women desiring men and having enough sexual agency to hook-up after a party (Reid et al. 2011). It was only afterwards, if the hook-up does or does not turn into a date/potential relationship, that women were judged more harshly than men (p. 564): "*Women are allowed to have fun at parties, but once it becomes a serious matter, traditional gender norms, which affirm men's prerogatives, take precedence*". In another study that surveyed attitudes of college students online, it was found that 3 in 4 students do not subscribe to different standards when it comes to males and females hooking up, although men were more likely to hold double standards (Allison and Risman 2013). And while it is now possible for women to take initiative in proposing marriage, or to assert the desirability of co-habiting, men still have more control over whether a fledgling relationship is formalised (Sassler and Miller 2011). This kind of deeper research does not easily conform to narratives in the scholarly literature about uni-directional gendered power.

Erotic Capital and Sexual Relations

If we are to begin to understand masculinity as spectacle, and as something that can be activated, undone or lie dormant, then eroticism is an over-looked issue, as intimated at the start of the chapter. Positioning eroticism as an powerful asset, it is not hard to understand why many feminist scholars would be annoyed with Catherine Hakim's analysis (2010).

Hakim argues that men have exploited patriarchal power in academia to prevent a proper examination of erotic capital, and feminists may have unwittingly colluded on moral grounds. Hakim claims that women have long nurtured and exploited erotic capital, frequently with access to (p. 499) "*greater erotic appeal than men*." Hakim outlines the elements of erotic capital including cultural ideas of facial beauty, bodily sexual attractiveness, social skills (e.g. flirting, developing emotional connections), liveliness/energy, presentation (e.g. fashion), and sexuality (e.g. sexual competence). Hakim firmly situates her theory of erotic capital in the doing of gender realm, acknowledging that both men and women who master the art of erotic capital can create distinct advantage for themselves.

Hakim's view, of course, is even more controversial in the #MeToo era, and there were critics beforehand. For example, it was argued that the concept of erotic capital is not new, that it over-reaches, and ignores the contexts in which it operates, such as the way that women have less power and become relatively less desirable than men as they age (Green 2013). Men on the other hand can take up desired positions as they age, like the "silver fox". Yet, erotic capital has to be acknowledged as a possible source of power for both women and men, however fragile. Masculinity is an erotic currency which gay men, for example, are well versed in (Ridge 2004). So much so, that it is argued that (self and other) pornography has become the centre-piece of global gay culture in the era of social apps like Grindr (Tziallas 2015). However, as with women, there are pitfalls for men who demonstrate erotic capital. For example, men considered "handsome" may suffer in terms of their job prospects in certain kinds of professions e.g. intellectual (Udry and Eckland 1984). While arguments put forward by scholars like Hakim are controversial in the current climate, the interesting emphasis on the audience, and less obvious forms of power, warrants attention.

Intersectionality

One problem of focusing on masculinity in relative isolation is that it can reify differences between men and women, while downplaying similarities (Springer et al. 2012). Additionally, there are a range of dimensions on which we may be different or the same besides gender, including (p. 1661) "*race/ethnicity, Indigeneity, gender*, *class*, *sexuality, geography, age*, *disability/ability, migration status, religion) and forms of systemic oppression (e.g., racism, classism, sexism, ableism, homophobia).*" If we are oppressed or privileged,

it may be for complex reasons. On a day to day basis, and depending on circumstances, men and women negotiate varying identities and social memberships, including gender positioning, social class, occupation, and ethnicity. Intersectionality is about the notion of (p. 1661) "*simultaneous intersections between aspects of social difference and identity (e.g., as related to meanings of race/ethnicity, Indigeneity, gender*, *class*, *sexuality, geography, age*, *disability/ability, migration status, religion)*" (Springer et al. 2012). It's an idea that has caused debate between feminists, including on social media, with some white middle-class feminists accused of lacking awareness of their own privileged positions and unconscious racism (Adewunmi 2012). Black women argue that discrimination is becoming increasingly specialised even if white women have won certain privileges (Williams 2013). In terms of masculinity, intersectionality could be seen to further question the value of focusing specially on social wide system of masculinities which are ring-fenced from other considerations. Coston and Kimmel (2012), for example, see privilege as uneven when it comes to men, affected by things such as disability, sexuality and class. They point to some of the strategies men might use to deal with their particular level of power (or lack thereof), such as exaggeration (think of very camp gay men), normalisation (we are just like you who have privilege), and militant chauvinism (where dominant groups claim superiority).

One study of US Black heterosexual men of low income uncovered intersecting social forces that created challenges for men, variously described as "the struggle" (Bowleg et al. 2013). Or as Paul, a college graduate in his 30s said, "*… to have less access to the system and … to work harder to get like results that maybe Caucasians, or people that come from higher economic backgrounds [readily get is] kind of depressin.*" The men talked about micro-aggressions they experienced everyday due to racism, for example, Sean noted at work "*White people get to come in late, and you know, feel what they feel, but we [Black employees] get written up for certain things [that the White employees would not get written up for].*" There is also the well-documented system of surveillance and harassment in law enforcement that Black men experience over and above white men. As Wayne put it, "*And it happens over and over … Just getting the once over [by police], just being harassed by cops [who are] always looking [at me] like I'm suspicious … like a suspect or something, a crim[inal] or something.*" Thus the lower-income black male experience is qualitatively different from that experienced by white men. Black men are engaged in a different game, it involves masculinity, but there are different dynamics and rules, not different masculinities.

Towards Masculinity as Spectacle and Game

As Mac an Ghaill and Haywood (2012) argue, scholarly work often ends up adopting a "simple gendered frame based upon singular categories of male and female", constructing men as "damaged and damage doing". Men are seen as not only toxic towards themselves, but especially hazardous for women, who generally figure as widely disempowered as well as innocent in this narrative. This binary split of "women good/men bad" tends to disconnect gender theory from the everyday complexity of life, where everyone has limitations, and women may also be toxic (Klein 1950; Colebrook 2010). The above narrative also risks alienating men who subsequently cannot relate to what feminist scholars talk about. Additionally, the combativeness and disconnection between theoretical discussions and the daily lives of men risks male subjectivity only be acceptable through particular filters that allow some experiences but not others. This situation was clearly never the intention of Connell and other scholars. But just as Connell delivered a devastating blow to sex role theory in the 80s, hegemony is also increasingly challenged. So much so, scholars are already talking about a post-hegemonic world. But what might replace hegemony is confusing, since masculinity appears to be in the eye of the beholder. As outlined above, masculinity has essentially become what different theorists and their tribes say it is.

Authors pronouncing the death of hegemony have tried to assert their own ideas. "Manhood acts", for example, conceptualises masculinity in terms of power exercised by more powerful men. Anderson and colleagues, on the otherhand, take an entirely post-feminist path, and talk about "inclusive masculinity", arguing that as the fear surrounding homosexuality has declined in the West, so too masculinity has softened and become more egalitarian (Anderson and McCormack 2015). While the authors put forward some striking qualitative evidence for this softening (e.g. increasing physical and emotional affections between heterosexual men), it has been argued that this "cheery" optimistic narrative also represents a return to conservative sexual politics, where patriarchy remains very much intact (O'Neill 2015). Further, inclusive masculinity is thought to overlook the privileges (power) that allow some heterosexual men to engage in homoerotic practices with latitude. But just as masculinity is not necessarily the same thing as unidirectional power (as argued in this chapter), masculinity is also more than what is organised around levels of hysteria around one issue (homosexuality).

In this chapter, I took some time to examine hegemony and plurality in masculinities, explaining how these ideas have been questioned of late. It turns out that hegemony is shifting and difficult to pin down, made all the

more difficult by the multiple ways in which different scholars have interpreted and operationalised the theory. Hegemony also tends to focus our attention on social wide structures and away from men and their subjective worlds, regardless of the original intentions of the theory. The theory also invites us to consider masculinity in isolation, even from femininity, focusing attention on gendered power as masculine and unidirectional (men do things to women and less powerful men). It is not specifically designed to conceptualise the democratisation of gender, nor instances where woman hold power over men, such as when women demonstrate superior relational abilities. Thus, it not only encourages us to apply an overarching structural framework to interpret male subjectivities, but it also invites us to turn a blind eye to those dynamics that do not fit the theory. The concept also focuses us on differences between groups of men, or between men and women, rather than the complex interplay of difference, privilege and disadvantage, such as negotiated by Black men every day.

The ideas of gender as something that is done rather than static, actively produced in everyday life, a position to take up, or an aesthetic, are now taken for granted by many scholars. But more overlooked is the idea that gender is variously interpreted, so it can be undone, it can be more or less important. Until now, it was generally considered that men are operating within considerable restraints set by the gendered order of society. That societies more or less agreed about acceptable performances of masculinity. But even the idea of brutal policing of gender is beginning to be questioned, as in the theory of inclusive masculinity above. Certainly, the idea that marginalised masculinity is a useful concept, or that marginalised men are really marginalised is questioned by some scholars (Tischler and McCaughtry 2011). Additionally, some scholars are now exploring the power that (at least privileged white, middle-class Western) women can wield. Masculinity is a site of contestation, and it is a public spectacle that audiences have a say in (as evidenced in the way scholars cannot agree, but nevertheless put forward theories of masculinity).

As outlined in this chapter, masculinity also needs to be understood as something that is experienced and performed from within bodies. While the body itself is a powerful indicator of masculinity to many audiences, masculinity still has to be performed, and the virtual (masculine) self must be observed by others. And despite the best efforts of gendered performances, judgements about masculinity reside with the observer. It is not that there are multiple masculinities, but multiple interpretations of masculinity, as is obvious now scoping the scholarly literature. Masculinity is in the eye of the beholder, and the audience itself has all kinds of investments in masculinity.

For instance, does the audience member notice bodies, eroticism, charisma, the social structures supporting gender, the power of men, or the power of women, or a mix of all these? Do they imagine toxicity or benevolence? A conceptual framework of doing, undoing and multiple interpretations of masculinity (not just based on unidirectional power) needs to be captured in new understandings of masculinity. Additionally, recognising a level of "knowingness" about the masculinity game, especially among men, is also important. Masculinity does not ultimately reside in a social system, or an individual, but in the inevitable variation in interpretations of that masculinity, and the way its importance waxes and wanes.

Said in another way, masculinity has to be willed into being, it has to be activated, and context is important here. Hitherto, the degree to which masculinity is a matter of personal taste, and multiple interpretations, has been neglected. As Frank and colleagues (2003) noted about gender over a decade ago, "*we need to think differently about … how we have come to 'know' the world through the more general artificial polarities which modern investigation and theorising has invented as 'real'.*" Ideas of audience and contested interpretations, and concepts like gamification are ways of reconfiguring masculinity away from the power of those who tell us what masculinity is, towards better understanding the (necessarily) different readings of masculinity. The gamification of masculinity can most easily be seen when men perform a masculinity but realise at some level that it is inauthentic. In the US, a study of formerly incarcerated Latino men who transition from being "knuckleheads" (i.e. "knowingly acting in ways that are harmful or risky" [p. 1765]) to responsible, community minded men is a good example (Muñoz-Laboy et al. 2012). Knuckleheads take up the bad boy persona for benefits like short-term gain in money and status (winning). Post-prison though, knuckleheads say they actually feel lonely and isolated, and risk re-engaging with crime to deal with their subjectively difficult feelings. But with support, men can become more reflective and empowered enough to feel that they can be more authentic and nurturing (of self and other). Like Pedro, who decided to prioritise his family above his previous street life (p. 1771): "*My way hurt me too much. My way never took no where different. I no longer feared the pains of change because my pain of remaining the same became greater than the pains of change. I vowed to fight against the feelings of loneliness. My life still had a chance and nothing or anyone would take it from me again.*" Somewhere beneath the masculine veneer is a real person with a subjectivity just like you and I.

Conclusion

It is not surprising we have reached a point where different scholars—whether masculinity scholars, feminists, or those in the men's movement—have widely differing ideas about masculinity. Masculinity might be "done" by men, but it is interpreted and assessed by others in different ways. And as in any review of a performance, is it not the point that perspectives will differ? The audience for any potentially gendered spectacle differs, and observers can be very particular about what resonates for them. Like movie critics, there will always be disagreements, although there will be some level of agreement about the movie. Is it a good, bad or mediocre production? At the same time, over the decades, particularly in light of great feminist advances, we have become much more ambivalent about the "masculinity game". The reactions to displays of masculinity range from admiration, all the way through to disgust and repulsion. Is it not the point of masculinity to evoke feelings in us, the audience? Because we still tend to locate masculinity in the individual or the social system (depending on our leaning), we have less awareness of our role in curating masculinity. Masculinity is a social rather than individual accomplishment, but one that requires the full range of actors, producers, directors and audiences.

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From Stereotypes to Archetypes: An Evolutionary Perspective on Male Help-Seeking and Suicide

Martin Seager

Introduction

In our current age it is unfashionable to think of human gender as connected with our biology and evolution. Gender is currently thought of primarily as a social construct, a theory that carries assumptions that gender can be fluid, moulded by education or even chosen as part of a lifestyle. Gender is increasingly seen as a collection of disposable social stereotypes, separate from and unrelated to biological sex. In practice, this means that we are increasingly accepting a view of gender that splits the mind from the body and brain. This hypothesis is bad science and even worse philosophy. Such a concept is at odds, for example, with the fact that many people have fought long and hard to have their homosexual orientation recognised legally as an integrated, essential and embodied part of their identity. If homosexuality is now rightly accepted as a natural part of the human condition, then gender itself must certainly be. And yet this is not reflected in mainstream attitudes and policies towards gender in our current times.

The social stereotype theory of gender has no single author and has not in truth been tested scientifically as a hypothesis. It has its origins more in political fashion than in an integrated bio-psycho-social science of the human condition. When held up against the anthropological and cross-cultural evidence, a social constructionist theory of gender cannot explain clearly observable and

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universal patterns in male and female behaviour and yet the theory persists as an accepted truth in a political climate where gender differences are denied or devalued, resulting in what has been termed "beta bias" or more recently "male gender blindness" (Seager et al. 2016b). Science has of course always existed in a wider and more powerful political and social context. At one time it was considered heresy to say that the Earth was not at the centre of the universe even when the observational evidence proved otherwise.

In a scientific culture where the very concept of biologically based gender difference is unfashionable it inevitably becomes that much harder to research and address observable differences between male and female behaviour even where these are strikingly obvious and urgent as is the case with suicide. In this chapter it will be shown that by simply allowing the obvious hypothesis that some male "stereotypes" are closer to "archetypes", much of the evidence surrounding male help-seeking, risk-taking behaviour and suicide itself can be explained. This approach will be shown to promise more scientific and humane ways of responding to male distress and preventing male suicide, to the benefit of all of us, men, women and children alike.

The Evolution of Sex and Gender—Difference Is the Point

Human beings are evolved mammals and they have never stopped being so. Whatever social, cultural and political structures are placed upon us as humans, these cannot erase our mammalian heritage and indeed are constructed upon and shaped by that heritage, though not determined or defined by it. Globally, across all human tribes or societies and throughout all known history and prehistory, allowing for inevitable variation across a spectrum, there are universal patterns of male and female behaviour in the human species. These evolved behaviours are related to our very survival through sexual attraction, mating and the rearing and protection of offspring. These patterns are indeed not even unique to our own species but apply to many other animal species. Essential within these patterns is the presence of sexual difference.

Within human beings perhaps the most obvious universal patterns of sexual difference are:

Female (1) Beauty, attraction and glamour (including body adornment)
(2) Bearing and nurturance of new-born infants and young children
Male (1) Physical protection (strength)
(2) Risk-taking

These patterns are instantly recognisable and they form from time immemorial a major influence on human occupational choices, lifestyle choices, domestic life, art, fashion, literature, social policy and popular culture. It is perhaps strange, therefore, especially in an age where diversity is celebrated in all its other forms, that the idea of gender difference and diversity relating to men and women has become so controversial. Our society has become unnecessarily confused about gender perhaps because of a false fear that difference means inequality or entrapment in rigid social roles. In reality of course gender differences are average differences and no two individuals, male or female, will ever be exactly the same nor should any human being be defined or confined by their gender. Some women can be more masculine on some dimensions than some men and vice versa.[1] However, the concept of meaningful group differences statistically between the averages of any two identifiable populations or categories, regardless of individual variation, is vital in science. Gender is no exception in this respect.

There also appears to be a strong fear that acknowledging any biological aspect to gender means subscribing to the view that gender is somehow fixed, biologically determined and unchangeable. In this chapter, it will be shown that whilst there are archetypal and universal gender differences in our species, these can still vary between individuals and be expressed differently and flexibly in a changing social world. This hopefully takes us away from a sterile debate between those at one extreme who see gender behaviour as totally fluid (social determinists) and those at the other extreme who see gender behaviour as totally fixed (biological determinists). Extreme determinism of any kind does not fit the evidence and yet if anything our current mainstream political approach to gender is very close to social determinism.

Universal Gender Patterns in Our Species—From Stereotypes to Archetypes

Risk-Taking

The academic literature including large meta-analyses (e.g. Byrnes et al. 1999) is consistent in showing that males universally take significantly more

[1]A small number of people across the human spectrum have less "binary" sex and gender characteristics, but even these people are a mixture of female and male. There is no third primary gender.

risks than females, however risk is defined. In all human cultures throughout history and prehistory there is consistent and incontestable evidence (in both archaeological and written records) of males taking high levels of risk to protect and provide for their family, tribe, community or nation either collectively as bands of hunters and warriors or as individuals. Human males have always undertaken dangerous roles and tasks both in times of war and peace. This is reflected equally in modern life by the fact that males in all countries account for the vast majority of deaths both in military combat and in the civilian workplace. In Great Britain, for example, men make up about half (53%) of the workforce and yet still account for almost all (96%) deaths in the workplace (Health & Safety Executive figures 2018). Two of the most common causes of such deaths in UK workplaces are "struck by moving vehicle" and "falls from height" which between them account for about 40% of the total. These sizeable gender differences in occupational choices, risk-taking behaviour and related death rates are matched in all other countries where records are kept. The fact that there is no public outcry or even political debate about this massive gender differential in work fatalities in the UK or elsewhere also clearly demonstrates that our social attitudes and expectations have evolved in parallel to see this as an accepted part of our human condition (Baumeister 2010).

Life expectancy itself is consistently lower for males than females across the globe but is not the subject of major programmes of research or intervention even in developed countries such as the UK where the current difference between male and female life expectancy is 3.7 years (Office for National Statistics 2014–2016). A similarly significant gap in life expectancy between men and women exists in every other single country measured (183 in total) according to World Health Organisation figures (2015). Other analyses from reputable sources show exactly the same pattern (e.g. United Nations 2010–2015). The average number of years that men live less than women across the world as a whole is between 5 and 6 years. The lack of any significant response in terms of social policies or actions in the UK (or elsewhere) to reduce this striking "gender death gap" in an age of gender equality therefore needs to be explained and illuminated as part of our own attitudes and behaviour towards ourselves as gendered beings.

And yet, in direct contrast to these concrete assumptions and expectations about male death and survival, the prevailing rhetoric in our modern western world is that men are acting too tough by masking feelings. There is in the UK, USA and other western societies a great deal of social and political pressure, both explicit and implicit, on men collectively to change their emotional behaviour by "opening up" or "softening up" and abandoning

what has been termed "traditional" masculinity. Such powerful pressures on men to change their very masculinity are rooted almost completely in social constructionist assumptions about gender.

Ironically, such sociological assumptions about masculinity ignore one of the greatest social factors of all, social class. Once we consider not just men as a whole but *working class men in particular*, the statistics relating to male risk-taking and death become even starker. Most of the male deaths in war and peace time up until the present day are those of *working class* men performing dangerous, dirty and physically demanding tasks on the "front line" whether as soldiers, sailors, airmen, firemen, builders, carpenters, electricians, tradesmen, navvies, refuse collectors, scaffolders, miners, quarrymen, deep-sea fisherman or steeplejacks. The highest rate of deaths at work in the UK falls within the industries of waste and recycling, agriculture and construction, all working class occupational areas chosen significantly more by working class men than working class women. This pattern of dangerous occupational choices, risk-taking and male death has always been the same across all societies throughout history. Working class men therefore are still the people in the real world upon whom all societies continue to rely for their physical infrastructure, safety and protection. There are still to this day, however, no gender-specific policies or services in the UK (or elsewhere) to protect working class men as a vulnerable group or even to acknowledge these statistics as a gender equality issue. And yet there are now many initiatives to encourage all men collectively (including working class men) to "open up" emotionally, seek help and abandon such risk-taking behaviour as if this was simply a matter of personal choice and as if there were no benefits to society from this behaviour.

However, social class is still not as powerful a factor as gender itself in explaining the global gender difference in risk-taking and protective behaviours. This is strikingly illustrated even at the start of the twentieth century not just by the horrendous death statistics involving young males of all classes across Europe in World War One (1914–1918) but also in civilian life during the same period by the survival rates of the notorious Titanic disaster in 1912 (Figs. 1, 2).

These figures show unambiguously that even at a time of supposedly high male privilege women and children of all classes were saved and protected relative to men of all classes. A woman or child travelling third class had a higher chance of survival even than a man travelling first class. In keeping with this, the female crew also had a much higher survival rate (87%) than the male crew (22%). These huge gender differences are clearly far from random and need a powerful explanation. There is really only one credible explanation for these figures: the men on board the Titanic were *protecting*

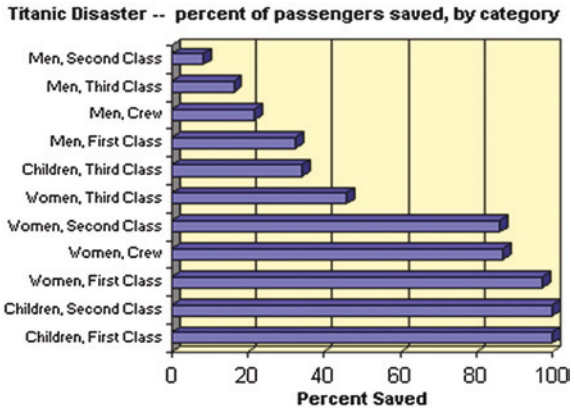

Fig. 1 Titanic disaster survivors, by category (*Source* Chuck Anesi, data from the British Parliamentary Papers, Shipping Casualties [Loss of the Steamship "Titanic"], 1912, cmd. 6352)

Titanic Disaster -- Official Casualty Figures

Passenger Category	Percent Saved	Percent Lost	Number Saved	Number Lost	Number aboard
Children, First Class	100.00	0.00	6	0	6
Children, Second Class	100.00	0.00	24	0	24
Women, First Class	97.22	2.78	140	4	144
Women, Crew	86.96	13.04	20	3	23
Women, Second Class	86.02	13.98	80	13	93
Women, Third Class	46.06	53.94	76	89	165
Children, Third Class	34.18	65.82	27	52	79
Men, First Class	32.57	67.43	57	118	175
Men, Crew	21.69	78.31	192	693	885
Men, Third Class	16.23	83.77	75	387	462
Men, Second Class	8.33	91.67	14	154	168
Total	**31.97**	**68.03**	**711**	**1,513**	**2,224**

Source: British Parliamentary Papers, Shipping Casualties (Loss of the Steamship "Titanic"), 1912, cmd. 6352, 'Report of a Formal Investigation into the circumstances attending the foundering on the 15th April, 1912, of the British Steamship "Titanic," of Liverpool, after striking ice in or near Latitude 41° 46' N., Longitude 50° 14' W., North Atlantic Ocean, whereby loss of life ensued.' (London: His Majesty's Stationery Office, 1912), page 42

Fig. 2 Titanic official casualty statistics

the women and children and at the same time the women and children were accepting this protection. The women and children were being given priority automatically and instinctively when it came to filling the limited number of lifeboats. Social class difference was clearly a factor influencing survival but less critical than gender difference. These clear and striking differences do not fit a hypothesis that attributes gender behaviour to social stereotypes. In times when our very lives and survival are threatened it is our primal and evolutionary instincts that prevail. And it makes obvious sense in

evolutionary terms to prioritise the survival of the female gender that physically carries the precious and vulnerable offspring.

A socio-cultural theory of gender however would predict cross-cultural, ethnic and historical variation in all behaviour including risk-taking and protective behaviours at times of emergency. Social learning theory would predict that on some occasions and in some societies men could receive protection as a group. However, there is no such evidence. Across all cultures and throughout all known history, women and children have received the collective protection of men. These differences cannot be random. When individual men hide their own personal vulnerability, therefore, they are in effect only conforming to a male archetype that is reflected in collective and unchanging societal expectations of men.

Help-Seeking

Perhaps it is not surprising that, if there are large gender differences in risk-taking and protective behaviour, there will also be correspondingly large gender differences in help-seeking. An individual or group that is more likely to take risks to protect others is also by definition less likely to seek help or self-protection. This is exactly what the evidence shows from meta-analyses (e.g. Nam et al. 2010) and even with samples from early childhood (e.g. Benenson and Koulnazarian 2008). This author could find no study or investigation anywhere or at any time in the world with any sample that has looked at average gender differences in help-seeking and found that men as a group seek help, however defined, more than women. This universal pattern of findings is very strong evidence of a genuine difference and cannot be random.

If this pattern of gender difference in help-seeking is universal across all cultures and all history as far as records are available, then scientific rigour demands a theory to explain this pattern that can account for its universality. A social constructionist theory would predict much more variability in gendered behaviour across different times and cultures. It would be expected that if help-seeking were primarily a matter of fashion, socialisation and cultural expectation, the differences between men and women would be disappearing or at least significantly fluctuating as different societies have evolved socially, technologically and politically. However, this is not the case.

Science is essentially about correlations and differences. We have to explain the observation that there are universal differences between men and women in both help-seeking and risk-taking. We also as scientists

have to accept the obvious negative correlation between risk-taking and help-seeking. The lack of significant cultural variation in these gender patterns clearly indicates that socio-cultural explanations do not fit the evidence. This means that attempts to change masculinity and male behaviour (including suicide) through social education are likely to fail. As we have seen, societal expectations of men are themselves archetypal. Because society expects men to take risks and tolerates higher levels of injury and death in males, there are no gender-specific policies or services to protect men at risk. This means that it is tolerance and acceptance of risks to men that remains the primary message. This has been called the "empathy gap" (e.g. Seager et al. 2016b). Whilst society remains relatively unaware of or indifferent to men's higher risk-taking and lower survival rates, the educational message to men that they should become more emotionally vulnerable and seek help is therefore inauthentic and counterproductive. This "empathy gap" towards men in society itself therefore must surely be closed if we truly wish to increase male self-empathy and help-seeking and at the same time substantially reduce male suicide.

In Brief: Two Other Major Examples of the Male Gender "Empathy Gap"

Domestic Violence

Domestic or intimate-partner violence within heterosexual couples is almost universally portrayed in our media, culture and politics as an issue where men are the perpetrators and women are the victims. Refuges and services for victims are correspondingly aimed almost exclusively at women whilst treatment for perpetrators, for example, the "Duluth Model" (Pence and Paymar 1993), is aimed almost exclusively at men. And yet the objective research evidence from meta-analyses shows a much more mixed and complex picture. For example, Archer (2000) looking at inter-partner violence across a wide range of studies in the USA found that:

> Women were slightly more likely than men to use one or more acts of physical aggression and to use such acts more frequently. Men were more likely to inflict an injury, and overall, 62% of those injured by a partner were women.

In the UK, even allowing for significant under-reporting by male victims, men still make up as much as 33% or even 40% of reported victims (Mankind Initiative 2018; Parity 2010). The proportion of safe spaces or refuge places for male domestic abuse victims in the UK, however, was less than 1% (60 out of 7560) of the total as recently as 2010. This significant gender imbalance in the ratio of victims to services supports the hypothesis that attitudes in society collectively are calibrated to be less empathic to vulnerability in men. This means that simply asking men as individuals to seek help when they are victims is not a satisfactory approach.

Street Homelessness/Rough Sleeping

The statistics portal, Statista, produced figures for London, the UK for 2016–17 showing that 85% of rough sleepers were male. Statistics produced by the Ministry for Housing, Communities and Local Government (Autumn 2017, revised February 2018) similarly showed that 86% of rough sleepers in England were men. And yet an international evidence review (Mackie et al. 2017) titled "Ending rough sleeping: what works?" quoted by the British Homelessness Charity, CRISIS, does not highlight male gender in any of its five key principles for tackling rough sleeping which are listed as: (1) recognise heterogeneity, (2) take swift action, (3) employ assertive outreach, (4) be housing-led, and (5) be person-centred. These conclusions claim to have been based on an analysis of over 500 studies and also interviews with 11 international homelessness experts. This global blindness to male gender in such a comprehensive analysis is powerful evidence showing that it is collective attitudes to male vulnerability that are the issue, not the behaviour and choices of individual men.

The Empathy Gap and Implications for Male Suicide

The evidence clearly indicates that males within the human species are universally more driven to take risks and protect others and correspondingly also less likely to seek help and self-protection. The evidence also indicates that society is correspondingly calibrated to expect this difference and is consequently less empathic towards male death and injury. If this is the case, then it must follow logically that men will be on average more driven than females to take their own lives because of:

a. A greater instinct to ignore personal safety and confront danger
b. A greater instinct to protect others (and greater shame at failing to do so)
c. A lower sense of entitlement to receive help or protection from others.

This pattern is certainly consistent with the suicide statistics across the globe. According to World Health Organisation data over many years, the male suicide rate is significantly higher in every single one of 183 countries in the world where records were sampled with the exception of just two, China and Bangladesh. These reversed gender differences, though not of such an order of magnitude, appear in China to be largely accounted for by the bleak and deprived existence of women in poor rural areas within that country in which women make up a much larger percentage (about 50%) of the agricultural workforce than in other countries. We have already seen (above) that agriculture is a high-risk occupational domain. In Bangladesh, the higher ratio in women may reflect the increased vulnerability in women who are single, economically dependent and illiterate. Whatever the reasons for the differences in these two countries, the fact that the male suicide rate is significantly higher in almost 99% of countries across the globe within a large and culturally varied sample clearly constitutes a major scientific observation that cannot be random and could not be explained as a social or cultural phenomenon.

In the UK during 2016 exactly 75% of all suicides were by men (Office for National Statistics). In the UK, there has never been a year since records began (1861) when the female suicide rate has exceeded the male rate, although the gap has varied, being at its greatest in the 1880s (5–1) and smallest in the 1960s (1.5–1) (Thomas and Gunnell 2010).

Expanding the Argument: Six Reasons Why a Socio-Educational Approach to Male Help-Seeking and Suicide Is Counterproductive

1. A "double-bind": encouraging men to seek help and open up to their more vulnerable feelings could only work if that message was congruent with society's other messages to men, but it is clear (above) that the expectations, actions and policies of society towards the male gender are not protective and actually give the opposite message. It is well recognised that "double-binds" actually contribute to serious mental health problems (Bateson et al. 1956). This means that in the name of trying to improve men's mental well-being our self-contradictory public health messages may in fact be damaging it further.

2. Stigmatising or pathologising masculinity: a masculine style of emotional processing and behaviour can be positive and adaptive especially in dangerous and risky situations in which military men and male civilians in many working class occupations are still expected to function. In high risk situations, it is adaptive to tune out from emotional vulnerability and focus on task performance. A blanket message to men that this emotional pattern is unhealthy could therefore itself be stigmatising, pathologising and damaging.
3. Ignoring the brain and biology: there is no strong evidence that emotional differences between men and women are taught, especially as most educators of young boys are adult females (see below), but there is a wealth of evidence linking these patterns to differences in the male and female brain (e.g. Baron-Cohen 2002; Brizendine 2010). Similarly, a recent meta-analysis by Todd et al. (2018) has shown that gender differences in toy preferences and play emerge instinctively at a very early age and cannot be explained satisfactorily by social conditioning theories. Males were found on average to prefer action toys with moving parts whilst females preferred dolls or toys that involved social relationship. Again this evidence fits the hypothesis that there are some archetypal and instinctive differences *on average* in motivation and behaviour between the genders.
4. The social education is being aimed at the wrong people: by targeting only masculinity and men themselves as needing to change rather than society as a whole, we are in effect blaming men for their own gender attributes of high risk-taking and low help-seeking. Ironically, we are using a social theory to locate a problem in only one part of an entire social system. In systemic terms, it is impossible to change one part of a system if the rest of the system remains the same. Such a message that connects male suicide with problems of masculinity pathologises males and also paradoxically reinforces the myth that men can never be victims.
5. Denial of cultural patterns of socialisation: children of both sexes actually spend significantly more of their developing years with adult females compared to adult males (e.g. Hofferth and Sandberg 2001; Parker and Wang 2013). This pattern is also consistent with an archetype-based theory of gender difference. This means that even if boys were being socialised unhealthily, there is an argument for introducing more fathering and masculine social influences, not less (Farrell and Gray 2018). There is a relative absence of male role models for young boys at school and at home. In England for example, Department of Education figures for 2016 revealed that only 15% of primary school teachers and 38% of

secondary school teachers were male. A social learning theory of gender would therefore predict that that the behaviour and attitudes of boys and men should already be changing in a more "feminised" direction, but this is not reflected in the low rates of help-seeking and high rates of suicide even in younger age groups of males.

6. People of any group are only motivated to use help if that help is empathic. Common approaches to male problems therefore that take a judgmental stance by focusing on "toxic masculinity" or "male emotional illiteracy" (e.g. the "Duluth model", see above) will therefore ironically only deter men from seeking help and demotivate those that do attend.

Towards a More Scientific and Humane Approach to Reducing Male Suicide

Assuming that male behaviour is a collection of stereotypes, as we have seen, leads to an educational approach directed at reforming men or masculinity itself which is unlikely to work for all the reasons stated. This assumption also prevents us from researching deeper-rooted archetypal gender differences. Given that being of the male gender is almost universally the biggest single risk factor for suicide since records began, it logically follows that suicide research if nothing else would be dominated by studies of male psychology and behaviour. In fact, the opposite is the case. Male gender is largely neglected in suicide research which instead focuses more broadly on social, cultural, class and economic factors. This again can be no coincidence. For example, even amongst the publications of the internationally respected Oxford Centre for Suicide Research, only one short paper (Hawton 2000) could be found that recognised gender difference as a central factor in the causation of suicide. This paper concluded encouragingly by recommending more research in this area and predicting that "gender specific approaches may be indicated". However, this research group has not followed up on its own recommendations. A subsequent book from the same research group entitled "prevention and treatment of suicidal behaviour" (Hawton 2005) does not refer to gender in the titles of any of its 20 chapters. Equally, it was not possible to find a reference to the male gender or even to gender at all in the title of any publication by the same group between 2006 and 2015. The same is also true of all the chapters in another apparently comprehensive book entitled "Evidence-based Practice in Suicidology" (Pompili and Tatarelli 2010).

This pattern of gender-blindness even amongst suicide researchers therefore reflects the very same "empathy gap" towards the male gender that can be postulated as contributing towards male suicide in the first place. However, by simply adopting the gender-specific hypothesis that male behaviour reflects universal male archetypes, a much more promising approach to suicide immediately begins to take shape. By simply allowing archetypal gender differences to be researched, understood and honoured, gender-specific solutions to male suicide can indeed be found.

Defining the male archetype is not difficult once the need to do so is acknowledged. The archetype can in fact be seen in many of the instinctive behaviours that are mistakenly labelled stereotypes and are visible in all human cultures. It would be strange indeed if the human species was the only species to be devoid of any instincts or drives relating to biological sex. One of the greatest psychological thinkers in the western world to date, Carl Jung, helped pave the way in this respect. He talked of archetypal patterns evolved within the human species and shared within a "collective unconscious". Included within this vision of humanity was a clear distinction and inter-relationship between universal masculine and feminine elements. In Jung's scheme, whilst individuals could vary in terms of their personal relationship to the archetype, an archetype was universal and embedded within us all. For Jung, this also meant that men had within them a universal feminine aspect (anima) and women a masculine aspect (animus). Jung's thinking in this respect was clearly influenced by the ancient Chinese conception of "Yin" and "Yang" in which femininity (one aspect of "Yin") is seen along with masculinity (one aspect of "Yang") as a complementary system of opposites within the natural universe.

More recently, our own research team has for clinical purposes come up with a simple and practical definition of the male archetype or "gender script" consisting of three schematic elements that we have begun to test in a series of studies:

a. Fighting and winning
b. Providing and protecting
c. Maintaining mastery and self-control.

Using these scripts, Seager et al. (2014) found in a survey of 348 women and 170 men, after controlling for other variables, that two male gender subscales predicted risk of suicidality: the more people thought they needed to be a Fighter and Winner ($P < .001$) and have control over their feelings ($P < .042$), the more suicidality they reported. It was also found that higher

scores on "family harmony" (feminine archetype) predicted decreased suicidality. Significant differences in the expected direction were also found between men and women in their scores on four derived subscales ("protection", "mastery and control", "attractiveness" and "pressure to have children").

These elements of a postulated male archetype may collectively be said to contribute to a sense of *masculine identity*, *honour and strength*. To the extent that a man feels that these elements are missing, he will feel the opposite state of *masculine shame and failure*. Once we begin to recognise these phenomena as archetypal and instinctive rather than as simply socio-cultural or educational, male patterns of emotional communication and behaviour make much more sense scientifically.

For example, within this archetypal perspective, the masculine emotional pattern of not directly sharing emotions verbally, which on one level looks like a wilful and unnecessary barrier to help-seeking, on another level can be seen to be an important way of achieving goals and indeed surviving when in dangerous and risky situations that demand control, mastery and focus. In such situations heightened emotional awareness and expression would impair performance and threaten survival itself. This pattern of focussed attention can be seen not just in dangerous military (e.g. bomb disposal) and civilian (e.g. steeple jacking) situations but also, for example, in elite sport where a "masculine" mind set of controlling emotion (including fear and aggression) and channelling it into precise and goal-driven action (composure) is vital for success. In dangerous and testing situations the male archetype turns out to be an age-old recipe for survival and success.

Why an Archetypal Approach to Male Suicide Works Much Better

If we assume therefore that men *on average* are more likely than women to be driven to "fight", "protect" and "retain mastery/self-control" then it is clear that trying to encourage men *collectively* to "open up", "be vulnerable" and "seek help" potentially violates deep-rooted masculine instincts. Such an approach may even increase a sense of masculine shame and failure. This is in effect saying to men that *strength does not matter* which is no wiser than saying to women that *beauty does not matter,* a message that would violate equivalent female instincts. Also, as we have seen, such a message cannot work if there are no correspondingly empathic policies for vulnerable men in society and virtually no male-specific services to back that message up.

However, if the same message is reframed to fit the archetype as defined, a totally different outcome can be achieved. If the archetype is honoured and not violated, the message can become positive:

1. "*By seeking help you are taking action, taking control and fighting your problems*"
2. "*It takes strength and courage to confront and master your problems*" or
3. "*Looking after yourself means protecting your family*".

By using male-friendly language and approaches the idea of help-seeking can therefore actually be integrated with an archetypal sense of masculinity rather than working against it. Language that emphasises weakness, vulnerability, stigma, deficiency or negativity is unlikely to work with any group including females too, but with vulnerable males the negative impact of such language is magnified further through the filter of the male archetype (Clement et al. 2015).

Because of gender-blindness most therapy outcome research has been gender neutralised, simply combining all data relating to gender and so overlooking possible important differences in the ways that men and women respond to therapy. The little research that has been done, however, confirms the hypothesis that there are such important differences. In particular, in the line with archetype theory, the available evidence indicates that men on average prefer to "fix" problems rather than "explore" them whereas women show the opposite pattern (e.g. Russ et al. 2015; Holloway et al. 2018).

It is more likely, therefore, that potentially suicidal men can be better helped by adapting new therapies and approaches to suit male psychological characteristics than by trying to change men to fit traditional therapies which can be described as "feminised" (Morison et al. 2014). If we take the male archetype seriously as defined, then it also makes sense to tailor male-friendly approaches to those situations that will provoke a deep sense of masculine shame, worthlessness and failure: these situations are the very ones that do show up in the suicide statistics if we actually care to look:

a. *Unemployment*—unemployment is bad enough for anyone but from the male archetype it can be predicted that a man will feel an extra drive *on average* to be a "winner", to protect his family and retain mastery, so will feel even greater shame when unemployed than a woman—this prediction is supported by the ONS figures in the UK for the two years following the most recent recession (2008–2010) which triggered an extra 878 suicides amongst men over and above the pre-recession statistical trend,

whereas in women 123 extra suicides were triggered. This gender ratio of 7–1 is even greater than the usual 3 to 1 male-female suicide ratio. This indicates that masculinity and unemployment are interacting as predicted. This therefore implies that male-friendly approaches to helping men deal with and overcome unemployment are vital in reducing male suicide.

b. *Loss of relationship with a partner*—Griffiths et al. (2008) found that single, divorced and widowed men are three times more likely than their married counterparts to take their own lives.
c. *Loss of contact with children or loss of the father role*—because society does reflect both male and female archetypes, loss of parental access to children is a factor which affects many more men than women. According to figures by Statista (2017) in the UK there were 1602 single mother households compared to 179 single father households. In the UK a study found that 96% of parents applying to the family courts for access to their children were men and less than 50% of such applications resulted in the father gaining the right to have his children stay the night (Harding and Newnham 2015). Male prisoners are granted significantly less access to their children than female prisoners (e.g. Evans 2015). A comprehensive research report by Samaritans (Wylie et al. 2012) concluded that "Men are more likely to be separated from their children and this plays a role in some men's suicides".
d. *Sexuality*—the archetype predicts that gay men will feel even more suicidal pressure than Lesbian women simply because negative attitudes to homosexuality will interact with the male archetype even more strongly than with the female archetype. This fits with the evidence from Cochran and Mays (2000) in the US who found that the suicide risk could be as much as 5 times higher for gay men than for heterosexual men.

Two Simple and Original Examples of Effective Male-Friendly Initiatives

"Man Talk" (Central London Samaritans, 2014)

Samaritans is an organisation founded by Chad Varah in 1953 whose central aim is to reduce suicide and whose primary method of trying to achieve this is through a 24-hour helpline. Samaritans has been effective in attracting a representative 50–50% gender split in callers. Whilst not explicitly designed with gender in mind, the Samaritans' general ethos of anonymity, self-direction and confidentiality appears to have attracted male callers who

might otherwise have been deterred by the shame of revealing their identity or by the fear of losing self-control. However, Samaritans like many mental health related charities and services has historically been "gender neutral" in its explicit training approach to listening to and responding to callers. In 2014, however, a gender-specific training programme called "Man Talk" was run for all volunteers at the Central London Samaritans, the oldest and largest branch in the UK. The theory behind this programme was that it was not possible to control or change the talking behaviour of male callers directly but it was much more possible to change the listening behaviour and responses of volunteers and this in turn would improve the quality of phone calls with men and improve the chances of helping potentially suicidal men to feel connected, valued, heard and understood.

The project consisted of simply exposing volunteers (80% female) across one calendar year to a range of training events and experiences that presented life from a masculine angle. These included (a) a conversational session with two musicians playing and exploring the lyrics and meaning of blues music (b) a session with female actors from the Royal Shakespeare Company playing male roles (including those with power and responsibility) in selected scenes from Shakespeare's "Julius Caesar" and discussing with the audience the psychological impact of this upon them and the insight it gave them into the pressures and responsibilities of these male characters (c) an interactive talk from a psychologist (MS) about masculine ways of dealing with and expressing emotion, emphasising the idea that men were not emotionally *illiterate* but rather *differently literate* and that men could be reached if the listener tuned into their archetypal language, focussing on *action, story* and *meaning* rather than *feelings*. This presentation was also punctuated by a piece of emotional classical music played by a solo male cellist.

By the end of the year the following *quantitative* results were obtained:

Pre-"Man Talk"

Out of a sample of over 1000 calls from men, 32% (1 in 3) lasted 5 min or less whereas out of a similar size sample of calls from women only 17% (1 in 6) lasted 5 min or less.

Post-"Man Talk"

Out of a sample of more than 1000 calls from men, 25% (1 in 4) calls lasted 5 min or less whereas from a similar sample of calls from women, the percentage of calls lasting 5 min or less remained the same (17% or 1 in 6).

These figures indicate that following the training programme the percentage of short (and possibly abortive) calls from men had been significantly reduced from about a third of calls to a quarter of calls. Also, the difference

between men and women in this respect had been halved from a 15% difference to an 8% difference.

36 volunteers also responded to a survey on the "Man Talk" project. Of these 89% (32 volunteers) said they found the programme helpful. Only 1 volunteer who attended any element of "Man Talk" said they found it unhelpful.

Many positive qualitative comments were also obtained from the survey and the following is a brief selection:

> Men may legitimately need support that addresses feelings implicitly not explicitly.

> When I get a male caller struggling to focus on his feelings … I give him time to find his own voice and have had better calls as a result.

> I realise that sometimes we treat men differently (and less sensitively) because we have preconceived ideas.

> Man Talk workshops and information were really insightful for personal relationships as well as supporting callers. As a woman I think there's a lot I can still learn.

Taken together, these quantitative and qualitative findings indicate that better connections can be made with troubled male callers by educating those who are offering help to them rather than by trying to educate men themselves. In other words, rather than trying to teach men to open up, it is better to teach ourselves to open up to men.

The Campaign Against Living Miserably (CALM)

The Charity CALM was originally commissioned to provide help for young men in Merseyside in 2000 and became a national charity in 2006. Campaigns have targeted males specifically (but not exclusively) and challenged societal assumptions about male distress and suicide. CALM operates through local community action in "CALMzones", a confidential helpline, a text/e-mail service, a website, magazine and social media. CALM uses high-profile campaigns that engage directly with young men by using role models such as rappers, musicians, comedians, sports stars and other highly admired celebrity figures and by using 'street-wise' language. CALM connects with men by using stories of men who have come through personal difficulties. Hearing stories of recovery and hope from people just like you

can be incredibly powerful for anyone, particularly for males who do not usually get to share stories of this kind. Over the first decade (1999–2010) since the first CALMzone was established in Merseyside, suicide rates in that area fell by a massive 55%, from well above the national average to significantly below it. These figures speak volumes about the value of honouring male pain in male-friendly ways and the effectiveness of doing so. These figures also show that men can seek and use help if we change the way we listen rather than expecting men to change the way they talk. Similarly positive results are obtained when "male-friendly spaces" are created in "Men's Sheds" (Golding 2015) or men's therapy groups (e.g. Seager and Thummel 2006, 2009) and yet such male-friendly services and approaches in the UK and elsewhere still remain the exception rather than the rule.

Conclusion

In trying to reduce male suicide there is essentially a choice to be made between two divergent approaches:

1. Socially challenging and reconstructing masculine behaviour and masculinity itself as a negative *stereotype* through educational methods with the aim of teaching males to seek help and share emotions more openly (i.e. change masculinity).
2. Changing the social attitudes and responses of society towards men and boys to create more empathy for masculinity as a positive part of the human spectrum, whilst also providing male-friendly services for men and boys that both honour the male *archetype* and offer new and better ways of expressing it (i.e. change society).

It is hoped that the evidence presented in this chapter will have demonstrated that only approach "(2)" can work in practice and this may even go some way towards achieving the aim behind approach "(1)". In a relatively small number of examples where approach "(2)" has been used, it has been consistently shown to be effective. On the other hand, approach "(1)" can only be counterproductive as in essence it involves blaming men for conforming to instincts originating from the male archetype. Sadly, however, approach "(1)" still remains to this day the mainstream approach to problems including suicide affecting men in our society. Unless this picture changes our efforts to reduce male suicide are in danger of becoming counterproductive or at least of having only a limited benefit.

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The Gaze: The Male Need to Look vs the Female Need to Be Seen—An Evolutionary Perspective

Jennie Cummings-Knight

A Visually Saturated Society

What human beings look at and what they see have always been of critical importance. However, the male and the female have tended to look at different things even from the moment of birth (e.g. Connellan et al. 2000). From early infancy, before verbal language gets started, boys on average respond more to toys that move and tend to be fascinated by the mechanics of how things work. Girls, on the other hand, tend on average to be more attracted firstly to faces and then more to dolls and cuddly toys (Connellan et al. 2000; Todd et al. 2017). These differences can be seen even more obviously during toddlerhood: "Sex-types play choices can be seen at about 2 years". Boys generally "spend more time playing with blocks, transportation toys, guns, and manipulative objects; girls spend more time playing with dolls, stuffed animals, and art materials" (Fagot and Leve 1998).

Our increased emphasis within modern western society on the visual sensory domain began with television, first introduced from the 1920s, with colour TV starting in the USA as early as the 1960s. Alongside television, the development of the computer was taking place, beginning with the Telex Messaging Network in 1933. First computer designs began as early as the 1930s and by 1942 the Atasanoff-Berry Computer was completed. In 1946, a popular Science Fiction magazine story named "A Logic Named Joe"

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predicted a worldwide network of computers. This was 50 years or so before the invention of the internet as we now know it. In the early 1990s, computer games began to be popular and by the present time it could be argued that a large proportion of the population has become addicted to visual computerised and computer aided experiences, with the mobile phone being by far the most popular.

Male vs Female Points of Focus

Kafetsios (2004) using an emotional intelligence test (Mayer and Salovey 2007) in a sample of adults, found that females were on average better than males at emotional perception. It is an established fact of education that girls gain mastery over language faster than boys and this has a neurological basis (e.g. Burman et al. 2008). However, a crucial foundational element of emotional intelligence and emotional response is the "*gaze*"—in other words, what the infant looks at. Females from an early age show greater interest in social and facial stimuli, spend more time holding eye contact and are better at reading emotions from facial expressions (Wingenbach et al. 2018; Baron-Cohen et al. 1997). Greater levels of sociability on average have also been found amongst girls compared with age-matched boys even in samples where all subjects are on the autistic spectrum (Head et al. 2014).

These gender differences are also reflected in the significantly different life and career choices made by men and women. For example, the counselling profession, like other caring and therapy professions, "attracts" many more women than men. Recent figures from the BACP put the difference at 84% women compared to 16% men (Brown 2017). Similar gender ratios in psychology (80% women) and nursing (nearly 90% women) also support the hypothesis that there is a deeper-rooted sex difference at work: women are generally pre-disposed to be more interested in looking at the finely tuned nuances of human relationship. The domain of relationship, reading emotions, tuning into facial expressions, decoding non-verbal signals and listening to verbal language about emotion, significantly appeals more to females than males and is also a domain where on average women may be more skilled. Perhaps this is not surprising from an evolutionary perspective, given that females have been designed to bear and nurture infants. Reading and empathising with the emotional cues of infants has been vital to the survival of our species. It would be surprising if humans were the only mammalian species to have lost these evolutionary differences.

Advertising

One of the by-products of the television and film age was that advertising became more visual, and with the increased interest in moving pictures of all sorts, ideals of female beauty became immortalised on "the big and small screen". The female need to "be seen" and therefore to be attractive enough to be noticed began to take an even more important place in society than it had done before, as "ideals" were displayed in pictorial form everywhere the eye might roam. At the present time this bombardment of female imagery can be anywhere from an advert on a building to images on social media, punctuated by models in shop windows and the real-time viewing of females, dressed in contemporary fashions, on the street or in pubs and clubs.

The male's need to "look" at the female is likewise fed by the media, by female images of all kinds that include media crafted "ideals", and by erotic material that is often highly visual and imaginatively stimulating. The modern female of the western world tends to dress to accentuate every line and curve, no matter what her size or shape, assisted by modern technology. The suggestion of line and form becomes ever more explicit, with particular body parts emphasised over others. The proof of this is in the booming cosmetic surgery industry, with breast enhancement being the most popular procedure (Gallagher 2014).

Ideals of Beauty

It is interesting to see how ideals of beauty have changed over time and how they differ between different cultures. For example, in the popular Middle Eastern folk tales known as the "Arabian Nights", some of which are more than 1000 years old, the ideal woman is frequently referred to as having "*buttocks like sand dunes*" which are allegedly driving the male "out of his wits" with excitement. This preference for an ampler female figure contrasts strongly with our modern western obsession for a slim female form (with the obvious exception of breast size). European portrait paintings through the centuries also demonstrate how fashions in beauty and the expression of the ideal female form can change. However, what does *not* change, regardless of time or culture, is the universal use of female images or models to represent the archetypal ideal of feminine beauty. Each age and each culture has its image of the "diva" or divinely beautiful woman who is there to be admired, gazed upon and even worshipped.

The high cost of this emphasis on idealised beauty in a visual age can also be seen in the pre-occupation of an increasing number of young girls with their physical appearance and the subsequent rise in eating disorders like anorexia and bulimia nervosa. For this very reason the first female bishop in the Church of England, the Rt Rev Rachel Treweek, is attempting to raise awareness about the young female obsession with body image with a campaign to help young women accept their physical diversity (as reported in the Daily Telegraph by Sturgis 2016).

The Evolutionary Male: Searching the Field for Prey

Whilst the female has always needed to "be seen", the male has, in an evolutionary sense, always needed to do the "seeing" in terms of looking for a mate, looking for prey to hunt, and looking out for danger. Hunting and gathering is accepted to have been the primary mode of subsistence both for our earliest alleged hominid ancestors ("*homo erectus*" who may have lived as far back as 1.8 million years ago) and our own human species ("*homo sapiens*") from its supposed origin about 200,000 years ago until the end of the Mesolithic period some 10,000 years ago.

A series of scientific investigations and reports by a range of researchers (e.g. Silverman and Eals 1992) have found strong evidence of sex differences in spatial ability between men and women, which they explain in terms of a differentiation of labour between males and females in hunter-gatherer societies. In such societies, males would hunt for prey and protect the social group, whilst females would gather plant food, tend to the home and care for the young. Gaulin and Fitzgerald (1986) have also found evidence that similar sex differences in spatial ability also apply to non-human species.

At this time of human existence, males required skills in navigation and orientation, hand-eye coordination skills, visuo-spatial perception skills and teamwork skills. These particular skills were essential for successful hunting and for survival itself (Dabbs et al. 1998). These sex differences can still be observed in our modern lives (e.g. map reading, car parking, risk-taking, team sport culture, nurturance, childcare, multi-tasking) but may often be mistaken for stereotypes or even misrepresented as sexism. Career choices and occupational preferences still to this day reflect these evolutionary differences. Females still *on average* tend to show more interest and aptitude

for caring roles and for the niceties of the domestic environment and have a good eye for what is close at hand (like finding lost objects in the home). So called "working class" men still to this day, like hunters of old, go outside the home and often work in teams to perform the most dangerous, dirty and laborious roles that provide the physical security and infrastructure for society to function (Fausto-Sterling 1985). According to statistics for the UK from the Health & Safety Executive, men accounted for 96% of workplace fatalities (HSE 2018). Women also excel in various tests of perceptual speed (Kimura 1999). These skills are also useful within the home where a subconscious eye can be kept on a number of things going on at the same time ("multi-tasking").

Parenting: Male and Female Focus

With regard to the traditional role of the female in looking after offspring, in spite of modern science and social reforms, the ancient physical differences between male and female which led to differentiated behavioural norms, still apply in terms of domestic life patterns, career choices, social attitudes and customs governing domestic and work life.

The obvious differences between traditional male and female "instinctual" parenting could be explained by the fact that the female carries the foetus "in utero" for 9 months before birth. She is therefore already prepared to "see the baby" in a different way to the father. He does not experience the changes in the mother's body first hand, as she does, and neither has he had years of monthly changes in his body to prepare him for the eventual potential arrival of a baby. The woman in normal health is reminded that she is a potential mother for a number of days every single month of her reproductive life. If she takes a pill to prevent pregnancy, she is reminded of this possibility every single day and knows that if she does not pay attention to this, unplanned motherhood could well ensue.

The woman is therefore "looking" at herself, the male and the world outside through a different lens to the male with regard to her physical body. The male, on the other hand, is able to be more focussed outwardly on his work goals without regular cyclical physical changes potentially affecting his moods, his energy levels and his stamina. The male has a different "outlook". He may not now literally be hunting prey in the fields, except for sport, perhaps—but his focus can be more external as he does not need to monitor regular internal physical changes, as the female does.

The Biological vs the Sociological: Constructions of Gender

We have been looking so far at some of the biological differences between males and females in evolutionary terms, but at the time of writing, sociological approaches to gender are prevalent. The field of mainstream academic gender study is currently preoccupied with the "socialisation of gender" and biological and evolutionary factors within our species tend to be played down.

A social constructionist approach to gender is epitomised by the influential work of Judith Butler (1990, 1993) which posits the concept that the psychology of men and women is shaped primarily by their social and cultural context rather than by any biological sex differences within the human organism. According to such theories, for example, girls like the colour pink because they are socialised within the family unit to do so from birth ("pink for a girl, blue for a boy") not because there are already underlying sex differences which these cultural practices have evolved to express. Likewise, it is proposed by social theorists of gender that if little girls tend to "play house" and little boys "play fight" this is because they are being taught or conditioned to do so without any major internal contribution from natural or evolved instincts or drives.

It is certainly true that social and cultural expectations shape the expression of gender in terms of etiquette, dress and fashion and it is also true that social beliefs, policies and laws governing what men and women are expected and allowed to do in the home, in the world of work and in public life, have changed considerably over history. At the same time, it is not at all clear that core sex differences in our species have been eroded by cultural changes. Gender differences in what baby boys and girls look at, attend to and how they respond to social stimuli and mechanical stimuli emerge pre-verbally and bear the hallmarks of instincts. As babies turn into toddlers and become more mobile and wilful, their motivations and choices in free play show remarkably consistent differences both over different generations and between cultures. In particular, it has to be accepted that boys *on average* are more motivated to play fighting games and girls *on average* are more motivated to play with dolls or toys aimed at little girls. These are important average motivational differences, but this does not mean that an individual girl who wishes to "play fight" or boy who wishes to play with a doll should be discouraged from doing so. At the same time, it would be equally damaging to force children away from their natural gendered impulses because of a mistaken belief that these are stereotypes imposed by society, rather than archetypal instincts.

Wright (1997) in his account of studies of twin behaviour noted the following: "*The field of psychology has been shaken by separated twin studies… suggesting that the development of an individual's personality is guided by his genes*". This also applied (p. 101) where a male twin was raised as a female from infancy after a botched circumcision operation and thankfully reclaimed his maleness as he reached maturity. Years of socialisation as a female had achieved no shift at all in his core gender identity.

Fagot (1994) and Fagot and Leve (1998) claim that a child's gender identity emerges early in life and that once the identity is established, the nature of play changes: "*Children's identification of whether they are boys or girls will result in playing more with other children of their own gender*". This tendency to play more with others of the same gender also increases as the children grow older in the preschool years (Maccoby 1988).

Alexander and Wilcox (2012) refer to evidence from research on older children and adults which demonstrates the masculinising effects of pre-natal testosterone on social and cognitive behaviour. This includes qualities such as empathy, aggression, toy preferences and spatial abilities (Collyer and Hines 1995). Sex differences between male and female from childhood also persist into adulthood. This continuity in itself argues against a purely social constructionist approach to gender, which would predict more variability and scope for developmental reversals as the years go by. Sometimes also science ignores the instantly recognisable quirks and subtleties of everyday life experience. In my personal life, I have frequently observed how males switch tack rapidly from a "feelings type" conversation towards something more objective. One example is that when I am driving in the car with my husband as passenger, I may be engaged in an anecdote to do with my analysis of a personal issue. He will suddenly break the "emotional tone" by saying something like, "Oh look, that is a fine example of Norman (or Saxon) architecture!" This tendency to focus on external objects rather than to mull over the intricacies of personal relationships, is a robust male predisposition which many of my female clients speak about. Relationship therapist Perel (2007a, b) also comments on male and female difference in focus being relevant in developing understanding about the building of intimacy between couples.

Women's Rights: Changing Targets and What Is "Looked for"

Mary Wollstonecraft (1792) wrote a famous and groundbreaking paper called "Vindication of the Rights of Women" where she looked forward to the day when 'honest independent women' would be able to fill 'respectable stations'

as physicians, farmers and shop keepers, "able to stand erect supported by their own industry rather than reduced to dependency". Wollstonecraft pointed out the importance of equal opportunities for women to earn their own living and compete in the traditional domains of men. Her ideas about women's rights represent very accurately what has become the default belief in the UK at the time of writing, more than 200 years later. It is a complete change from the traditional idea of "women's rights" where a home with a family of her own was considered to be the primary right of every woman. In some parts of the world, this idea still holds sway but no longer in the majority of the Western world. Previously, when children were the woman's primary focus, the man was expected to go out to work and provide for the woman to safeguard these rights. However, because of disregarded but persistent biological differences in our species, this social push for gender equality in more traditionally male career domains has, by default, left the female still predominantly in charge of the domains like "glamour", home keeping and childcare—or still often literally "holding the baby". Likewise, "working class" male domains that involve heavy manual work and high levels of physical risk are still dominated by men, who *tend* to be bigger and stronger physically.

This means that there is some danger of a societal imbalance where women may be feeling too much pressure "to do it all" and men may be feeling a corresponding loss of direction. Socio-political theories of gender equality, based purely on a notion of political rights but ignoring differential instincts based in evolutionary biology, can therefore unwittingly have some negative effects. Such an approach can become as detrimental as "patriarchy" has been claimed to be, in the Western world, in terms of devaluing the importance of the maternal function in society, whilst at the same time doing little to value the importance of fatherhood. My belief is that it is much more honest to accept that sex differences are still in place and are often positive. Equality does not mean sameness and unity comes best out of difference and diversity. Whilst there is great variation between *individual* men and women, both sexes have genuine power that derives *on average* from different domains of interest and expertise. These domains partly relate to instinctive, hard-wired, biological differences, but also partly relate to culture and environment. Likewise, Maguire (2004) states: "*…each sex has access to different forms of power and control which arouse intense envy in those who lack them*".

The basic "dance" between male and female is a complementary one—it does not need to be framed as a play for power supremacy by either of the partners, although it often can be viewed as such.

The "Gaze" of Different Sexualities and Gendered Identities

Male Homosexuality

The process whereby an embryo is masculinised or feminised during foetal development is a matter of complex biology involving delicate interplay of genetics and hormones that can vary or be disrupted (e.g. Wu and Shah 2011). This means that there is potential scope biologically for individuals to develop differently in terms of their place on the sex and gender spectrum. The genital organs of the foetus are fully formed after about 4 months of gestation, whilst the brain and neural functions continue to develop for another 5 months after that. As we saw earlier, in 2016 in the UK, the vast majority (93.4%) of adults identified as heterosexual. This indicates that there is a natural process by which sex differences have evolved, but it also implies that this process can be potentially subject to variation to the extent that for about 6.6% of individuals, there may be more of a mixture of masculinity and femininity.

However, because of a mainstream sociological approach to gender and sexuality, the focus has been on the social and political "rights" of homosexual people and of others who present within a range of non-default heterosexual orientation, rather than on the natural and biological basis of their sexual orientation.

Sociological theories of gender not only persist, but occupy the mainstream in contemporary gender studies. Such theories have therefore inevitably led to similarly dangerous notions of "toxic masculinity" alongside "patriarchy" with the implication that masculinity itself, being seen as a social construct, a lifestyle choice or pathology rather than as a natural part of the human condition, can be reformed or reconstructed by social therapies (Seager et al. 2014; Barry and Seager 2019, in this volume).

If the default heterosexual male has a need to "look at the female", then what is the homosexual male looking at and how does he want to be seen? Answers to such important questions are complex, but one simple observation is that homosexual men may often still be attracted to the female image as a "beautiful object" (one manifestation of this being homosexual fashion designers for women such as Christian Dior)—but framing this attraction more as something to admire rather than as a pure object of sexual desire. However, the evidence suggests that many homosexual men, unlike most heterosexual men but like most heterosexual women do experience an inner

desire to be "looked at" and admired as beautiful. This can be inferred from the popular use of and identification with female "gay icons" and "diva" images in the culture of homosexual men.

Lesbian Women

The notion of the "diva" also raises an important question about women who are attracted to other women. If they are in some sense more "masculine", do they have the same need to "look at" their objects of desire as heterosexual men? Does this mean they will use pornography more than heterosexual women? Do they share with heterosexual women a similar need to be "looked at" as a "desirable female"? Are homosexual partners, both gay and Lesbian, differentiated on the gender spectrum to enable attraction to occur or is the attraction based on complete mutual identification? Anecdotally and from clinical experience, it would appear that the Lesbian woman still needs to "be seen" but this also entails a female partner who is "doing the looking". The evidence in terms of inter-partner violence statistics would also indicate that homosexual relationships for males and females are no less likely to become fraught, conflictual and violent than heterosexual relationships (Stiles-Shields and Carroll 2015).

Transgender

In spite of the fact that we are being encouraged to believe that gender is a social construct, we operate with a double standard in society by accepting the desire and the potential need for someone to transition from one sex to another. What we understand about this desire is that, at some point, often in early puberty, a sense of intense *dysphoria* about being almost "imprisoned" in the "wrong body" can take hold. This suggests that gender dysphoria may potentially have a primarily biological origin, but there is also evidence that some individuals who transition regret doing so afterwards (Djordjevic et al. 2016). The fact that there are about three times more "male-female" (MTF) than "female-male" (FTM) transgender people is interesting and worthy of further research.

Transgender people, like all individuals, have a "self-image" based on a felt internal sense of their gender. But for many transgender people, how they feel inwardly clearly does not match how they look outwardly to others. Because of gender differences in the need to "look vs be looked at", this will have very different implications for transgender men and transgender women.

Pornography: What Is Being "Looked" at and "Looked for"?

Significant differences between male and female sexual preferences can be understood better in the context of the use of pornography.

Since the advent of computers in every household, the consumption of pornography is higher than it has ever been. As has been noted, "People spend more money on pornography in America in a year than…they do on all the performing arts combined. Sex sites are estimated to account for up to thirty percent of all Internet traffic" (Lehrer 2009).

The need for the male to look at the female is further illustrated in the much greater use of online porn by males in particular (e.g. Hald 2006). The evidence from pornography appears to support the theory that women on average have less need to "look at" and more need to be "looked at". There is however, a growing market for pornography aimed at lesbian couples, as an internet search will reveal.

The general male preference for the use of "fetishes" also reflects the male pre-occupation with the visual in sexual encounters (Scorolli et al. 2007). Fetishes of a sexual nature have traditionally been associated with the male, and represent the development of associations of objects or specific parts of the body with sexual desire. They can form an important visual link between the brain and bodily sexual arousal (Foucault 1987; Foucault and Sennett 1981).

The Celebration of Difference

Yin and Yang

The ancient Chinese world believed that the interlocking building blocks of the universe were best understood by the terms "Yin" and "Yang". The terms refer to complementary principles of Chinese philosophy, "yin" being negative, dark, moist and feminine, and "yang" being positive, bright, fiery and masculine. They can be thought of as opposite forces interacting in a complementary way, to form a dynamic system in which the whole is greater than the parts. The formation of the embryo begins with the fiery "yang" of the sperm penetrating the receptive but stationary form of the egg. The "yang" (symbolised by the sperm—whose DNA "packets" unlock the potential of the egg) is believed to be responsible for the formation of the spine

and skin and to enclose the embryo within its protection (Keown 2014). This concept shows us how the "masculine" is considered to be a protecting force for certain "feminine" aspects within ancient Chinese philosophy. The masculine therefore enables the full functioning of the female aspects of the personality.

Yin needs Yang and vice versa, and the two need to be in perfect balance for health and harmony in the body. This concept of interlocking, reciprocal and complementary aspects of the natural universe appears to offer a more promising model for gender studies than the sociopolitical theories that currently predominate in the Western world. The notion of Yin and Yang allows for an organic and natural integration of different and relating levels of human existence: body, mind, spirit and culture. The idea of Yin and Yang also strongly influenced Carl Jung's (e.g. Collected Works 1991) well known theories of archetypes within a shared "collective unconscious" including universal interrelated elements of masculinity and femininity, so that even males had an "anima" within them and females an "animus".

Natural philosophy theories such as these recognise that difference is essential to creativity and that opposite elements are also interdependent. Unity and diversity are essential to each other. These theories are better placed to explain sex gender differences as natural and related phenomena, rooted in our biology rather than sociologically constructed. Such theories also make it harder to justify concepts that view the genders comparatively as naturally in competition or conflict. Clearly, the natural state of gender relations is, on the contrary, systemic harmony.

Complementary vs Conflicting Roles

There is of course the theory that "Women are from Venus and Men from Mars" (Gray 1992) but the important point is that they are both from the same solar system. Men and women do certainly have different outlooks based on evolutionary differences that *can* lead to conflict and misunderstanding, but primarily these differences have co-evolved to be complementary. In my work as a relationship therapist, I find time and again that I may need to explain to couples the differences in what men and women are *looking at*, to begin the process of better understanding between them, and that this often leads to a more harmonious outcome.

Put simply, sex difference can bring couples together or come between them. A woman feels more like an ongoing sexual relationship if she *feels* emotionally close to the male, whereas a man can often feel like a sexual

encounter purely on the grounds of being attracted by what he *sees*. This does not mean that a man is any the less capable of a faithful, longstanding relationship and very deep love for his partner. It just means that in evolutionary terms, he is "hard-wired" to be sexually attracted in the first instance to the woman primarily on the basis of what he can see.

Now, increasingly in the Western world and other communities also, the woman has changed her focus from inside the home to outside of it. Her career takes the first place, and the family, if indeed she chooses to have one, should ideally fit around her work needs. But this does not change the archetypal "beauty imperative" and the fact that essentially, the woman needs to be "seen" in just the same way that she has always desired to be seen. She needs to be seen to be attractive, to stay attractive as she ages, and she needs to have her emotional needs validated, or "seen" by her male partner rather than to be offered practical solutions (a common source of friction between couples where this is not understood). She needs to have her maternal instincts satisfied, (including within many lesbian relationships) and in many cases children still feature largely in her focus on "what she is looking at".

It is interesting to remember that alongside the rise of feminism and some considerable progress in attaining "gender equality", women are spending more than ever before on cosmetics and surgical enhancements, and at younger ages too (Gimlin 2002). Whilst complaining about the ongoing objectification of the female body by the male, most women take care to look as good as possible for as long as possible. This is because the drive for female beauty is not simply created by the male but is part of the female archetype.

Because of this unchanging archetype, a high proportion of women will still always feel the need to adorn their bodies according to cultural fashion to accentuate and emphasise their feminine shape and beauty. However, it is noteworthy that this powerful display of female sexuality is not frowned upon as potentially intrusive to the eyes of male onlookers in the same way that the gaze and attention of the male onlooker is often viewed with suspicion. However, whatever the social and cultural context (currently at the time of writing dominated by the #MeToo campaign), the female still needs to be "seen" by the male, and he responds as he always has done, and in the way that he has been biologically wired to react—by looking.

Some female writers such as Heather Heying have recently challenged the current fashion for pathologising the male gaze by coining the term *toxic femininity* to refer to the process whereby females use intense sexual display to evoke sexual hunger in men and then condemn the display by men of the

very hunger that they have "stoked up". Psychologist Gad Saad (2018) also comments that in spite of the current western pre-occupation with "male dominance" women in fact are often "*attracted to 'toxic masculine' male phenotypes that correlate with testosterone, and they are desirous of men who are socially dominant, who are strategically risk-taking in their behaviours*".

Conclusion

We see in the natural world a continual cycle of death and re-birth, played out over the seasons and in the birth and ageing process of all organisms. Species that are at the top of the food chain would die out if the species lower down the food chain became extinct themselves.

If there were no animals to hunt, carnivores would all die out. The food chain exists because each part of it is inter-dependent on the rest of the chain for its survival.

Likewise, if men did not want to look at women, women would have much less reason to be concerned with their appearance. It could be argued that women vie with one another to be better dressed or more fashionable for reasons of status, but the roots of a desire to flaunt the body still originate in mating behaviour. This is discernible in animal life in display colours and rituals. Examples of this amongst the bird kingdom are the most obvious and numerous, although amongst the avian population it is usually the males that display their looks for the females.

The life force that we can see all around us, especially as spring returns each year as the leaves unfurl and mating begins once again, is sustained by the rhythm of need and response.

The basic instincts of reproduction are still present in the human species and represented in the majority of adult relationships. The attraction of opposites is what keeps the "dance" going on and what creates excitement and innovation in relationships.

The male feels that his manhood is affirmed as his need to "look" is responded to. Likewise, the female's need to be looked at is fulfilled by the male's need to look at her, and she feels a sense of completion when she is truly "seen" and appreciated. The joining of "Yin and Yang" in procreation, sexual intimacy and social intercourse results in a new surging up of the life force that sustains and inspires both male and female in all aspects of their lives.

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We Are Warriors: The Psychology of Men at War

Rod Eldridge and Edward Fraser

Introduction

Before starting the chapter, readers should be mindful of two details that will help them navigate the upcoming discussion. Firstly, in keeping with the wider purposes of this book, the chapter focuses exclusively on male service and ex-service personnel. Although most service personnel are male it is important to be aware that women are playing an increasingly significant role within the British Armed Forces today (Dempsey 2018) and the experiences of female personnel living and working in an overwhelmingly masculine environment deserve greater attention. Secondly, by striving for simplicity, the chapter may give the impression that military men are all identical. This is of course absurd! As a self-selecting community, we might expect the British Armed Forces to be composed of individuals with similar values, attitudes and beliefs, and the broad themes discussed here do seem to permeate the male service and ex-service populations in a very general way. However, it should be noted that military men, much like their civilian counterparts, come in all shapes and sizes. The only thing that members

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of the British Armed Forces *necessarily* have in common is their current occupation. New recruits come from different backgrounds with different life experiences. They have different reasons for enlisting and their military careers will follow different paths. To that end, this chapter is primarily concerned with those individuals for whom the values of military culture hold especial relevance. More specifically, the discussion focuses upon men from the ranks who serve, or served, in combat roles with the British Army. This is not to denigrate members of the Royal Navy and the Royal Air Force, but the British Army is by some way the largest Service, most personnel who develop mental health conditions are soldiers, and the first author has 27 years' service as an army mental health nurse.

Military Psychology: Hyper-Masculinity in Action

> From this day until the ending of the world but we in it shall be remembered. We few, we happy few, we band of brothers. For he today who sheds his blood with me shall be my brother.
>
> Henry V, William Shakespeare (c. 1599).

Few narratives of manhood are as compelling or enduring as the narrative of men at war. With the rise of feminism in the 1960–1970s, discourse around gender has shifted away from stereotypical "norms" based on supposed fundamental and innate differences between men and women. Arguably, there is no longer any single or shared concept of masculinity, as men with a diversity of attitudes and experiences find various ways to make sense of their place in the world (Connell 2005). Nonetheless, traditional masculine virtues, such as those outlined earlier, have retained a particular relevance through the years (hence the continued usage of terms like "man up") and the notion that military service is in some way fundamental to the essence of manhood remains very persuasive. Many young men who choose to serve in the military do so as way of proving themselves, and those who have not served may express regret at not being able to do so, as though their lack of military experience has somehow marked them out as less manly. This narrative of men as soldiers is a social construct, the genesis of which may be learned at our mother's knee—"big boys don't cry", "my little soldier"—or developed in a boy's imagination, dressing up and playing at war with sticks and toy guns. The construct is further nurtured in comics and stories and Hollywood provides a feast of movies to glorify and romanticise war, reinforcing a very specific perception of how

men should behave during armed conflict. The British Armed Forces make use of this narrative in recruitment, where potential recruits are encouraged to test their mettle and prove themselves to "be the best".

Approximately 200,000 men and women serve in the British Armed Forces today and it is thought that the ex-service, or "veteran", community numbers some 2.6 million in the United Kingdom. While it may be of general interest to many men, some individuals find armed service particularly appealing. Recruits to the British Armed Forces disproportionately come from disadvantaged socio-economic areas and tend to have low levels of educational attainment and histories of childhood adversity (Gee 2007). A large number of recruits come from families with a strong tradition of military service, but a significant proportion may also enlist as a last resort due to a lack of civilian career options (Gee 2007). For many young men, the military heralds a fresh start and the chance for a better life, with access to experiences and opportunities that would not otherwise have been possible. For some, the military will become a first real family. Teamwork is a central part of military life and recruits learn to depend upon their new comrades, first in basic training and then on the battlefield, where they will potentially face the ultimate test side by side, each man placing his life in his comrades' hands. These bonds of fellowship, forged in the crucible of combat, are not easy for civilians to comprehend, and the brotherhood between military men remains of great importance to many ex-service personnel long after they have been discharged.

Service in the British Armed Forces is, for the most part, a rewarding experience, and the majority of ex-service personnel reflect positively upon their time in the military. Some evidence even suggests that experience of operational tours can actually increase psychological wellbeing (Hacker Hughes et al. 2005). Strong camaraderie can be immensely protective when it comes to building emotional resilience, and it has been suggested that unit cohesion and effective leadership could play a key role in the relatively low rate of mental ill-health observed in personnel who have been deployed on operations (Du Preez et al. 2012; Jones et al. 2012; Sundin et al. 2010). However, the fact remains that a significant minority of personnel and veterans are living with mental health conditions, whether as a result of active duty or, as is more often the case, some other event or life experience. And for many of these individuals, the tightknit military family can become something of a strait jacket, obstructing them from seeking the proper treatment and support.

The problem is that the military's hyper-masculine culture, in which armed service is fundamental to one's identity as a man, can make it difficult for personnel with mental health conditions to reconcile themselves to the fact that they may need help, resulting in a range of powerful and specific psycho-social barriers to care. In order to forge efficient soldiers, sailors and airmen who will be able to flourish and survive in the harsh military environment, all recruits to the British Armed Forces are taught through constant repetition that stressful and hostile situations should be overcome through strength and dominance. Such social capital is invested in a man's abilities as a warrior that, even within the military, there are, in effect, hierarchies of manhood; servicemen from elite units such as the SAS, Parachute and Royal Marine Regiments enjoy special status and are regarded as more manly than regular soldiers.

The very language that we routinely use to talk about mental health seems to be fundamentally incompatible with this kind of thinking, and it is not difficult to understand why men who define themselves in such a way would not wish to be associated with a community of people who are described as "victims" and "sufferers". Military men pride themselves on their courage under fire, and the sense of helplessness that often accompanies the onset of mental health difficulties is, experience suggests, complete anathema. To the military psyche, then, succumbing to mental ill-health is regarded as a weakness and personnel who go on to develop problems may feel that they have failed to live up to the expectations of manhood.

This is not unique to the military. Men from all walks of life tend to be less willing than women to access mental health treatment and support (NHS Digital 2016), for a variety of reasons discussed elsewhere in this book. However, for men who serve in the British Armed Forces, the issue of male pride is intensified by the idiosyncrasies of military life. For instance, the intensive operational demands of the British Armed Forces require personnel to put the welfare and safety of the unit above their own and recruits are conditioned early on to "square their s**t away" so as to avoid letting their comrades down, potentially risking lives and jeopardising the mission at hand. A consequence of this kind of mentality is that personnel who are struggling may feel that they are not only failing themselves, but that they are also failing their comrades, resulting in immense shame and guilt. Remember, the military brotherhood is very intense, and servicemen will go to great lengths to avoid being seen as weak by their comrades, especially if their comrades themselves do not appear to have fallen short of the test of manhood.

The notion that mental ill-health is some kind of weakness is therefore reinforced for each serviceman through contact with other military men, and personnel who are on the verge of asking for help need only remember their Regimental motto ("Swift And Bold", "Fear Naught") to be reminded of the expectations of those around them. In this way, it was not uncommon for personnel who were medically repatriated from Iraq or Afghanistan (on mental or physical health grounds) to feel that they were not worthy to receive their campaign medal or to attend their home coming parade because they believed that they had failed to complete a tour and had not contributed to the proud history of their Regiment alongside their comrades. Likewise, personnel who were held back while the rest of their unit deployed learned to live with the shame of being a REMF ("Rear Echelon Mother F****r").

The significance of this barrier to care becomes apparent when we consider that personnel are constantly surrounded by their comrades, with whom they must live, eat and sleep as well as work. Military mental health services are generally situated on base, which means that it is all but impossible for personnel to seek help incognito. Living and working alongside comrades may also lead some servicemen to minimise their issues in order to fit in with perceived group norms. For example, if a soldier is experiencing traumatic symptoms as a result of a time when his unit was involved in a firefight with the enemy, he may assume that the other men in his unit are experiencing similar symptoms and therefore consider his experiences to be normal and not symptomatic of a mental health condition. Servicemen do not generally consider it "manly" to talk about their feelings and so it is unlikely that any members of the unit will come forward to shatter the illusion. Instead of discussing his experiences with his comrades, he may use alcohol, the traditional refuge of military men through the ages, to quell his symptoms. This habit can be difficult to shift, and he may continue drinking through his problems in denial or ignorance for many years after he has left the military.

Whether or not the British Armed Forces do enough to safeguard the welfare of personnel by combating these issues is a matter of some debate and controversy. Before discussing some of the current strategies to reduce stigma and promote awareness, we will examine historical attitudes towards mental health within the military, if only to illustrate how much progress has been made and how far is left to go.

Historical Attitudes Towards Mental Health Within the Military

> At first shell-shock was regarded as damn nonsense and sheer cowardice by Generals who had not themselves witnessed its effects. They had not seen, as I did, strongly, sturdy, men shaking with ague, mouthing like madman, figures of dreadful terror, speechless and uncontrollable. It was a physical as well as a moral shock which had reduced them to this quivering state.
> *Now It Can Be Told*, Philip Gibbs (1920).

We should be careful before attributing current diagnostic models to historical cases, but symptoms of what we now call Post-Traumatic Stress Disorder (PTSD) are evident in the very earliest accounts of war. So it is that ancient Greek and Roman texts, such as Homer's *The Iliad* and *The Odyssey*, describe soldiers traumatised by war, for example the terrible grief and rage of Achilles at the death of his close friend Patroclus during the war with Troy: "Nothing matters to me now but killing and blood and men in agony" (*Iliad*, 19.225–226). However, the effects of warfare upon the emotional lives of warriors did not truly enter mainstream consciousness until the twentieth Century. At this time, the world was engulfed in two wars in which developments in weaponry resulted in mass slaughter on an unprecedented scale, perpetuated beyond all expectations by the newfound economic resilience of modern industrialised powers.

World War One

When we commemorate World War One (1914–1918) in the United Kingdom, we quite rightly pay tribute to the all the hundreds of thousands of men who were killed or wounded in action at the Somme, Ypres and other major offensives along the Western Front. But as awful as "going over the top" invariably was, in some ways taking the fight to the enemy might have been preferable to the unrelenting misery of trench warfare, where life was wet, cold and dirty and death was constant and indiscriminate. The utter helplessness and hopelessness that follow from being besieged by artillery shells, poisonous chemicals, armoured tanks and other weapons of terrifying destructive power while unable to retreat and powerless to retaliate is brought to life in the writing of poets such as Wilfred Owen (1893–1918), whose scathing and wonderfully ironic *Dulce Et Decorum Est* contrasts sharply with the early war jingoism of Rupert Brooke (1887–1915),

Jessie Pope (1868–1941) and others in a fine exemplification of the frustrations felt by many in the later stages of the war.

Unsurprisingly, some soldiers struggled to cope with the horrors they had witnessed in the trenches and on the battlefield. The trauma manifested itself in a number of strange behaviours. Some men found themselves unable to eat, while others developed insomnia and relived their experiences in terrible nightmares, flashbacks and hallucinations. They were languid and depressed (the now infamous "thousand yard stare"); anxious and hysterical; dizzy and disorientated. There were physical symptoms too: paralysis, limping and muscle contractions, blindness, muteness and deafness and heart palpitations. This behaviour greatly vexed the authorities of the day, who had enough problems finding replacements for troops with tangible physical injuries. Men displaying traumatic symptoms were said to be suffering from "funkiness" and it was suggested that tighter discipline would prevent further issues. As the war dragged on and the fighting intensified, the number of soldiers leaving the trenches unable to fight due to non-physical illnesses grew exponentially until they amounted to 1 in 3 of all medical discharges. This development forced the British Army to take the matter more seriously and a new term, "shell shock", was coined. This term sat well with the military, because it had a tangible element based on the premise that shells exploding in close proximity caused bruising to the spinal cord and brain, thereby rendering soldiers ineffective. The explanation was soon refuted when post-mortems found no evidence, and the phrase "Not Yet Diagnosed (Nervous)" was preferred, a definition whereby symptoms were interpreted as psychological rather than organic (Jones and Wessely 2014).

A good many medical professionals endeavoured to understand and help shell shocked soldiers, but, generally speaking, the condition was treated as a sign of emotional weakness or cowardice by military authorities. Sufferers were induced by their Medical Officers to face their illness in a manly way; such was the Freudian thinking of the day that only women were expected to suffer from hysteria. Many shell shocked soldiers were charged with desertion, cowardice, or insubordination and some were executed having been convicted by courts martial. Those who escaped this fate had no choice but to acknowledge that their reputations as soldiers and men had been severely compromised, both within the army and at home, where they found themselves greeted with shame and silence.

By the end of hostilities, the British Army had dealt with 80,000 cases of shell shock, approximately the same number of soldiers serving as regulars today. Regrettably, it seems that the military learned precious few lessons between the wars.

World War Two

World War Two (1939–1945) saw the introduction of mental health screening for the first time, which did not prove reliable, and more appropriate terms—"battle neurosis" and "combat fatigue"—to describe personnel who were struggling to cope with the traumas of war, but general attitudes remained much the same. Pressure was placed on Medical Officers to avoid a diagnosis of neurosis and more discharges on grounds of dishonour were granted instead. The Royal Air Force used the rather disingenuous label "Lacking Moral Fibre" (LMF) to explain the refusal of air crew to continue flying combat missions, even though some had completed as many as 25 operational sorties, each one with a 1 in 5 chance of being killed. As before, LMF was seen as a flaw in an airman's character, but this time it was blamed on his psychological development in his formative years. Similarly, Field Marshall Montgomery hand-picked regiments who had fought for him with distinction in North Africa for subsequent battles in the invasion of Europe but they failed to deliver the expected effect, the men having known what was coming and finding that they had little appetite for further combat (Taylor 2013).

More Recent Conflicts

Fortunately, our current understanding of psychological health is rather more sophisticated. This is principally a result of the large numbers of American veterans coming forwards for help with trauma in the aftermath of the Vietnam War (1955–1975), which prompted a new research interest in military mental health in the United States and led to the introduction of PTSD as the first formal psychiatric label to diagnose personnel presenting with the kinds of symptoms that had been observed during the two World Wars and later conflicts (Van Der Kolk 2014). The impetus arrived much later in this country, and it was not until the British Armed Forces' prolonged involvement in Afghanistan (2001–2014) and Iraq (1990–1991 and 2003–2011) that research attention began to intensify on the psychological impact of military service upon the men and women returning home from those conflicts, as well as the wider veteran community.

As our understanding has improved, so too have our methods of prevention and treatment. Today, the British Armed Forces employ various measures to promote emotional awareness and resilience. The psychological welfare of personnel is primarily considered to be the responsibly of the chain

of command. To that end, all personnel receive mental health awareness lectures before, during and after deployment and promotion courses for both officers and the ranks cover stress management. Many units have TRiM (Trauma Risk Management) practitioners, who are specially trained to identify and support comrades who may be at risk of developing mental ill-health after a traumatic event. Personnel who are struggling can seek support from their Unit Padre, Unit Welfare Officer or Regimental Medical Officer. Specialised outpatient treatment is provided by Field Mental Health Teams and Departments of Community Mental Health, while inpatient care is provided in a small number of specific NHS hospitals. More generally, there are strict guidelines about optimum lengths of deployment (usually six months, followed by a 24-month break) and personnel will spend a period of decompression, or rest and relaxation, following operational service.

It appears that these new developments are paying dividends. Although there has been a steady rise over the last decade, assessments for mental disorders at military mental health services remain very low, at around 3% of all British Armed Forces personnel (Ministry of Defence 2017a). Much higher rates of mental ill-health have been observed in US studies and it has been suggested that this disparity may be explained by the fact that US personnel typically deploy for 18 months, rather than six (Pinder et al. 2012). That said, research suggests that approximately 60% of service personnel who experience mental health problems do not seek help (Sharp et al. 2015) and there is compelling evidence to suggest that, in spite of the progress that has been made, mental health remains stigmatised in the military. Both authors were recently involved in a qualitative study exploring attitudes towards mental health in a sample of 30 ex-service personnel from Norfolk and Suffolk (Fraser 2017). This research identified stigma and a failure to recognise the need for help as key barriers to care, a finding that is consistent with a number of other studies (e.g. Sharp et al. 2015; Forces in Mind Trust 2017). This discussion has focused on men from the ranks, but it is worth noting that officers may face particular challenges here, as they are perhaps more likely to manage large and stressful workloads in search of promotion.

From extensive personal experience and detailed interviews with ex-service personnel, both authors are in no doubt there is more that the British Armed Forces could do to root out antiquated and unconstructive attitudes towards mental health from within their hierarchies. The protracted and often unpleasant process of seeking compensation from the Ministry of Defence for a mental health illness, as compared to a physical injury, suggests the persistence of these historic attitudes. However, this is not to say that servicemen who are struggling with their mental health will necessarily

face as little sympathy and understanding as their fathers and grandfathers faced before them; the issue is rather more nuanced than that. For our knowledge of the impact of warfare may have developed through the years, but the fundamental purpose of the military remains much the same as it has always been. Just as the British Army needed soldiers who could maintain a "stiff upper lip" through the horrors of the World War One trenches and the Royal Air Force required air crew who would continue to fly bombing raids over Nazi Germany, the British Armed Forces today need members of staff who are ready to deploy into combat anywhere in the world at a moment's notice. This means that even the most sympathetic and understanding Commanding Officer has to bear in mind the needs and objectives of the mission at hand when responding to mental health disclosures. To that end, while it would rarely be acceptable in mainstream employment for an employee's mental health to affect his job prospects, given the nature of armed service, it may well be entirely appropriate for personnel who disclose they are struggling to be downgraded on medical grounds.

This section closes in some sympathy for the British Armed Forces for the scale of the task that confronts them as they look to balance their duty of care to safeguard the mental wellbeing of staff with their bottom-line operational requirements. So long as military service appeals to men who value masculine virtues and so long as these virtues are required for the training of successful soldiers, sailors and airmen, it is unlikely that mental health will ever be truly de-stigmatised in the British Armed Forces. For how can we expect the same men whom we ask to engage and kill the enemy without hesitation, mercy or compassion to be comfortable participating in an open dialogue about their feelings, doubts and fears, especially if they suspect that anything they choose to reveal may have implications for their reputation among their comrades and their future prospects within the military? Clearly, there is a fine balance to be struck. One possible solution might be to move away from traditional binary views of "health" and "illness", towards a recovery-based narrative, more accommodating of physical and psychological challenge—and the human response to them.

Legacies of War

> Men who went out to battle, grim and glad; / Children, with eyes that hate you, broken and mad.
> "The Survivors", Siegfried Sassoon (1918).

In October 2014, the British Armed Forces were preparing to withdraw the last few troops from Afghanistan. By this time, sensationalist stories had already begun to surface in the media about impossible numbers of servicemen and women returning home from Iraq and Afghanistan haunted by the mental scars of combat. A narrative quickly emerged of dashing young heroes, broken by war, abandoned by the military and left to struggle on alone, often sleeping rough and seeking refuge from their memories at the bottom of a bottle. Newspapers issued dire warnings about a "ticking time-bomb" and threatened the NHS with a "tsunami" of veterans seeking help for PTSD and other mental health conditions (Royal British Legion 2014). At the same time, an old statistic, popular in the aftermath of the Falklands War (1982), was revived in the claim that more ex-service personnel were committing suicide than had been killed on active duty fighting the Taliban (Royal British Legion 2014).

Such headlines are grossly misleading. Academic studies have consistently shown that the prevalence of mental ill-health in service and ex-service populations is not significantly different to the general population, where mental health is thought to affect around one in four of us (Fear et al. 2010). On the whole, suicide rates in the military are actually lower than in the general population (Ministry of Defence 2017b), although broad brush comparisons are often unwise and there is a lack of data about veterans, some of whom, possibly including young men, may be at increased risk (Bergman et al. 2017; Kapur et al. 2009). Of course, a significant minority of our veterans really do struggle with mental health, behavioural and social difficulties and, of course, these individuals deserve nothing less than the very best treatment and support we can provide.

Problems of Transition After Leaving the Military

Given the various barriers to care associated with military psychology that were outlined earlier, it should not be surprising to note that male veterans often do not ask for help until many years after they have left the military, by which point their conditions can be difficult to manage. Indeed, one of the UK's leading military mental health charities, Combat Stress, reported that veterans were waiting, on average, 12 years before seeking help from their services, although the delay is significantly shorter (about 2–3 years) for men who have left the military more recently (Murphy et al. 2015).

Moreover, veterans may present with conditions of considerable clinical complexity, such as multiple trauma and alcohol co-morbidity, and they may slip through the cracks between services; too complicated for primary care but not considered appropriate for secondary services, which are traditionally designed to meet the needs of patients with life-long conditions such as schizophrenia and psychosis (MacManus and Wessely 2013). For these reasons, it has been claimed for many years, particularly by military charities, that the NHS is largely unsuited to the meet the needs of ex-service personnel and a disproportionate amount of care is provided by voluntary and community organisations. Policy interest has increased considerably since Iraq and Afghanistan, and NHS England now commissions a range of specialist mental health services for veterans across the country, although the current iteration of these services has only been running since April 2017 and so it remains unclear whether they offer a more effective treatment model than the mainstream services commissioned by local Clinical Commissioning Groups.

While the picture is slowly changing, national policy has tended to focus on treatment for conditions that are service attributable; i.e. related to military service. Historically, this has meant combat-related PTSD, which is still widely considered as the quintessential service condition. In some ways this approach is justified, for it seems reasonable to expect the British Government to offer specific support and, if necessary, financial compensation, to those men and women whose conditions are associated with the time they spent in service to their country. Deployment and subsequent exposure to combat can, of course, be detrimental to mental health and symptoms of PTSD in service and ex-service personnel are associated with a wide range of adverse outcomes. That being said, the focus on service attribution, and PTSD in particular, is unhelpful. For one thing, other mental health conditions are far more prevalent. PTSD seems to have become something of a badge of honour within the military and veteran populations, likely because it is more palatable than other stigmatising diagnoses, but the condition is actually thought to affect only 4% of individuals, even if slightly higher rates have been observed in Reservists and individuals in a combat role (Fear et al. 2010). By comparison, 67% of servicemen and 49% of servicewomen are thought to be engaged in harmful drinking (Fear et al. 2007), and nearly 19% of male personnel may be living with common mental disorders like anxiety and depression (Goodwin et al. 2014).

Moreover, many personnel and veterans will be living with conditions that are not obviously attributable to their time in the military; even taking PTSD as an example, only half of all cases can be directly related to service

(Jones et al. 2013). Human beings are complicated creatures, and it is likely that armed service will be just one of many factors in the development of mental ill-health.

Early Service Leavers

Of all ex-service personnel, those who were in the military for the *least* amount of time (less than four years) are the *most* likely to struggle. These individuals, known as Early Service Leavers (ESLs), account for about 40% all discharges from the military (Howard League for Penal Reform 2010). The fallout from such a blatant perceived defeat so early in the quest for manhood upon the psyche of male ESLs is yet to be fully explored.

ESLs suffer from a disproportionally high suicide risk and rate of mental ill-health, as well related wellbeing difficulties such as social exclusion, unemployment, homelessness and criminal offending (Bergman et al. 2016; Buckman et al. 2012). Given their short length of service, the adverse outcomes experienced by ESLs are unlikely to be operationally related, but rather result from pre-enlistment disadvantages, as they tend to be younger, poorer, less educated and so on than other military recruits. Roughly one third of all ESLs (Ashcroft 2014) fail to complete basic training (a recruit only needs to complete one day's service to count as a veteran) and it is probable that this process creates a selection effect by filtering out those medically or psychologically unfit for service (Bergman et al. 2016). ESLs have traditionally received less support than other service leavers, but the British Armed Forces now offer a range of specific interventions to help ESLs make a smooth transition into civilian life, for example the "Future Horizons Programme". In this way, the narrative of mental ill-health among ex-service personnel is not always one of brave heroes abandoned by uncaring authorities; more often than not it is a broader and somewhat less romantic narrative, in which vulnerable young men, who happen to have spent some time in uniform, struggle to find a place for themselves in British society.

That said, the period of discharge can be a potential area of vulnerability for many personnel, even those who have enjoyed long and illustrious careers, and it is not uncommon for veterans to report mental health and related difficulties that either started or intensified once they had left the military. When personnel are discharged from the military, they leave behind the protective factors that helped maintain their resilience, such as the camaraderie with other military men. In addition, some of them, particularly those who leave on short notice (including many ESLs), for example on medical,

disciplinary or redundancy grounds, may face specific challenges reintegrating into civilian society. The British Armed Forces provide a good deal of transition support around education, employment and training, although the extent to which this is utilised remains to be seen. However, much less work is undertaken to prepare personnel *psychologically* for life "outside the wire".

Military Training and Its Psychological Effects

Part of the problem relates to military training. It is important not to make too much of this issue, as there is a need for further research, but growing evidence suggests that basic training leads to appreciable and long-lasting changes to the personality, attitudes and behaviour of servicemen and women (Gee 2017). While these changes may be necessary in order to transform civilians into effective soldiers, sailors and airmen, a problem may arise if the process is not reversed before discharge, because the kinds of attitudes and behaviours that are useful in the military environment may not be constructive in civilian life. For example, personnel are repeatedly drilled until they react immediately and unthinkingly to stressful situations with aggression and anger. This could well help to save lives in combat, but it is not an appropriate response to the mundane challenges of everyday life, and neither is it conducive to long-term mental health. Similarly, it might have been a necessary precaution for a soldier to be hyper-vigilant as he patrolled the crowded streets of 1980s Northern Ireland, but, now that he has left the military, he no longer needs to be in a state of high alert every time he leaves his house to go to the shops. A period of readjustment following discharge is entirely normal, particularly for individuals returning to peaceful suburbia from active deployment, but some veterans never really manage to forget what they learned in the military. The British Armed Forces expend much effort and resources in order to militarise civilians when they enlist; perhaps there should be more activity to "civilianise" soldiers, sailors and airmen when they are discharged.

More broadly, successful transition can be complicated by the fact that the hyper-masculine military culture into which a serviceman was assimilated as a recruit is ruled by very different standards and values to those that now confront him in civilian life. Whereas his status as a soldier may have depended on his bravery and dominance, his new civilian context rewards pacific attitudes like mutuality and agreeableness. Whereas he was conditioned in the military to follow orders without question, civilian society requires him to think autonomously and take responsibility for his actions

and decisions. Whereas he used to be surrounded by comrades whom he knew would watch his back, such profound relationships do not seem to exist between civilians, even his civilian friends and family, and he no longer knows who he can trust. And so forth. In this way, leaving the military can be something of a "culture shock" and can lead to a wide range of adjustment issues, which in turn can fuel and/or result in various health and well-being difficulties. These issues may be worse for individuals who joined the military at an early age, which includes most combat troops, and those who have served for a long time. This is because these individuals are the most familiar with military life. Personnel do not have to worry about the everyday concerns of civilian existence—food, clothing, housing et cetera—because the military sees to all of their basic needs. Standard NHS practices, such as registering with a GP and 28-week waiting lists, with which civilian adults are familiar, are mysteries to new veterans, because they are used to very responsive primary and occupational healthcare provided on base. In this way, when personnel leave the military they are not only leaving their job, but often a home and a way of life that makes sense to them, with friends and family they can count on and a range of practical conveniences. It is little wonder that some veterans never really stop being soldiers, and struggle to find a sense of purpose in unfamiliar civilian roles as husbands, fathers, uncles, brothers and sons.

Implications for Practice

> There are a certain number of our gallant soldiers for whom no proper provision is at present obtainable but is sorely needed. They are suffering from very severe mental and nervous shock due to exposure, excessive strain, and tension. If not cured, these men will drift back to the world as wrecks, and miserable wrecks, for the rest of their lives.
> Lord Knutsford, letter to the editor of the *Daily Mail* (1914).

It is not the purpose of this chapter to make any formal recommendations for research or practice. However, drawing on the previous discussion, the authors would like to make two very general reflections that may be of some use to readers working with male service and ex-service personnel, especially in healthcare, social and welfare settings. The first reflection relates to the importance of military sensitivity. As noted in the previous sections, servicemen and women are bred to consider themselves to be different from civilians. Some individuals will leave service wanting nothing more to do

with the military, but many veterans continue to identify on one or more levels as soldiers, sailors and airmen long after discharge. In this way, service and ex-service personnel who are living with mental health conditions may believe that only professionals who have military experience will be able to understand their issues, a notion that is further propagated by military charities. A perceived lack of sensitivity is one of the main barriers to effective engagement with services, particularly for veterans. It is true that military men can quickly forge deep connections with each other, but, as with all things in health and care, what truly matters are a professional's skills, experience and personal qualities.

Nonetheless, it is important for professionals to be culturally sensitive when working with service personnel and veterans. For one thing, a veteran's military experiences may provide the specific context for his presentation. Perhaps he served in United Nations and NATO peacekeeping missions in Bosnia, Rwanda or Kosovo; awful deployments in which the traditional rules of engagement were challenged and broken. Perhaps he witnessed the mistreatment, injury and death of non-legitimate combatants, such as women, children and the elderly. Perhaps he feels immense guilt and shame for being unable to defend the helpless, a purpose which he feels is central to the essence of his identity as a soldier and a man (Edwards 2018). Or perhaps he is consumed by anger at the death of his comrades, who fell in combat with the Taliban. Perhaps he rages at his own helplessness, deeply ashamed of his fear under fire and the fact that, even after all his training, he was not strong or brave enough to save his friends. Perhaps he has come to regret the things he did as he sought vengeance. Such insights can be very helpful during therapy.

Even if an individual's condition is not service attributable, recognising the ongoing importance of the military to many veterans and taking the time to understand the ways of military life can lead to a more constructive professional relationship. Service and ex-service personnel will inevitably use a lot of jargon and abbreviations, as well as the gallows humour for which the Armed Forces is famed. Some individuals may reveal a strong sense of entitlement for having suffered in the service of their country, which can present in frustration or anger towards the system. Showing an interest in a serviceman's military career (their Service, Regiment or Corps, their trade, their rank and so on) may help to establish trust, for many servicemen will be justly proud of their achievements in the military, although it is worth noting that some will embellish certain details. While one should be curious about a serviceman's military experiences, it is advisable not to push, initially at least, for detailed "war stories", in case these are damaging and lead to re-traumatisation, but rather to let them share their

experiences in their own time. As noted earlier, veterans may not be familiar with the NHS and may need additional help to navigate services. It is important to be presentable and punctual, as this is valued in the military, and service and ex-service personnel will expect consistency and reliability. Everyday NHS occurrences such as cancelled or rescheduled appointments may give them an excuse to disengage altogether and effective, proactive communication is key to continued engagement. If personnel disclose that they were discharged from the military on mental health grounds then they will have had some form of assessment and treatment in service, and knowledge of this may be useful. It is also worth noting that service and ex-service personnel, and their families, have specific entitlements, including special consideration in cases of service attributable conditions, under the NHS constitution (Ministry of Defence & Veterans UK 2018).

The second reflection is that much of what has been discussed around hyper-masculine beliefs, and the consequent issues that arise when it comes to mental health and help-seeking behaviours, is not unique to the British Armed Forces but may be applied to many men from other walks of life. Quite unconscionably, suicide remains the greatest killer of young men in this country (Office for National Statistics 2017) and, in spite of recent policy efforts, mental health is still stigmatised in the male population, as discussed elsewhere in this book. While the military context is, of course, important, one should not to lose sight of the fact that the vast majority of service and ex-service personnel are male. Some of the comments made in this chapter may therefore be of general application beyond the Armed Forces community, and there are opportunities for cross-pollination in terms of research and practice. To take veterans as an example, the wide range of specific healthcare, social and welfare support in the voluntary and community sector means that this population is well prepared for models of care based around the recovery principles set out in the "Five Year Forward View for Mental Health" (NHS England 2016). Moreover, some new therapies are taking advantage of the team-working skills developed in the military to encourage veterans to come together in groups and fight their mental health illnesses side by side, just as they would have engaged the enemy while they were still serving, thereby turning a traditional barrier to care into a therapeutic opportunity (see Shields and Westwood, this volume). Lessons from the battlefield have long informed improvements in civilian healthcare, and it may be that advances in mental healthcare for veterans can be used as a basis for the development of more effective models of care for men the male population in general.

Concluding Remarks

> Soldiers are not merely civilians in uniform: they form the distinctive group within our society that need a different set of moral values in order to succeed in circumstances which greatly differ from those prevailing in civilian life. For no other group in society is required either to kill other human beings, or expressly sacrifice their lives for the nation.
> General Sir Michael Rose, 'How soon could our Army lose a war?', *Daily Telegraph* (1998).

War has been with us since antiquity. Throughout the ages, we have devised more and more sophisticated weaponry with which to fight, and, as swords and spears gave way to missiles and drones, we have found increasingly effective methods of training our warriors to wield these new weapons. The best way to safeguard the mental health of the men and women who serve in our military would be to put a stop to this process. Unfortunately this is unlikely to happen. We should be mindful, therefore, of the costs of war before we deploy our troops into active duty; we should expect some of our troops to return to us forever changed by their experiences, and we should be ready to offer continued support to all those for whom the fighting did not stop when they put away their gun. In short, whatever care we put into preparing our men and women for war, we should also put into preparing them to come home.

This chapter set out to provide an insight into the British Armed Forces psyche as it pertains to masculinity and masculine beliefs. There has been a focus on individuals who struggle as a result of these beliefs, but, again, it should be stressed that the majority of men and women benefit from their time in uniform, and the strong sense of purpose and belonging cultivated by the military can be very protective. That said, male service and ex-service personnel face a range of specific barriers to care that can make it very difficult for those who are struggling to ask for help. As a result, too many of these men are suffering in silence, far beyond the awareness of professional services and desperately alone. If readers who are working in healthcare, social and welfare settings could take away one message from this chapter, the authors hope that it would be this: to look closely at the man sitting opposite them, obstinately silent, in their GP consulting room, or at the inebriated or otherwise "out of it" individual who keeps turning up in A&E, or at the tattooed youth wasting everybody's time at the job centre, and to ask them if they serve or have served in the British Armed Forces. And, if their answer is yes, to be mindful that there may well be reasons to explain

their behaviour, to remember that military men may have specific needs and entitlements, and to be reassured that there are many specialist resources to help them and their families, both in the NHS and in their local communities. These resources, have a track record of successfully helping even those ex-service personnel who may seem to be the most "stuck" to move on in their journey of adjustment, healing, and recovery. In our experience, in working with such men, a little experience goes a long way.

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Part II

Practice

Attention Deficit Hyperactivity Disorder (ADHD): A Case Study and Exploration of Causes and Interventions

Bijal Chheda-Varma

History and Aetiology—Neurodevelopmental Perspectives

Attention Deficit/Hyperactivity Disorder (ADHD) was first recognized close to a century ago in children, mainly boys. It was initially labelled as hyperkinetic disorder which indicated a difficulty in children to manage behaviour through physiological conditions. Hyperactivity hence formed the key aspect of how ADHD was recognized. The earliest records of ADHD were established in 1885 when Heinrich Hoffman wrote about his patient called "Fidgety Phil" (Stewart 1970, cited in Kapalka 2010). The publication of Diagnostic and Statistical Manual or Mental Disorders-III (DSM-III) by the American Psychiatric Association in 1980 made the term Attention Deficit Disorder official. The fourth edition of the DSM-IV introduced the complete version of ADHD in 1994.

Recent research has been informed by neuroimaging and identifies ADHD with clear brain disorder links. Four major studies performed in 1990s and reviewed by Swanson and Castellanos (2002) using Magnetic Resonance Imaging (MRI) scans showed that children with ADHD exhibited patterns of neuroanatomical abnormalities. Environmental stress, trauma including difficulty trauma at birth are also considered as increasing the vulnerability towards ADHD. Problems at home, anxiety, conflictual or difficult

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relationship with parents would increase a child's predisposition towards ADHD. Barkley (1990) stated that behavioural issues were also correlated to distorted cognitions and unrealistic mindsets developed and maintained through child–parent conflicts.

Genetic Factors

Twin, family and adoption studies conducted highlight important generic links to ADHD. Individuals are 60–90% more likely to develop ADHD if there is a family member who has ADHD (Gizer et al. 2009). Neurotransmitters and genetic coding for specific genes are linked with ADHD traits. However, the complicated gene pattern has not been clearly defined. Hyperactivity in children has also been linked to bilateral cortical activity secondary to lack of interhemispheric inhibition.

Environmental Factors

Maternal lifestyle before, during and post birth have also been indicated in brain abnormalities which lead to ADHD traits. For instance, prenatal alcohol exposure is linked with disruptive, hyperactive and impulsive behaviours (D'Onofrio et al. 2007). Hyperactive behaviours were reported in connection with maternal smoking as nicotine receptors modulate dopaminergic activity which if disrupted, leads to emerging ADHD traits. Amongst other factors, low birth weight, birth complications and a diet low in omega 3 and 6 and low iron were seen in mothers of children who were eventually diagnosed with ADHD (Curatolo et al. 2010).

Symptoms of ADHD

Kapalka (2010) who mainly researched ADHD in men, clarifies that the diagnosis of ADHD is based on two behavioural dimensions, hyperactivity/impulsivity and distractibility. These are recorded through different clusters and impairment in either one (or both) is necessary for a positive diagnosis. Hence the diagnostic criteria of ADHD according to the DSM-V (2013, APA) suggests that ADHD is usually first evident in childhood or adolescence, with children who present with early onset demonstrate significant severity. The symptoms also progress into adulthood for a vast majority of cases (Laufer et al. 1957).

Diagnostic criteria of ADHD according to the DSM-V (2013, APA) are as follows. The DSM-V does not highlight any gender differences in diagnostic criteria. However, it separated final diagnosis into three categories: ADHD Combined Type where an individual meets criteria for both inattention as well as hyperactivity/impulsivity symptoms, ADHD Inattentive subtype where an individual only meets criteria for inattention, and finally, ADHD Hyperactive/Impulsive Subtype where an individual meets criteria only for hyperactivity and impulsivity symptoms. Case K described in this chapter was diagnosed as a child with ADHD Combined type; this is a typical presentation for a male child.

Inattention: Six or more symptoms of inattention for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of inattention have been present for at least 6 months, and they are inappropriate for developmental level:

a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities.
b. Often has trouble holding attention on tasks or play activities.
c. Often does not seem to listen when spoken to directly.
d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g. loses focus, side-tracked).
e. Often has trouble organizing tasks and activities.
f. Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework).
g. Often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
h. Is often easily distracted.
i. Is often forgetful in daily activities.

Hyperactivity and Impulsivity: Six or more symptoms of hyperactivity–impulsivity for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of hyperactivity–impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for the person's developmental level:

a. Often fidgets with or taps hands or feet, or squirms in seat.
b. Often leaves seat in situations when remaining seated is expected.
c. Often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless).
d. Often unable to play or take part in leisure activities quietly.

e. Is often "on the go" acting as if "driven by a motor".
f. Often talks excessively.
g. Often blurts out an answer before a question has been completed.
h. Often has trouble waiting his/her turn.
i. Often interrupts or intrudes on others (e.g. butts into conversations or games).

In addition, the following conditions must be met:

- Several inattentive or hyperactive-impulsive symptoms were present before age 12 years.
- Several symptoms are present in two or more setting (e.g. at home, school or work; with friends or relatives; in other activities).
- There is clear evidence that the symptoms interfere with, or reduce the quality of, social, school, or work functioning.
- The symptoms do not happen only during the course of schizophrenia or another psychotic disorder. The symptoms are not better explained by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Case K

Case K is a 36-year-old male. Other details of his identity will remain anonymous. He presented at a psychiatric hospital and was referred to me for CBT and behavioural interventions for anxiety, low mood and the backdrop of ADHD. K was diagnosed with ADHD Combined type in his childhood. This meant that he suffered from both inattention/focus as well as hyperactivity/impulsivity. Symptoms were evident since childhood as he struggled with hyperactivity, restlessness and an inability to focus and concentrate. K reached early milestones in crawling and walking and consequently was climbing and jumping off things with a poor assessment of risks. K's difficulties emerged significantly at school as he was unable to participate in classroom work. However, his high energy and risk-taking abilities allowed him to be a good athlete from a young age. K struggled to complete school, however remained involved in horse riding from the age of 7–10.

ADHD Versus ADD

A diagnosis of ADHD—Inattentive subtype implies that the person suffering only presents with symptoms related to inattention. This subtype is sometimes referred to as ADD or Attention Deficit Disorder. Brown (2005) noted that ADD symptoms followed a specific pattern of presentation. The key components of the struggles were seen through the following categories:

- Difficulty with activation involving prioritizing tasks, organization and difficulty with focus and attention
- Difficulty with sustaining efforts and shifting attention spans
- Difficulty with managing alertness, processing speed and sustaining effort
- Trouble regulating mood and in particular anxiety and worry
- Some difficulties with working memory
- Struggles with managing motivation for self-driven tasks and goals.

Several individuals who show signs of combined type ADHD during the childhood often only display ADD-like symptoms by the time they are adults. Hyperactivity is known to reduce in adulthood as individuals learn to manage their traits of restlessness and may have developed compensatory strategies. K clearly fit this description and was able to sit still and show no signs of hyperactivity during therapy sessions. However, his sense of restlessness was internal as he often became caught up in a fast-paced mind or an intense sense of frustration. K's difficulties with impulsivity remained through his adulthood. However, the impulsive behaviours changed form. For instance, as an adult, he was no longer in trouble due to disruptive climbing, but he engaged in gambling impulses leading to financial chaos.

An interesting parallel between ADD and what may feel like depressive symptoms is important to distinguish. Since both ADD and depression leave an individual with attention, motivation and memory issues, it is easy to confuse the two diagnoses. ADD is also known to be more prevalent in females with a "dreamy disposition".

Gender Difference in Presentation of ADHD

Boys with ADHD are three times more likely to be diagnosed with ADHD than girls. This is attributable to subtle but important differences in how it may present in girls versus boys. The symptoms in girls are less obvious and they may not fit the common stereotypes of being disruptive and difficult to manage in their behaviours. The tendency for girls to internalize their energy into anger, pain and inverted inattention and restlessness leads to a different presentation from boys. This was noted in by Hinshaw and Scheffler (2014) in his book The ADHD Explosion. He stated further that the internalization of their difficulties also makes girls more susceptible to self-harm and other self-injurious behaviours. When left untreated, girls may encounter difficulties with adjusting and also show an increased risk in chronic fatigue, anxiety, low self-esteem, substance misuse, eating disorders, anxiety and depression.

Falling Between the Gaps—When Traits and Symptoms Are Moderate

Children may be misdiagnosed with a learning disability such as dyslexia when they may actually be suffering from processing difficulties due to ADHD. However, as their symptoms are not very evident, the risk of misdiagnosis is high with moderate symptoms. Moderate symptoms become evident as the academic demands on an individual increase, hence they may only be diagnosed during early to late teens. Symptoms may also become complicated by secondary issues such as low self-esteem, low mood and anxiety as the individual may have had to cope with symptoms without the right method of help. This is unlike Case K whose difficulties were present from early school and identified as behavioural disruption quickly at home and school.

Assessment and Diagnosis

The 2008 National Institute of Clinical Excellence (NICE) guidelines state that that the assessment and diagnosis of ADHD should consist of psychometric scales as well as a structured interview focussing on all psychosocial aspects of development and life. The guidelines recommend the use of scales developed by Arcia and Conners (1998), Barkley (1990) and the Brown Scales (2005). These are cross-referenced with the DSM diagnostic criteria and provide a comprehensive assessment of symptom presentation in order to aid a treatment plan. A thorough assessment and formulation of symptoms reduces the risk of misdiagnosis. This is especially important as the medication for ADHD can pose high risks in the absence of symptoms.

Pharmacological Treatment for ADHD

The 2008 NICE guidelines chart the role of drugs for the treatment of ADHD. Clear guidance on prescribing is provided for psychiatrists. Medication for ADHD is prescribed either as immediate release preparations, or modified release which have longer effects. Common preparations used are methylphenidate (Ritalin), atomoxetine and dexamfetamine in children and adults.

The treatment of ADHD focuses on the use of stimulants such as Ritalin to improve performance at school and home. Research supports the use

of medication, however it has been observed that patterns of instability in behaviour and performance are not fully resolved through medication. For instance, Retz and Retz-Junginger (2014) found that Ritalin, which is widely used to treat ADHD, did not produce an adequate response in all patients. Fisher (1990, cited in Kapalka 2010) noted that despite medication, adults continued to show emotional issues and dysfunctional patterns of interaction.

Overall, medication targets the specific areas of the brain called fronto-subcortical circuits, and dysregulation of noradrenaline and DA neurotransmitter systems. Contrary to the common misconception that Ritalin and other ADHD medications suppress energy, ADHD drugs regulate the activity of noradrenaline and DA neurotransmitter systems. Medication also increases DA signalling. Dextroamphetamine for instance increases the synaptic activity of DA by increasing the release of the neurotransmitters into the synaptic cleft, decreasing reuptake back into the presynaptic neurons.

Barkley in 2000 presented a commentary on the concerns with the multimodal treatment study of ADHD (Multimodal Treatment of ADHD). The MTA study was known as a landmark in the history of treatment research for ADHD. It evaluated the combined treatment approach for ADHD that included medication and behavioural approaches. However, Barkley in his commentary highlighted that the psychological treatment approaches for ADHD required more attention and formulation.

Safren et al. (2005) described the essential components of cognitive behavioural approaches (CBT) including psychoeducation, organization, distractibility, problem-solving, adaptive thinking and relapse prevention. Toplak et al. (2008) highlighted the benefits of behavioural and cognitive interventions. However, Chronis et al. (2006) highlighted that despite vast literature supporting medication, the clear need for behavioural interventions, including parent and teacher training, was identified. More recently, Chacko et al. (2014) concluded that neurocognitive and skill-based treatment shows higher efficacy for ADHD. Raagi and Chronis in 2014 highlighted that "stimulant medication, clinical behaviour therapy and classroom behavioural interventions" have a profound effect on symptoms. Finally, Sibley et al. (2014) stated that a combination of stimulant medication and behaviour therapy produce greater overall benefits on measures of impairment.

There is literature on the use of psychopharmacological, neurocognitive and behavioural interventions for treatment in children and adolescents. Safren et al. (2005) offer a breakdown of treatment interventions for adults, but comparability of behavioural interventions for adults compared to those for children needs further research.

Despite his struggles, K was an extremely talented athlete and a professional jockey at a very young age. He was referred by a consultant psychiatrist at the age of 31. K had been stable on medication for ADHD and he had decided to engage in therapeutic interventions in order to manage co-morbid anxiety. At presentation his symptom list included anxiety, worry, tendency to misuse alcohol, distractibility, poor memory, impulsivity (impulsive purchases and spending money, gambling), ruminative thoughts, sleep disruption, procrastination, avoidance of tasks and difficulty engaging in administrative tasks leading to financial disorganization. Treatment for K started through focusing on a formulation and psychoeducation about ADHD. Considering that K was on prescribed medication, it could be argued that it would help in the management of some symptoms—mainly motivation, drive, energy, sustained focus, anxiety and ruminations. Brown (2013) highlighted that medication helps patients build psychosocial interventions but does not completely take away all symptoms. Studies by Ramsay and Rostain (2008, cited in Brown 2013) and Safren et al. (2005) found that a higher percentage of participants responded better to combined treatment.

Cognitive Behavioural Modification Model—Managing ADHD

Behavioural therapy and pharmacological treatment have both been shown to benefit ADHD patients. A longitudinal study of the efficacy of different treatments (an intensively monitored medication program, behavioural therapy, combination of medication and behavioural therapy or treatment as usual by community care) showed after 8-year follow-up that all four of the original treatment groups had a similar outcome: all showed improvement in comparison with pretreatment baseline scores, but none demonstrated superiority [58].

The National Institute of Health (NIH) based in the United States, published a key paper in 2008 by Knouse et al. reviewing psychosocial treatments for adult ADHD. The paper provided a summary of psychosocial interventions used mostly as an adjunct to stimulant based medication. Knouse et al. reviewed and compiled a table of empirical studies conducted from 1999 to 2008, including Safren et al. (2005) and Raggi and Chronis (2006), for the evaluation of treatment of adult ADHD. Their review highlighted that structured CBT were helpful in addressing functional difficulties, as seen in case K, who was able to improve daily management of structure and tasks. Psychosocial approaches were generally seen to help more with inattention symptoms than hyper-activity-impulsivity symptoms. However, the studies reviewed by Knouse et al. were all noted as "uncontrolled" or "small randomized trials".

The key issue highlighted by the Knouse et al. (2008) review was that studies evaluated were based on multimodal treatment interventions, i.e. psychopharmacology and psychosocial interventions. Hence it questioned whether psychosocial interventions would significantly impact core symptoms without the use of medication. Thus more research is required to see if cognitive behaviour therapy (CBT) would be effective as a standalone treatment intervention for individuals who are not prescribed or will not take medication.

Case K had stabilized on medication, but this was not enough to address psycho-behavioural and emotional issues caused by the difficulties with ADHD. Case K's significant struggle and complaint throughout the process of therapy was his inability to form meaningful structure and routine that would help him achieve adequate levels of intellectual stimulation and emotional activation. This was seen from the start. Psychological interventions were aimed at neurobiological symptoms—poor attention, disorganization, focus, memory and managing emotional frustration as well as behavioural and emotional difficulties. A review of Case K's treatment has been divided in six components based on the Brown's 2005 model of symptoms.

From the model, it was evident that motivation and drive, commonly referred to as activation in relation to ADHD, was an important concern for K. For example, he struggled to organize tasks and give priority to important chores. Building focus and maintaining it was another significant issue for K. Anxiety and frustration due to difficulty in managing tasks was expressed. K's tendency to ruminate and worry meant that anxiety was perpetuated. Impulsivity was more a concern when he was younger. Treatment for case K may be understood through the six components described below.

Component 1—Organizing, prioritizing and activating to work

Interventions used—Awareness of symptoms and difficulty with executive functions was increased through psychoeducation. Behavioural interventions were: maintenance of chart/log to monitor activation levels which generally describes low energy in the morning on a daily basis, engage in daily scheduling through the use of diary and timetable, learn and employ prioritizing skills using hierarchy of importance model, learn and employ problem-solving skills and engage in exercise or physical activity in the morning.

Patient response and outcome—Case K understood why organization was a struggle for him and how it manifested. Although K made progress in daily diary and appointment management, he struggled to fully implement a meaningful structure. K understood why he suffered from poor activation. When he was able to engage in exercise, he noticed an improvement in his feelings.

Component 2—Focussing, sustaining and shifting attention to tasks

Interventions used—Psychoeducation around executive functions of focus and attention continued. Other interventions used for this goal were a combination of behavioural and cognitive.

Component 3—Regulating alertness, sustaining effort and processing speed

Interventions used—Awareness of sleep hygiene and regular nutrition was built through psychoeducation. Other interventions were based on behaviour modification. For instance case, K was encouraged to build behavioural activation which is building activities that have a hierarchy of increasing re-enforcement when completed. Case K was encouraged to build healthy behaviours around exercise, sleep rituals and regular eating.

Patient response and outcome—K understood how low levels of dopamine were responsible for poor motivation and difficulty in sustaining efforts.

Component 4—Managing frustration and modulating emotions

Interventions used—Build awareness of emotions, thought rumination, viscous trap of worry and anxiety, CBT-based understanding of negative thought processes on emotions. K was encouraged to catch worry before it turned into anxiety.

Patient response and outcome—K was able to hold awareness of worry and ruminative thought patterns. Sometimes, he was able to defer these or defuse worry through the use of behavioural distraction.

Component 5—Utilizing working memory and accessing recall

Interventions used—Use of diary to log tasks, reminders.

Patient response and outcome—K had not initially highlighted a major issue with memory, but benefitted from diary keeping and reminders.

Component 6—Monitoring and self-regulating action

Interventions used—K was encouraged to stick to the behavioural plan to build in an automatic way of managing routine.

Patient response and outcome—K continued to struggle with building a meaningful pattern of work and stimulation. This remains an ongoing goal and will augment his recovery and quality of life.

Case K was helped to learn about his symptoms. However, some areas of his functioning remained difficult for him. He was unable to organize a sustainable and meaningful routine and structure. He struggled with low activation levels and hence found mornings difficult to get started. He also suffered from poor activation which impeded progress as he was unable to feel driven with what was required to implement. Despite the cognitive knowledge of how to improve, it appeared that Case K knew what needed to be done but had a hard time "doing" it (Ramsay 2011).

Depue et al. (2015) found that several areas of the brain are linked to behavioural struggles in ADHD, such as prefrontal cortex, dorsal striatum, ventral striatum, posterior cortex and cerebellum. Poor brain activity of these regions leads to compromised attentional control. If K was not taking any medication to help with neurobiological processes, his ability to engage in behavioural interventions would have been further compromised. A study based on the use of Stroop test to demonstrate direct attention and activity of brain regions found that direct attention helped with proactive goal attainment and maintenance of motivation (De Young 2014). Thus behavioural tasks can help in tasks such as timetabling, mindfulness-based task completion and structured activities broken down into small components (similar to the Stroop test). This would improve core symptoms of ADHD.

Case K's progress demonstrated a significant difficulty in "doing". Wu et al. (2012) published a meta-analysis of the role of dopamine receptors in ADHD and found that low dopamine was responsible for poor motivation and behaviour maintenance. In Simchon et al. (2010) established that when spontaneous hypertensive rats were used in an animal model of ADHD and administered methylphenidate, amphetamine-induced dopamine was released. Simchon et al. concluded this was transferable to change factors in neurobiology for humans. Case K's struggles to motivate and sustain behaviour appeared attributable to the lack of amphetamine-induced dopamine. This may have maintained poor motivation and consequent struggle to transfer cognitive understanding of issues into behaviour change. Case K would come back week after week complaining of drop in motivation and drive, despite the fact that we addressed cognitive blocks to build behavioural change. Sometimes poor sleep and external stressors such as uncertainty of routine contributed to this struggle further.

Brown (2013) confirmed that impairments in ADHD did not change through didactic instruction. K presented with a similar dilemma. Whilst he understood cognitive challenges and cues, he was unable to implement changes. Behaviour modification was key to progress. When he was unable to "do" enough to change his structure and routine, he continued to struggle with poor motivation and drive, particularly in the morning.

In each area of impairment, a cognitive understanding was not enough to address symptoms. This is best illustrated through his struggle with attention and focus on tasks that did not interest him. K promptly implemented a "diary management and task list" and was able to notice a positive impact on his ability complete to tasks. However, he did not sustain this technique over time, and it resulted in unresolved internal restlessness and a drop in motivation.

Treatment with case K utilized interventions to help with daily management of time and routine. He was encouraged to maintain a diary and use planning and prioritizing skills to manage daily affairs. These interventions required both cognitive restructuring and behaviour management as they targeted areas of executive functioning. Barkley et al. (2011) studied executive functioning deficits in five dimensions of daily struggles (self-management to time, self-organization/problem-solving, self-discipline, self-motivation and self-activation/concentration), and work with case K addressed these areas. The use of diary keeping and self-cues addressed self-activation and concentration issues. Techniques relying on simple step-based instructions that case K was able to apply helped in completion of mundane and boring tasks. Information sheets and handouts describing these techniques were provided to aid implementation. Barkley et al. (2011) demonstrated that individuals with ADHD required higher levels of cortical activation in order to sustain attention. Case K confirmed that the more he engaged in completing tasks and used self-cues in a deliberate manner, the more engaged and attentive he felt towards a task. For instance, case K eventually reported back that he was able to work a project that involved various IT and administrative tasks assigned to him by a friend's mother.

Case K struggled with sustaining effort which requires self-discipline and self-motivation. This was specially seen when he was not stimulated and interested by his engagement in tasks or daily routine. Case K also struggled with self-regulation in sticking with plans and sleep routines. It was noted that whilst case K complied and agreed with plans, he was unable to implement them. Kapalka (2008) in a study based on management of behaviours in out-of-class settings for school children, highlighted the use of behaviour management to improve self-regulation. The study utilized Barkley's (1997) model of positive re-enforcements and token economies to help children improve their out-of-class regulation. Although Barkley's concept of "motivational anchor" was utilized, case K was unable to improve self-regulation. Motivational anchors encourage adults to explore benefits and gains from change and use these to build further motivation.

Motivational interventions such as daily exercise to improve energy levels and daily routine stated in appeared helpful for self-motivation in case K. A study of boys administered focused behavioural motivation interventions found reduced symptoms (Curtis 2010). It was observed that when case K was able to engage in a balance of achievement and pleasure activities, he described an increase in sense of motivation. This was particularly noted whilst he was away on holidays involving physical activity such as skiing.

A key barrier aspect of building quality to case K's quality of life remains around avoiding lapses into "not doing much". Consequently, treatment looked at building reminders and internal self-cues. Alderson et al. (2013) examined central executive and storage rehearsal processes in individuals in ADHD and confirmed a trajectory of working memory deficits related to ADHD. Continual repetition and reminders appeared to help case K. However, it was also noted that if case K did not attend therapy regularly (such as during holidays) he found it difficult to maintain and build upon progress.

Finally, the management of ruminative thinking, dealing with worry and regulation of emotions was an important part of treatment. Case K was helped to learn about the nature of worry. Cognitive restructuring and cognitive diffusion techniques were used. Case K reported back his observations of emotional states and thoughts each week. He complained of anxiety and worry

during the initial periods of treatment. However, as he began to build a meta-awareness of his thoughts and cognitions he became adept at managing worry and interrupting anxiety. We used Beck's (1976) model of managing worry and unhealthy thought processes.

At the time that this chapter is written, Case K continues to address his need for a meaningful yet attainable routine and structure. This pursuit has highlighted significantly the need for higher stimulation in order to convert impulsivity driven through adrenaline into productive hyperfocus and engagement with tasks and life. Hyperfocus describes extreme, deep and intense concentration. Case K's background as an athlete provided him the forum for such stimulation and he continues to experiment with how to establish this into his daily life. It is to be highlighted that whilst this remains the only part of his journey into a more fulfilled life, his strengths that are attributable to his personality as well as ADHD require celebrating. His hyperfocus in therapy has aided his path to recovery, and his compassion appears at the heart of his success in various aspects of life.

Tips and Tricks for Parents and Partners

ADHD can have a significant impact on relationships with parents and partners. Some symptoms of ADHD lead to difficulty in functioning well within the family environment, often causing stress. Trouble paying attention to conversations, being forgetful and disorganized can lead to conflicts with others. Impulsive behaviours present as a key challenge for family members and partners. This includes losing tempers and engaging in harmful behaviours with consequences for the family to face. Case K was very aware of the impact of his ADHD symptoms on key relationships. Fortunately, he shared a supportive relationship with his mother who formed a significant source of support through his struggles with impulsive gambling.

Parents and partners can help and support by implementing simple things. Recognizing how ADHD manifests in the relationship and trying to be empathic about symptoms is essential for family members. Open and face to face communication or a specific time to "sit down" and address helps. Lifestyle management through nutrition, exercise, reasonable structure and routine helps in reducing any stress that can compound poor activation and impulsivity. Parents can help their children by implementing simple techniques to improve attention. Exercises for cerebellar stimulation such as balancing on a wobble board, standing on one leg and core & centering exercises can also be of help. Using humour to manage misunderstandings and recognizing the strengths that come with ADHD can sometimes help relationships.

Love Your ADHD

Finally, in neurodevelopmental disorders such as ADHD, although there are areas of struggle originating from neurodevelopment of the brain, this might also lead to clear strengths which are unique to ADHD. In a study examining the evolutionary context of ADHD, Eisenberg and Campbell (2009) state that hunter-gatherers show traits such as unpredictable behaviours, crucial in protecting our ancestors against livestock raids, natural calamities, etc. This suggests an evolutionary advantage of ADHD-type characteristics, and the importance of neurodiversity to survival. Individuals with ADHD should begin to connect and identify with these in order to actualize their potential. For instance, hyperfocus of ADHD sometimes provides great drive. Also, although they might have social difficulties, individuals with ADHD often have a charming personality with a generous spirit and ingenuity. They often have a strong sense of fairness and justice. The symptom of impulsivity allows them to take risks where others may hold themselves back, which in some cases might lead to bravery. Many ADHD sufferers are enjoyable conversationalists. Humour and romance form other lovable attributes as well as their ability to motivate others through their warm and compassionate ways.

Conclusions and Further Implications

This chapter sets out an exploration and description of ADHD in men through the illustration of Case K. It provides a neurodevelopmental perspective to the aetiology of ADHD. Diagnosis and various subtypes are briefly described. Case K further highlighted the effects of medication as well as psychological interventions on core symptoms. The role of neurochemical and brain activation issues on executive functioning require medical management and are not manageable solely through psychological interventions. Effective components of treatment were the behavioural interventions namely—activity and daily scheduling, diary management, prioritizing, problem-solving, sleep routines and using a stepped approach to goals, i.e. implementation of "baby steps".

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Autism in Boys and Girls, Women and Men Throughout the Lifespan

Patricia van Wijngaarden-Cremers

Introduction

Autism Spectrum Disorder is the current name of a clinical syndrome. It is characterized both by two important communalities and at the same time an incredible variety of clinical pictures that in each individual changes over the lifespan.

The communalities, the Triad of Wing, were named after a research pioneer in the field of autism, Lorna Wing, who was an eminent clinician, scrupulous and perseverant scientist and mother of a daughter with pronounced autism. The seminal characteristics were included in the Triad of Wing that form(ed) the backbone of the DSM and ICD classification systems:

1. Impairment in the quality of social interaction (later named "in the development of social reciprocity").
2. Abnormalities in the use of speech (later: Impairment of development of language and communication).

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3. Elaborate routines, overall patterns of interest and abnormalities in symbolic imaginative play (later restricted patterns of behaviour and interest and repetitive stereotypies.

In the most recent classification, the DSM 5, the first two dimensions have been merged because research showed that they are indiscernible: one cannot imagine having greatly impaired social relationships with normal speech and communication skills and vice versa.

In first instance this Triad of common dimensions in autism was distilled from the analysis of the cases Lorna Wing and her colleague Judy Gould (1979) found when making a cross-sectional study of the population of the London borough Camberwell (with roughly 100,000 inhabitants). This marked a turning point in the history of autism after decades of parental blaming after the two independent and seminal papers in the 1940s by Leo Kanner (1943) and Hans Asperger (1944). In retrospect Kanner and Asperger described children that all had the syndrome of what we now call Autism Spectrum disorder. They seemed to have described two sides of the same coin. Kanner's patients (mainly boys) were aloof in their social interactions and had either no speech, or abnormal speech e.g. direct or delayed "echolalia" (repeating what had just been said, directly or after some time, out of the context). Kanner's children had a pronounced developmental delay, with sometimes surprising islands of abnormally brilliant functioning (especially in the area of memory or routine computing). Finally they had very good visuospatial skills and demonstrated strong motor stereotypies despite pronounced motor handiness. Asperger by contrast described only boys that were passive or active, but odd in none reciprocal social interaction; their language skills were elaborate, but only used for one-sided conversations. They were intelligent though often disharmonic in their profiles (high verbal scores versus poor performance scores) and very clumsy when it came to their motor skills. At first glance very different, but both described under the term "autistic": Kanner "Autistic disturbances of the social affect", Asperger "Autistic psychopathy".

Developmental (Psycho)Pathology

An important notion is that autism spectrum disorder is a developmental disorder. So before looking into the developmental aspects of the clinical presentation and its pitfalls, let us take a closer look into developmental disorders as their mechanism is of importance for understanding autism

spectrum disorder, its potential causes and what affects it causes during the lifespan.

Dante Cicchetti and the late Cohen's (1995–2016) books on developmental psychopathology offer an important insight in the underlying mechanisms of development. Development in humans can be conceived as an ongoing transactional process of interplay between nature (the genetic material at the conception) and nurture (all psychological and social influences). Gender is an interesting third dimension. On the one hand gender is a biological fact. This is an important determinant of behavioural and emotional coping strategies and reaction patterns. Also parents play an important role as they act and react in a different way to boys as compared to girls. In the case of autism this translates as follows: biologically (as an evolutionary outcome) females are more social than males (Brody 1999). Thus even in autism, girls will try harder to get in contact with others. Externalizing behaviour (angry and aggressive) as mostly displayed by boys, is far more challenging and difficult to manage for parents and teachers than internalizing behaviour (shy, withdrawn and anxious). In a later paragraph we will see that such differences may act as masking factors that delay the diagnoses ASD in girls as compared to boys. Thus gender is an important component in the developmental interplay (van Wijngaarden-Cremers 2015).

So what about nature? Each individual starts off with a unique genetic material wrapped up in forty-five chromosome pairs and in addition two sex chromosomes (XX for females XY for men). The genes are the genetic codes spread out over the chromosomes. Yet as from the first cell division after the conception, external influences play a role, and so do accidental miscopies during the incredible cell proliferation throughout embryonic and post partum life. This implies that even identical twins, despite extremely strong alikeness, will as from the conception develop in very different ways. The likelihood that they will have the same features or develop the same conditions is called "concordance". For many physical characteristics, the concordance between identical twins will be 100%: this holds true for the colour of their eyes, their skin complexion etc. When it comes to communicable disease the concordance rates drop dramatically. For most conditions, such as cardiovascular diseases, diabetes, high blood pressure, depression, schizophrenia and anxiety, the concordance levels are below 50%. Interestingly for neuropsychiatric conditions such as Attention Deficit Hyperactivity Disorders the concordance is well above 50%, and for autism spectrum disorders it attains its highest with 90%. Thus it can be said that it is not the disorder that is inherited but there is a heightened vulnerability to developing a disorder. The development and course of the condition into an

impairing disorder is complex because along with genetic vulnerability, different external factors play an important role as from conception. This creates difficulties for the predictive validity of ASD measures (Fig. 1).

The first level is the genotype (the genes). Between that level and the phenotype (how the person presents in social encounters), a number of "hidden" levels can be discerned.

The second level is that of the "epigenetic" alterations of the genetic make-up. The genetic expression can be altered by "mutations" (small changes in the coding). These mutations can occur just by chance (spontaneous mutations), by transcription errors or caused by external toxic agents (radiation, infections, drugs, hunger). Thus the vulnerability for e.g. autism can be innate or acquired.

The (epi)genetics determine embryogenesis. This process is a speedy individual pathway from protozoa, via a fish stage to a little human after twelve weeks. In this first trimester of the embryonic development the "wiring" of the brain occurs through differentiation and migration of neuronal material. Obviously during these weeks the development is extremely vulnerable to external agents as defined before. It is known that rubella can have a lasting effect when the maternal infection occurs around the 7th–8th week of gestation.

The brain is a dynamic organ and its functioning is highly interactional e.g. every human being is born with a capacity for developing language and

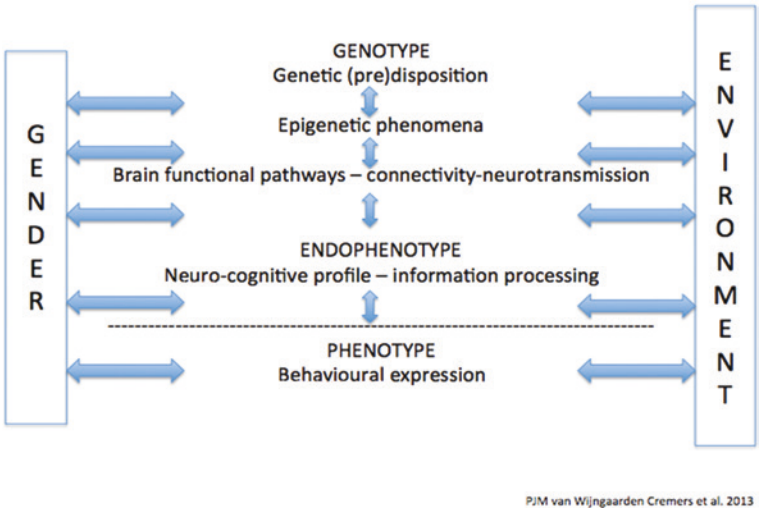

Fig. 1 The interplay and the cascade of developmental features

speech, but these parts of the brain will only develop if there is hearing perception and auditory input. A large body of research into structural causes of autism has yielded only few consistent findings, namely significantly bigger brains and fewer Purkinje cells in the cerebellum (Hampson and Blatt 2015). Both these findings can be related to less efficient information processing. More recently, new brain imaging techniques have revealed that in autism more primitive connections (local connectivity) remain active whereas in typical individuals the brain gears up to far more efficient information processing modalities that enable quick and flexible adaptation. In autism the rigidity in behaviour and habits can be explained by their brain sticking to slow, and far less efficient information processing strategies especially in the social domain. The impaired social information processing shows also in deviant profiles of neuropsychological functioning. Firstly, the overall level of functioning as measured by IQ tests in ASD shows a broad variation (ranging from severe learning disabilities up to scores far above the average). But in nearly all cases the profile of the intelligence is highly disharmonic, with roughly two extremes: in the more Kanner type individuals with autism the verbal IQ is far lower that the performance IQ whilst in those with the more Asperger type of autism, the contrary holds true.

How do these disharmonic profiles translate into neuropsychological abilities? In at least three domains of neuropsychological functioning, individuals with ASD show poor performances (Rajendran and Mitchell 2007):

1. The Theory of Mind refers to one's capacity of understanding others' minds and being able to inhibit one's own point of view to take into consideration the other's perspective. A vast body of research shows that individuals diagnosed with autism, regardless their overall ability, are slower in developing this capacity and often never really get it right.
2. The Central Coherence refers to an individual's capacity of discerning crucial details from irrelevant features and of seeing the global picture instead of a multitude of details. Here again individuals with autism, characterized by their strong "local connectivity" as described earlier, tend to latch onto details and have difficulties in getting the overall picture right. So where typical individuals get the whole picture at glance and may focus on details in second instance, individuals diagnosed within ASD tend to proceed the other way round (they focus on all the trees and it takes them time to realize that all these trees together for a wood/forest).
3. Executive Functions: this is the overarching name for capacities steered by the frontal lobes of the brain that enable individuals to plan and organize their behaviour and adapt to changing circumstances. By just defining

this neuropsychological asset, it becomes clear that individuals with diagnoses within the autism spectrum will have great difficulties with these. They tend to be rigid, detail focused and incapable of anticipating others minds and actions. This makes them anxious because they cannot anticipate much of what happens to them.

Does This Insight into Developmental Psychopathology Reveal Solid (Biological) Markers for Autism Spectrum Disorder?

So does this view of developmental psychopathology help us to identify underlying markers of ASD? Many researchers had hoped for that to be true. Every time an abnormality was found to be thought specific for autism, this finding was followed by disappointment. Deviant patterns can be discerned, but at the current stage of our knowledge these factors are by no means specific to autism or any other form of (developmental) psychopathology. A deviant gene is by no means specific. The same genetic vulnerability can express itself a series of seemingly unrelated conditions, as for example autism, schizophrenia, depression, bipolar disorders, ADHD etc. Likewise the dysfunctional connectivity patterns found in individuals with autism that distinguish them significantly from normal controls and individuals with learning disabilities are by no means specific for autism but can be found in the other disorders listed here above and even in healthy individuals. The same holds true for the neuropsychological dysfunctions.

So further understanding of the impact of environmental factors is crucial in order to understand why specific vulnerabilities can lead to such different outcomes in a clinical sense. Understanding the impact of gender is crucial too. We know (van Wijngaarden-Cremers 2015) that under the same kind of environmental stress, males will tend to develop very different pathology than females e.g. men will react with high blood pressure, gut problems or a lowered threshold for infectious disorders, whereas women will develop depression and/or autoimmune conditions (Goel et al. 2014).

In summary, in the field of development of non-communicable diseases many questions remain still to be addressed. At this stage we must conclude that there is no construct validity to underpin the diagnosis of autism spectrum disorder. The predictive validity is weak (in terms of predictable outcome). Although the "face validity" of a distinct clinical syndrome is very strong (Lord and Jones 2012), but the clinical expression of impairments in

terms of clinical symptoms is very broad. In the next paragraph we will look into this diversity along a series of different dimensions.

Differences in Phenotypical Expression in ASD

In the previous paragraphs we have made it clear that ASD is a complex developmental disorder. It can be perceived as a definite clinical syndrome with a large range of symptomatic expressions along the dimensions that define it (Triad of Wing). We have also seen that the symptoms can vary in their expression according to gender and change as development progresses. In this paragraph I will discuss the different types of clinical expression and underscore in each of the gender differences and changes of time as far as known.

Which are these dimensions? Wing and Gould (1979) defined a series that still prove helpful when assessing patients:

1. Impairments of Social Interaction.
2. Impairments of communication.
3. Impairments of Imagination (better translated as "of Thinking and Behaving").
4. Abnormal responses to stimuli.
5. Extreme emotional expressions and inadequate behaviours.

1. Impairments of Social Interaction: originally three expressions were distilled from the big group of individuals in the Camberwell Study (1979) (aloof, passive, active but odd). Later "over-formal and stilted" was added.

- The "*aloof*" expression is the first group of impaired social interaction: according to the Oxford dictionary the adjective "aloof" refers to conspicuously uninvolved, cool and distant. The term was first used by Leo Kanner to describe the deviant quality of the affective contact. Aloofness is for many lay people the main characteristic of autism. But in autism research it is generally only seen in very young children. As it is a prominent and impressive feature it is obviously one of the first signals that raises concerns and signs in detecting autism in very young children. For parents "aloofness" in their baby is puzzling and frustrating. Oftentimes these children are suspected of having severe visual of hearing impairment, as they do not seem to react at all to their environment. Frustrating for parents mainly in the sense that it puts them off. Studies (Dawson 2008; Wan et al. 2012; Green et al. 2015)

have shown that there is a limit to parents stimulating verbal engagement if their child does not respond and encourage them by responding with attention and eventually a rewarding smile or laughter. Avoidance of eye contact fits into aloofness. These children do not respond to spoken language, do not engage into joint-attention and seem utterly insensitive to cuddling. They are often described as living in a world of their own. Fortunately "aloofness" tends to fade away during the natural course of development in which even children with pronounced autism and marked initial aloofness seem to "defrost" and become more open to contact.

In terms of *gender*, aloofness is associated with extreme autistic aloneness encountered in very young children, and especially girls with a pronounced developmental delay. In high-functioning ASD girls and women it is seldom seen, as they tend to be more eager, though clumsy in trying to engage in social interaction.

In terms of *development*, "aloofness" tends to fade away, but can persist in association with (marked) learning disabilities (Wing 1996; Beadle-Brown et al. 2002).

- The "passive": This variant is characterized by the fact that the individual themselves does not engage in social contacts, but may open up and engage in some interaction if cautiously and adequately approached by adults that manage to keep the stress levels low. In these children the gaze avoidance is lesser, they may eventually make eye contact and engage in joint activities. These activities are mostly more in parallel than truly interactive and in a reciprocal way.

  From the point of view of *gender* the passive disengagement in girls is often misperceived as "shyness". Being shy fits into the perception of girls by parents. Parents with daughters that are "passive" tend not to worry as much as parents of boys with the same type of behaviour that are alarmed by the lack of initiative that they attribute to boys.

  In terms of *development* the "passive" expression fits into the "natural" course of development. Often aloof children, turn into passive at the end of their childhood and often become "active but odd" as adolescents and adults. It is often this changing variation of awkwardness in social interaction that makes them seem so very "different". The late Sula Wolff (1995) described this condition extensively in a book on her studies of this group under the well-chosen title "Loners".
- The "active but odd": This variant of impaired social interaction seems a kind of paradox. Why? Because people with this "active but odd approach" do make contact with others but their approach is blunt and

inappropriate. They may approach others with questions that may look impertinent. Or tell unasked stories about their interests of preoccupations. The inappropriateness lays in the fact that their approach is one-sided. There is no mutual reciprocity. The eye contact may be poor, or often too prolonged. The oddity may extent to shaking hands or hugging too hard. In *females* this may wrongly be interpreted as a desire of opening to sexual intimacy, which can make them vulnerable to abuse.

- In boys it may also be complicated; let us illustrate this with a clinical case:

> Ivan is the only child born to his parents who were already older when he was born. His then 62-year-old dad was a successful banker with a touch of eccentricity, whereas his mother was a teacher in Latin and Greek. They met at a computer hobby group. For both it was the first really meaningful relationship. As a boy Ivan was fascinated by vinyl disks with displays on them and his parents indulged this peculiar hobby and travelled great distances to attend auctions. At elementary school he was strangely popular because he knew every thing and could talk about it in an entertaining way. He played the clown to make people laugh at his clumsiness. Basically he was a loner that was handy at computer hacking as from a very young age. As an adolescent he ran into trouble on various occasions because he assaulted girls and women sexually, ignoring in a most indecent way what they said or did, merely following his sexual urges and gaining great satisfaction from this indecent behaviour. As a student in informatics he would show off by hacking a big company or a bank. When he hacked the headquarters of N.A.T.O by means of curiosity, he was arrested. During the trial he pretended being a spy. In prison he was finally diagnosed with autism. Strangely but partly understandably he loves being in prison, and as soon as he is released does anything, from hacking, to robbing violently without any remorse elderly people, in order to be able to return to prison. His recurrent behaviour is a nightmare for his mother and an inextricable puzzle for professionals.

This case illustrates several aspects of ASD in boys and men. First case of elder parents: It appears that autism occurs more frequently in elder fathers but also mothers. Often these parents tend to be more indulgent towards the behaviour of their little boy, who in consequence is insufficiently corrected, when he with his odd behaviour violates other children's boundaries. Secondly the lack of empathy of a male with autism can influence in an awkward manner their attitude towards others, especially women and sex. Autistic men tend to report gaining more satisfaction from intimate relationships than autistic women. The latter tend to make wrong interpretations of men's desire, assuming that they long for an intimate relationship and not merely to use them for sex (Byers et al. 2013a, b). Finally in men

with ASD their potential "psychopath" like aggression and callousness that makes them to be overrepresented yet not always acknowledged in the incarceration system (BMJ 2016).

The "over-formal and stilted" expression is seen in individuals with autism that try hard to relate. Often girls and women show this very formal excessively polite way of interacting. They tend to stick to the rules of social interaction very hard, unfortunately without the result they hope for namely making acquaintances and friends. This style can also be seen in high-functioning men with a slightly pedantic style as described by Hans Asperger (1944) both in his patients, and their fathers. Asperger alluded to the fact that many of his patients had bright fathers, often professors in theoretical subjects. Baron-Cohen refers to the overrepresentation of engineers amongst the fathers of patients with Asperger's and confirmed this hypothesis by showing that in high-tech places like "Silicon Valley", his own university town Cambridge and Eindhoven the cradle of the technical multinational Philips the prevalence of ASD is much higher than in the general population. This led Baron-Cohen (2009–2011) to formulate the "autism as a defect of empathizing and the extreme male brain" hypothesis, with the complementary explanation that females with ASD had been exposed in the womb to higher levels of testosterone as usual.

2. Impairments of Communication.

In a number of very young boys and girls with severe autism and a marked developmental delay, spoken language may never develop. But in most individuals on the autistic spectrum there are peculiarities and oddities in "using speech" that should be noted:

- "Using speech"
  - Echolalia, repeating words or sentences immediately, or later out of the context, after the other has uttered them. This is a normal developmental feature in young children in their second year of life, when they acquire and practice spoken language. In individuals with ASD it may persist far longer, sometimes well into adulthood.
  - The phenomena of "delayed echolalia" may be misleading. Adults unfamiliar to the child can be in first instance amazed by the "adult like" elocution in young children that out of the blue produce the most beautiful sentences.
  - Another particularity in using speech can be palilalia. This is the involuntary repetition of syllables, words or phrases.

  - These three speech abnormalities occur often in people with ASD but can also be encountered in individuals with developmental delay, without autism.
  - Other speech peculiarities include: answering questions in a far too detailed manner. Or omitting "linking words" as e.g. 'because' or "joining words" that are part of the pragmatics of language and are necessary to help the other understand the context and sequence of what one wants to tell. In sum, individuals with ASD are not good at "tuning into the listeners' needs", a capacity that is utterly important in conversation.

- "Pragmatics". Using and understanding non-verbal communication. Along with using specific "linking" and "joining" words, pragmatics of communication include usage and understanding of facial expressions and gestures. Individuals with ASD lack both these pragmatic skills or may use them in a clumsy or unnatural manner. This holds true especially for girls and women.
- "Understanding speech". Most children with autism do develop understanding of spoken language, sometimes through additional visual cues or by singing instead of uttering. Difficulties may arise when words sound very much alike, but the biggest problems children and adults encounter with understanding language comes from the fact that they tend to stick to the literal meaning. They therefore experience great difficulties in understanding sarcasm and getting jokes.
- A variant to the previous point is the incapacity to lie or deceive, expressed in an extremely naïve honest way of telling.
- Pitch of voice and Intonation: modulation of tone and pitch are essential in human conversations. People with autism tend to express themselves in a monotonous and often loud and mechanical fashion.

3. Restricted, repetitive patterns of behaviour, interests, or activities, "Impairments of Imagination" and abnormal reaction to stimuli.

As in many of the differences in expression of symptoms of autism, when it comes to imagination it is either too little or too much. In individuals who lack imagination the problem is that they tend to take every thing literally and cannot anticipate, because they cannot imagine what is about to happen. On the contrary if they have too much imagination, they get carried away and imagine the worst. In both cases the normal function of imagination, that is to help anticipate what could happen and work through what has occurred, is missing. This was dropped as a separate domain as the

lack or overflow of imagination is best understood too as an expression of defective regulation of basic functions.

So before entering into details of the expression of the regulation systems, let us describe them and looking into gender differences in the process: in individuals with ASD we often encounter remainders of primitive affect regulation in very young children: flapping with excitement, rocking to sooth down, putting things in a specific order, special interests in particular topics car brands in boys and horses and ponies in girls. These activities are meant to regulate arousal: both stimulating when bored or to calm down when too excited or anxious.

Regulation of their arousal is a challenge that individuals with autism solve in two different but functionally linked manners. The first is through the soothing effect of:

- Motor stereotypies: these can vary from
  - Repetitive movements: like flapping, rocking, spinning one self or objects
  - Sticking to early childhood routines like smelling, tasting, bringing objects to their mouth.
  - Engaging in more complex ritual routines like placing object in lines or sorting them.
  - Getting in trance by listening to or watching spinning machines.
- Focusing and getting heavily preoccupied.
  - This can range from bizarre obsessions with dinosaurs, historical figures, nature, timetables and the weather, dates or clear operations like knowing all the prime numbers, or developing incredible multiplication or other mathematical skills.
  - In females the confusion can stem from the fact that their preoccupations are less bizarre and often near normal. In girls: horses and ponies, preservation of the environment, concerns about the future of the planet or involvement in (romantic) literature.
  - Preoccupations that were functional at a young age may in the course of development turn into dysfunctions, obsessions and compulsions after puberty. Sometimes preoccupations are not easily recognized. For example “transgender” feelings and ideations are far more common in

individuals with ASD than in the general population (de Vries et al. 2010). When looking into it more closely, the preoccupation with gender identity may reflect uneasiness with sexual maturation and identity in general more than the genuine feeling of living in the wrong body.

Abnormal response to stimuli.

This very important feature, described both by Kanner and Asperger and observed by Wing and Gould in the Camberwell study, was not included in DSM until DSM 5, and appears in one way or the other in nearly every individual with ASD.

- Hypersensitivity: people with ASD may be oversensitive to sound and noises (including some pitches of voice), light and colour, texture of clothing, interior design or architecture but also to being touched, cuddled, kissed or merely being looked at.
- Hyposensitivity: individuals with ASD can be (relatively) insensitive to heat and cold, but also to pain. This can lead to medically dangerous situations, when they sense no pain in life-threatening situations like appendicitis, injuries, burns or malignant diseases.

It may be extremely confusing when a person with autism has both hyper- and hypo-sensitivities e.g. the person that gets angry at every noise in the central heating system, can easily get scolded when taking a shower without noticing.

When even their "strange" arousal regulation systems fail to help them cope with situations that are stressful for them it is not unusual that they get extremely upset and experience extreme emotions (blind panic) or tantrums. ASD boys can become extremely aggressive and perform challenging behaviour towards objects but often too against people, in particular the most near and dear ones. In ASD girls/women this can lead to self harm and suicidal behaviour This behaviour in individuals with ASD is often misperceived by others and labelled as "challenging" or "provocative", whereas it is most often "reactive" to unexpected changes, confusion, or overload with stimuli. So the solution is to address both the behaviour and the environmental triggers to the behaviour. For example, the person with ASD that can be taught to signal hyper-arousal before it becomes overwhelming.

Late Diagnoses in ASD (in High-Functioning Individuals)

Clinical picture/vignette

Mary was 22 years old when she was first referred to our clinic. She had already had several unsuccessful treatments in addiction clinics before entering our clinic for the treatment of Substance Use Disorders (SUD), Post Traumatic Stress Syndrome (PTSS) and borderline personality disorder. She was addicted to heroin, cocaine and also used cannabis, ecstasy, speed and alcohol on a regular basis. She started using drugs when she was 14 years old. Her father had physically abused Mary. At the elementary school she had aggressive outbursts, which disappeared at the age of 10. At the same time a 16-year-old boy from the neighbourhood began sexually abusing her. Later, in high school, she also was sexually abused by one of her teachers. After detox, Mary was a very anxious, shy, chaotic, restless and clumsy young woman who had difficulties expressing her self in the group. Though she did not interact much with the group, she was not a real loner. The group members instantly liked her. One poignant habit of Mary's was to take showers several times a day. Both her shyness and her frequent showering were interpreted as a consequence of her history of sexual abuse. During her treatment in our clinic, we did not observe any symptoms to confirm the diagnosis borderline personality disorder. Due to her chaotic and clumsy behaviour, a hetero-anamnestic confirmed history of lifelong concentration problems and hyperactivity, we first performed a standardized clinical assessment on ADHD, which confirmed the presence of ADHD. For both ADHD and PTSD she received treatment according to our guidelines. Unfortunately, after a short period of improvement, her situation seemed to worsen: Mary became afraid of leaving the clinic and spent a great deal of time alone in her own apartment, avoiding the necessary steps to build up a social life. She became more and more anxious, with increasing insomnia and nightmares and coincidentally she developed more compulsive behaviour such as showering even more often and for a longer time than she did before. Moreover she developed a specific and strict ritual for showering. The staff observed these changes and felt increasingly concerned. On closer examination it appeared that she simply did not know how to live her life. She had gross difficulties in interpreting social situations. And new situations simply scared her off. Her lack of imagination made it impossible for her to anticipate correctly. It became clear why she had been so vulnerable for sexual abuse: she had misinterpreted the intentions of her abusers. She did not dare to say "no" because she thought that she had to comply to meet their expectations, and was also afraid to lose their friendship. Her history revealed that all these problems had been there as from her most early days. And finally after a standardized comprehensive assessment, according to the Dutch Guidelines, an ASD diagnosis was confirmed.

This vignette highlights that shyness and a variety of psychiatric symptoms may mask the ASD in women. Intelligent females with ASD appear to look carefully at what other girls of their own age do. They are eager to be accepted. And in order to achieve that goal they merely copy the other "girls'" behaviours. But whilst they think to act correctly they do not realize that all too often they miss the point. They misinterpret others' intentions which make them acutely vulnerable to (sexual) abuse. Finally it is not uncommon that they start taking drugs to overcome their fear for social encounters.

Missed and Wrong Diagnoses

It remains unclear why, in so many cases, especially in women, a condition as severe as ASD can be overlooked for such a long time. As children they go unnoticed. In adolescence problems will only start if the demands for social skills and flexibility reach beyond their capacities. Several studies showed that parameters such intelligence, a predictable environment, a series of comorbid psychiatric disorders such as anxiety, obsessive-compulsive disorders (OCD) depression or {micro}-psychoses (Kanne et al. 2009; Ragunath et al. 2011) and being female (van Wijngaarden-Cremers et al. 2014) can be considered to be "masking" factors with regard to their underlying autism.

Sometimes parents manage to cope with the ASD in their child by running very strict and well-organized households that provide enough structure in which they act as "help-egos" to their ASD child unintentionally compensating for his deficits and in the process masking the autistic disorder.

Comorbidity Patterns

Comorbidity is extremely frequent in autism spectrum disorders. Lifetime psychiatric comorbidity may range up 70–100% in patients with ASD (Rosenberg et al. 2011). These co-occurring conditions include both internalizing disorders such as anxiety, obsessive-compulsive, depression and mood swings as well as externalizing disorders such as ADHD, aggressive behaviour and disturbances in sleep and eating patterns (Rosenberg et al. 2011).

Anxiety disorders, for instance coexists with ASD in at least 30–50% of autistic subjects (Simonoff et al. 2008) in adulthood. This includes specific phobias (30%), OCD (17%), social anxiety disorder and agoraphobia (17%), generalized anxiety disorder (15%), persistent separation anxiety (9%) and panic disorder (2%) (Van Steensel et al. 2011; Kanne et al. 2009). The diagnostic confusion is caused by misinterpreting ASD problems in social reciprocity as "social anxiety", and ASD preoccupations as OCD (Kanne et al. 2009; Ragunath et al. 2011).

The frequency of depressive episodes in children with ASD appears to be extremely variable, with estimates ranging from 1.5 to 38% (including up to 10% of major depressive episodes). In contrast, the variation in prevalence of bipolar disorders is estimated only to be 2.5–3.3% (Ragunath et al. 2011).

Gender Differences

The prevalence of ASD is approximately 1% in the general population (Fombonne 2009). The overall sex ratio is estimated to be 4–5 males versus 1 woman (Baird et al. 2011). In individuals with co-occurring intellectual disability the sex ratio drops to 2:1 or tends to be equal, whereas women are grossly underrepresented in high-functioning individuals with ASD.

ASD may show a bimodal distribution in females: there is a group of severely impaired girls who are diagnosed in very early childhood. But on the other side there is a group of girls with milder or atypical symptoms that are overlooked until adulthood or often not diagnosed at all.

There is quite solid evidence that there is a specific female phenotype in autism representing severe cases of autism with co-occurring marked intellectual disability that subsequently are diagnosed early in life (Ozonoff et al. 2010; Rivet and Matson 2011). Several studies have shown that girls with milder symptoms and a normal IQ tend to be diagnosed at a later age than boys (Kopp and Gillberg 1992; Siklos and Kerns 2007; Giarelli et al. 2010; Russell et al. 2011; Begeer et al. 2013) or are systematically misdiagnosed (Kopp and Gillberg 1992; Nilsson et al. 1999; Begeer et al. 2013).

In research it is obvious that there is a very strong male bias in ASD: boys and men are overrepresented, whilst the diagnostic criteria are wrongly presumed to be applicable to both sexes (Lai et al. 2011); the DSM criteria are mainly based on male behaviour and so are the thresholds for qualifying to the diagnosis (McLennan et al. 1993; Holtmann et al. 2007; Lai et al. 2011).

When we look into the studies that focus on gender differences in ASD, the findings are inconsistent and the conclusions can be ambiguous

(Lai et al. 2011). However, once the diagnosis of ASD (according to the current criteria) has been established, studies show that there are no differences in the type or severity of the core symptoms, and the same type of comorbid conditions accompany ASD in girls and boys (Lugnegård et al. 2011; van Wijngaarden-Cremers et al. 2014). This indicates that there is a definite ascertainment bias. Females that do not meet the "male criteria" for ASD will remain undiagnosed as long as we have not been able to define the female variants for the male criteria.

Management and Course

ASD itself is a persistent problem and no treatment can cure the condition. But "prosthetic" measures and adjustments of the environment can greatly enhance the quality of life in people with ASD and help them live a valuable and happy life within their limitations.

What are the characteristics of the clinical guidelines for ASD?

In most clinical guidelines, as summarized in the recent NICE guideline both for children and adolescents (2012) as well as adults (2017), it is emphasized that specific knowledge and expertise are required in order to be able to be helpful to patients with ASD and their close relatives.

First of all an adequate and adapted way of communicating is needed. Professionals dealing with patients with ASD should know how to communicate with people with ASD and how to genuinely take their point of view and needs into account. They have to be prepared to team up with parents and/or relevant relatives, and take a comprehensive approach ensuring quality of life in all its facets.

This means the management plan should focus on:

a. Psycho-education in which the patient and parents/relevant relatives are provided comprehensive information on ASD in general, as well as specific information regarding the personalized diagnostic profile.
b. The diagnostic profile stemming from a systematic assessment should give a realistic picture of strengths and vulnerabilities as well as the risk and protective factors within and around the individual in question. These are key features and the basis of a personalized management plan.

Then the treatment plan should include:

c. Training of social skills individually or in a group.

d. Offering adequate interventions aimed at preventing or reducing challenging behaviour if present.
e. Looking into adapted living and school/working conditions being prepared to help in providing information (together with the patient) and eventually coach employers/co-workers—i.e. teachers and fellow students on ASD, and how to approach, involve and help the individual with ASD in every day life.

ASD is a lifelong condition. Services should be prepared and funded to offer ongoing support adapted to the circumstances throughout the lifespan. Likewise a program for an individual with ASD needs to be tailored to his/her individual needs and thoroughly explained to the person with ASD and all those in her/his environment. This is often one of the main reasons why it is so difficult for individuals with ASD to find a job or a meaningful daytime activity. Employers and co-workers need explanation on the specific strengths and weaknesses of this individual with ASD and learn how to read and understand her/his idiosyncrasies. On the other side, the individual with ASD and his near ones need to be coached in what is expected in the "real world", because sometimes in the sheltered home situation idiosyncrasies may have become accepted and overlooked as socially utterly inappropriate.

Future of ASD

For Research

We argue that research should take a different approach, namely targeting genes and endophenotypes at a different level, and take development and gender into account as crucial features when studying developmental {psycho} pathology, instead of sticking to behavioural categories that do not have solid and specific underlying {biological} markers.

For a better understanding of the gender issues in ASD, retrospective but also prospective studies are badly needed to help and understand how ASD presents in girls as they develop, and which factors mask the diagnosis of lead to misdiagnoses or late diagnosis. Finally, more research is needed to develop screening instruments that are better fitted to help defining and identifying a female phenotype of ASD.

For Clinical Practice

Clinicians should favour individual multilevel diagnoses above mere classifications and take gender into account. It is important that they assess the individual's environment in order to trace (gender-linked) risk- and protective factors. Clinical awareness of broader underlying categories and developmental (and gender) aspects will be of great importance.

Education and training of medical and other healthcare professionals is needed in order to help foster the change of focus from a segmented approach to (psycho) pathology with a "one-fits-all" guideline treatment approach, to a far more integrated personalized approach.

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Working with Adolescent Males: Special Considerations from an Existential Perspective

Miles Groth

Introduction: A Sex, a Profession, and a Philosophy

Currently, men are experiencing a period of having to remake or even reinvent themselves in the wake of important social changes. It is the result of the appearance of new, challenging concepts of gender and masculinity, pressure from some quarters to redefine the relationships between men and women (and with other men), and the gradual disappearance of opportunities to engage for compensation in useful, satisfying and respected work for men who lack the credentials of higher education. For these and other reasons, young males in particular now face personal issues for which consulation with a psychotherapist may prove to be useful, if they choose to avail themselves of what we are able to give them when offered in a certain way. One such approach is existential therapy (ET). In what follows, I will describe its features and application with young males.

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Existential Therapy

One Existential Therapist

ET is my approach to working with adolescent males. It has developed and been modified during the past thirty years. As part of my preparation to "do" therapy, in the 1980s I experienced a four-year classic psychoanalysis with a woman (a non-medical analyst affiliated with one of several lay psychoanalytic institutes where I prepared) and a longer, two-phase period of psychoanalytic psychotherapy with a man (a psychiatrist who had been trained in the classic psychoanalytic tradition).[1]

I saw my first "patient" in 1976 after I had completed my first master's degree. He was a late teenage boy brought by his parents to a small town general hospital's outpatient mental health clinic. After interviewing me about interning there as psychotherapist to-be, the director of the service turned the young man over to me under his supervision. This could never happen today since I was not then licensed in the state.

Briefly, I sat alone with the boy in the office provided to us while his parents waited just outside. He returned a half-dozen or so times. About a week after what turned out to be our last conversation, his mother telephoned to say her son was doing so much better, in school and at home, that she was now no longer worried about him and he would not need to return to meet with me.

I had *no* idea what I had done to accomplish this miracle, but took credit for it, reported it to the director of the service, and summarized in the last of the notes I was required to keep for the clinic what his mother had reported to me by phone. Only years later did I understand that a fundamentally existential approach to therapy was already at work. Before that realization was achieved, however, I served a two-decade "apprenticeship" as a psychoanalyst. I imitated the analysts I met and was treated by, but finally realized the artificiality of all that. In the end, my psychoanalytic "training" had made plain to me only a great deal about what one should *not* do as a therapist.

Since the mid-1980s, I have spent quite a lot of time working with male adolescents in a variety of settings. During the 40 years after I talked with

[1]The strong influence of the psychoanalytic tradition on ET in my case will not be lost on most readers. On the other hand, I have found a wide variety of basic sources from multiple perspectives that dovetail nicely with my version of ET. Mark Kiselica et al. (2011) has been assembling a series of anthologies of papers on counseling males of all ages that take a "person-centered" conventional approach.

that young man I have sat across from them in various settings, institutional and private. For a while I shared an office with a psychiatrist in the heart of an urban university campus in New York. In other settings I have seen young male inmates (most of them Black and Hispanic) from Riker's Island, New York City's most notorious prison; wealthy adolescents (most of them white) at a private school; clinic patients at two psychoanalytic institutes; and students—many students at four colleges and universities in the Northeast of the States. I have lost count of the number of young males I have spoken with as their therapist.

I have learned that working with male adolescents from an existential perspective requires possessing certain attitudes, aptitudes, and skills. These skills are required across the board, no matter whether the therapist is male or female and the other is male or female, and regardless of the pair's respective ages, social background, and experiences, whether therapy takes place in a semi-rural setting (such as where I began) or in a large urban center such as New York City (where I have lived and worked since 1980), in a clinic or hospital, a private consulting room, or an office on a college campus. The skills cannot easily be described. I am certain they can be learned but just as certain that they cannot be taught, such as a surgical technique. The aptitudes and attitudes are grounded in certain features of personality that include a capacity for empathy, patience, a sense of humor, a good memory, and a steadfast respect for the uniqueness and privacy of the other. A therapist is expected to be fairly well emotionally no matter how difficult it is to define just what mental health is. Freud spoke of it as minimally the capacity for loving and working. That will do nicely.

ET can perhaps best be described in terms of what it is *not*. Existential therapy is *not* humanistic psychotherapy, including the highly influential client-centered or person-centered therapy of Carl Rogers. Humanistic psychology, which came to be known as the Third Force in clinical psychology (following psychoanalysis and the cognitive/behavioral modalities) has all but dropped out of the armamentarium of the clinical psychologist as a neatly definable modality. A few humanistic training institutes remain, most of them on the West Coast of the continental States and to some extent at least currently at the Chicago School of Psychotherapy. On the whole, however, the humanistic movement in clinical practice lost much of its credibility by being persistently associated with the New Age lifestyle that emerged in the 1960s and '70s. Being supportive and kind—the hallmarks of humanistic psychotherapy—turns out not to be necessarily therapeutic unless the client is disposed to want to change and become a "better person". Although being nice to someone is "nice" and its effects very likely

cannot do any harm, providing unconditional positive regard for the person or affirming his basic goodness is not necessarily therapeutic. Nor are these attitudes always missing among the personality characteristics of the tough, no-nonsense providers of cognitive-behavioral therapy (CBT), who are therefore also humanistic in the broad sense, even though the paternal program for bringing about improvement in a client is far different from the more maternal forms of humanistic counseling.

Nor is ET a form of *psycho*therapy. Putting the psyche as the object of therapeutic work at the center of the process reduces existence to a thing, a "what" instead of a "who". Behaviorism, which has also dispensed with the psyche (and consciousness), has substituted for it another entity: the neuromuscular mechanism of our animal body, especially its brain and nervous system. But existence, though embodied, is not a physical thing, even the organism as conceived by Gestalt therapy.

So just what *is* ET? ET is perhaps best understood as an encounter between one *who* and another *who*. For that reason I have abandoned the term psychotherapy for what I do since the psyche is a what, and speak instead simply of therapy as a uniquely human endeavor in the tradition of the *therapeut*.[2]

For ET, therapy is not a helping profession. No one ever "helped" another person with "his" or "her" existence the way a surgeon helps her patient with a body's broken bone or inflamed appendix. Intervention and management of a "case" are the hallmarks of professional helping (medical practice, lawyering, guidance counseling). Something else is going on in ET, however. Nor is ET about the care of someone's soul, which is how Freud conceived psychoanalysis (Bettelheim 1983). There is no place for the self, ego, or soul in ET. We recall that Freud considered he was working with the soul (*Seele*) of the patient.

Rather than helping the other, the practitioner of ET *attends* the other (Laing 1988). The hallmark of ET in contrast with psychotherapy is that it is *non*interventional.

The existential therapist knows that what the other assumes is the reason for being there is mistaken. The purpose of the encounter is not to identify and name signs and symptoms, render a diagnosis, and enter into a tried and tested course of treatment to relieve the patient of his symptoms as a result of the physician's interventions. Its purpose is not curing or healing. As R.D. Laing said so eloquently, the "treatment" in genuine therapy is the

[2]See Groth (2014a, b) on the term 'therapeut'. From this point on I will use either the term for "existential therapist" since it stresses the fundamental attentive nature of the therapeutic relationship.

way the therapeut treats the other. It is not in any way similar to medical care for a disease or injury.

The therapeut also knows that the similarities between the therapeut and the other are more important than their differences. The therapeut knows that both are in the same boat, as it were—the ship of fools we are all onboard with each other: life with its imponderable provenance, exigencies, surprises, unanswerable questions, and above all limited span (mortality), where, as Heraclitus said, change is ongoing. Each of us is faced with the ultimate concerns that human consciousness affords us, perhaps as the early story has it as the result of our fall from grace. These include coming to terms with our knowledge (1) that our time on earth is limited (mortality), (2) that life offers no guarantees and often appears to be without discernible purpose or meaning, (3) that we are free to change the direction of our life (within the limits of our physical make-up) provided we take responsibility for what we do, and (4) that, alas, at the outset and at the end we are alone in the world. All of these concerns occur to all of us at some point, but especially during adolescence and early adulthood and certainly no less in young males than in the general population.

The ultimate concerns of human existence are the sources of distress and misery that present as the so-called symptoms of mental illness in the world of psychiatric disorders. They are disguised as disturbances of affect, memory, consciousness, perception, cognition, speech, and conation that present as delusions, phobias, retrospective falsification, logorrhea—and so on for the whole catalogue of psychological disturbances. Physicians know that patterns of symptoms do not necessarily add up to the presence of a disease process, although sometimes they do. Malingering aside, one can feel sick—be ill—and not have a disease, or one may have a disease that is asymptomatic and therefore not be ill.[3] The former is always the case in the world of psychiatric illnesses since there are no diseases of the mind or soul.

The existential givens are the stuff of tragedy but they are not psychological disorders. The "psychological" and the "existential" are not equivalent, which means the notion of "existential psychology" makes no sense. "Existential psychiatry" makes as little sense as "medical Christian science".

What, then, is the goal of ET, if not to treat diseases or achieve the classic goal of medical care, the elimination of symptoms? I will make a series of assertions without much explanation in an attempt to convey a sense

[3]See the legendary debate between Albert Ellis and Thomas Szasz (Ellis and Szasz 1977) in which Szasz vividly explains the difference between disease and illness.

of the goal of ET. For detail, I refer the reader to previous publications (Groth 2014a, b, 2016). Then I will turn to the question of the special considerations of ET with adolescent males.

The Goal of the Therapeut

The goal of the therapeut is to provide a situation in which the other may resume or recover his present. Recall the principal "affective disturbances" in the history of psychiatry: depression and anxiety. The depressed person we say is "stuck" in his past. The anxious person is frantically trying to control his future. But existence is the present. More correctly, existence makes (the) present. It is not *in* the present as though the present were a span such as time passed or times to come. The present is *in existence*. Existence makes the present. We are not "in" time. More to the point, as Heidegger famously said: "Time is existence" (Heidegger 1982) There is no better way to formulate this that I have found.

Rather than searching through the past as though it were something like an archive or a bank holding contents such as memory traces or images—which is the goal of psychoanalysis, the classic psychodynamic psychotherapy—or rehearsing new strategies for thinking and behaving in the hours and days to come and in that way somehow determining and controlling how the future will unfold—which is the goal of rational-emotive and other cognitive behavior therapies—the approach of ET is to make it possible for existence to recover, resume, or take back its present, to turn fully into it in the present of (in terms of shared environmental space, in the presence of) the therapeut.

I hope enough has been said for us to be in a position to describe why some experiences are therapeutic for young males when the venture is ET. I will do this by listing a few of the therapeutic tactics (understood as aspects of an art or *tekhnē*) used by existential therapists when working with male adolescents.

Male Emotional Life

Before cutting to the chase so to speak, we must consider why ET works so well with adolescent males. Here I point out what I take to be the most important features of being male that in general seem to be distinctive. To what extent the features are genetically determined or expressible and to what extent dispositions are manageable by upbringing remain questions,

and how the two factors co-determine each other remains undecided. Or perhaps we are asking the wrong question when we formulate it in terms of nature and nurture. Or perhaps the matter is in principle undecidable.

On the basis of the findings of direct observation of infants and children across many cultures we can say the following about males that will be relevant to our discussion of why ET is especially effective with adolescent males.[4]

Attention, Movement, and Mood

Infant males are, from birth on, more kinetic than females. They tend to inhabit and manage space in distinctive ways and exhibit certain distinctive play patterns that emerge spontaneously and are not the result of training or exposure to certain kinds of games.

Boys engage in "rough-and-tumble" play more than girls. Related "play fighting" is not an expression of aggression but instead an outlet for the surplus of energy (hyperkineticism) just mentioned. Very likely mediated by testosterone, which occurs in much greater quantities in the male body, such play may also express practice at competing with other males that has evolved in relation to mating or defending (or attempting to take over) patches of the landscape (an area of desert, the side of a mountain, the land between two rivers).

With respect to accommodation to and use of space, boys are centrifugal and eccentric (in the sense of moving away from a central point) in the disposition of their bodies. In general, young females tend to be convergent and contain space, orienting themselves centripetally toward a fixed spot, both as individuals and in all-female groups. Being brought up in a certain geographic and cultural settings, the male-specific tendencies may be discouraged in boys and encouraged in girls. Boy-rearing practices in some cultures limit rather than promote the expression of random, erratic movement. Swaddling, for example, among some traditional Native American groups affects the infant's range of movement. Boys react against this more vigorously than girls, and practices of restraint may produce hyperassertive men.

[4]The literature on development is extensive and familiarity with it is by the reader is presupposed. A partial bibliography would include Arnold Gesell, Erik Erikson, Jean Piaget, and Lawrence Kohlberg. Much of this literature has been challenged for being ethnocentrist but it bears reading if only to learn how to carry out qualitative research.

Boys are more distractible than girls and more eagerly follow moving objects with their eyes than girls are. Consequently, their gaze does not remain settled on an object for as long as one typically observes in infant girls.

Boys are crankier and more difficult to and console than girls. In this sense, they are more emotional than girls. Later, this usually plays out as being more impulsive.

Father Hunger

Boys are more in need of a *male* second parent than girls, mostly for the purpose of identification with a male as a male but also with that ubiquitous status, manhood (Gilmore 1990).[5] I am convinced that girls are also in need of a male parent as well as a mother but for different reasons. American culture has discouraged boys from expressing intimate physical contact with their fathers after late childhood (see Zoja 2001). This is in contrast to the freer expression of gestures of affection among, for example, Mediterranean and Middle Eastern fathers and their sons (and in general between males). Across the world, greater physical intimacy can be observed between Jewish fathers and their sons.

The consequences of an essentially Anglo-Germanic style of fathering in most American families cannot be underestimated. Missing an emotionally and physically expressive father has caused many American boys to experience more father hunger than boys raised by both parents. The great passion for contact sports among American male adolescents is probably an effect of the need for male-to-male nonsexual physical contact that fathering provides.

Developmental Considerations and Ambivalence

Boys are about a year behind in overall developmental of higher functions compared with girls until about age 17 when they "catch up" with same-age females. Their poorer performance early on in school is legendary and attributable to this. At puberty, the boy's earlier discovery of his penis (perhaps as early as the second year of life) is revisited, now in the context of

[5]Zoja's book is, in fact, entitled *Hector's Gesture*, which refers the ritual assumption of responsibility of fatherhood by a male for the male infant presented to him by its mother, whether or not the boy is his own. Only recently has genetic testing made it possible to be certain about this. Before that and even now, in principle, this is what every father does with his sons (and daughters) on becoming the father and not just the progenitor of his offspring.

spontaneous erections that can lead to ejaculation, while asleep in "wet dreams", or awake as a result of masturbation, which is universal in healthy boys. Early overvaluation of his penis by others and early shaming of him about displaying it produce in boys a notable ambivalence about the phallus. Focus on performance (displays of competence) and strength elsewhere in the boy's body are results of this ambivalent attitude. Body strength and bulk (being "pumped" and "buff") is symbolically compensatory and reproductive power becomes displaced to public displays of physical prowess and skill and an obsession with exerting power over others, male and female.

Genital development is not limited to the penis, however. Boys and men are extremely vulnerable to painful feelings if the testicles are bumped or struck while playing or being punished. In boys, paddling is an assault as much on the testicles as on the buttocks. In boys this adds to another dimension of overcompensation, this time for the physical and emotional vulnerability of their "testifying" genitals (the *testes* are literally "witnesses" to the phallus).

Obscuring visible evidence of the genitals is a design feature of most male clothing in contemporary fashion. Trends to highlight or emphasize the genital area have occurred (codpieces) but are discouraged in most contemporary cultures.[6]

Verbal Behavior

One further distinguishing feature of males is especially relevant to our topic. Boys have the tendency to say less and express in actions rather than words what they are feeling. For example, to show gratitude to his mother or love for his father, a boy is more likely to make something for a parent and hand it over as a token of love, allowing the gift to speak for itself—that is, for him. A girl is more likely to say something to a parent about how she feels. In essence, she explains *why* she is feeling gratitude and affection: "Mummy, I love you so much! See! I made this for you!" The boy thrusts his gift under Mom's nose or leaves it on Dad's chair.

Obvious questions are whether boys are discouraged from talking or whether they are simply less capable of finding words for feelings than girls

[6]None of what is asserted here implies that such features grounded in male anatomy and physiology should not be introduced and encouraged in the upbringing of girls. Female masculinity may well be encouraged. So may male femininity. Both, however, will contend with the facts of anatomy and millions of years of evolution.

are—so-called alexithymia? This is a discussion that pervades gender studies and social psychology, and one we must leave for another time. That after puberty most males say less than most females is clear—the exceptions being college professors and politicians—and apart from the fact that general poverty of words for emotions in American English and all natural languages, males talk less about their emotional lives than girls and women do. Just why remains a puzzle, but it may have evolutionary roots in the need for males to cooperate on the hunt without uttering sounds and in that way not signaling their presence to animal prey.

Recalling now ("Introduction: A Sex, a Profession, and a Philosophy") what was said earlier about the changing status of the male, the vicissitudes of masculinity, and manhood in contemporary society; ("Existential Therapy") that ET is about the ultimate concerns of existence, including the experience of lived time; and ("Male Emotional Life") the singularities of development attributable to male body's anatomy and physiology, and the cultural meaning of manhood, we are finally prepared to offer some special considerations for working with adolescent males in ET. I will single out just six.

Working with Adolescent Males

Access to the present is the goal of ET, but precisely that is compromised by many of the features of a typical adolescent male's life. Getting at his existence—his present—will mean getting past what he is presumed to *be* by virtue of being a young male in order to get to the ultimate concerns that are just occurring to him. I am aware that I have begun to use the masculine pronouns and that I have asserted that existence is genderless. The attempt in ET to suspend and transcend the givens of everyday life (what Edmund Husserl called "the natural attitude") nevertheless begins with them, in this case the predicament in which so many young males find themselves enmired. More important, it is not specifically "male issues" that concern us but instead bringing home the point that the goal of ET is to unmask and encounter the ultimate concerns masquerading as the symptoms that bring a young male to meet with us.

When working with an adolescent male and with the goal of ET in mind, certain considerations of practice have priority. I now turn to these. Whenever possible, I will refer to the singularities of male—especially young male—experience, keeping in mind that ET with anyone, male or female, young or old, has essentially the same goal. Having spoken of generalities,

it should be obvious that the essence of ET is found in its recognition that each therapeutic encounter is unique since each of us is different: each other sitting across from me is one of a kind and changes from meeting to meeting, and the same holds for me as therapeut.

Reluctance and Privacy

In our time, the mere fact that a young male is sitting there across from me is something of a miracle, given that males are taught to deny they are feeling uncertain, afraid, unhappy, or anxious—or feeling anything at all except perhaps anger. If they are experiencing any of these, they are reluctant to admit it. Historically, access to care by a counselor or psychotherapist has not been encouraged for males after their days with a pediatrician. This follows the pattern of a relative lack of interest in and attention to the health needs of males—their general well-being, andrology (known in the States as urology) research, education and prophylaxis, and the creation of male-positive healthcare policies, especially those that pertain to the ubiquitous competitive sports programs more or less *de rigeur* for boys in the States. Young men are not supposed to get sick or be injured. That is a sign of weakness. They are certainly not supposed to have emotional problems, and who among men is permitted awareness of the ultimate concerns (with a few exceptions: Shakespeare, Kierkegaard, and a few others).

In ET one approaches a young male by focusing on what is right about him. He needs to know that being there in the consulting room is not an indication of some sinister abnormality. In ET (as in family therapy, by the way) diagnosis is irrelevant. The ultimate concerns are its focus, and as I have argued the facts of life are not pathological. I may offer to some adolescents I work with that I sought out "counseling" when I was an undergraduate and found it helpful some of the time.

I have found that self-disclosure is essential when the therapeut and the other there with him are both male. It is unclear whether a young man is less likely to be open with a female therapeut, even (or especially) if she is an older woman. On the other hand, being a young male therapeut is not necessarily an advantage when working with a man only a few years younger.

It is essential to repeat that what is said where we meet remains there between us. Not friends, not school authorities or parents, not medical doctors—no one will be privy to what either of us has said. I do not take or keep notes, let alone case histories. After completing my institute work, which required keeping case notes, I have never written anything during

or after a session except, for example, to jot down a telephone number or address. Consequently, I have nothing in writing to turn over to a third party or to discard. Working in an institutional setting where records are kept entirely for the protection of the agency or school precludes in principle the practice of ET in such a setting, and this is perhaps one reason ET remains the province of private practice.

I do not consult test results or referral reports, if there are any. I also do not accept insurance payments. If parents wish to give their son money to pay my fee, that is between them. But their offering to fund a son's therapy does not entitle them to know what he and I talk about. I make that clear during the first meeting with the other. The fee, I have said, is for the use of a space for which I must pay rent or a monthly maintenance fee, not for my "services".

Shame

Privacy and shame are related in males since as boys what once he was supposed to be proud of—his genitals—soon were to be hidden away and revealed only in private. They unexpectedly turned into an unacceptable embarrassment in public. As a result, shame is related to the threat of exposure of the hidden and private, not only body parts but also thoughts and emotions. What has applied to the body applies to what is said. It is there, but one must not admit it or talk about it, except in jokes, and that means dismissing it as painfully funny. This is an especially difficult matter as one approaches the ultimate concerns.

Given the mysteries of gestation, female clients have an appreciation for the hidden as well a conscious investment in the future that the prospect of pregnancy implies. The secret and private may be experienced ambivalently, but pregnancy nearly always has a positive valence. Inner space may be mysterious but it is generally respected and valued even if not fathomed by both males and females.

The young male other is reluctant to expose himself emotionally to others. Early on a boy's mother may be the exception, but after puberty she is the first to be deprived of access to his body and then to his feelings. He will not want to appear nude in his mother's presence. Boys begin to bathe themselves and toilet routines become shrouded in secrecy. This makes sense since many adolescents first masturbate while on the toilet or in the shower.

Fathers play a different role in the boy's life, and different fathers do this differently. The Eastern European and Asian bathhouse in which males of all ages have congregated for millennia is unknown in the West. Yet this is a

site where males have met their father, grandfathers, brothers, uncles, other males and where sexual tension is minimal and there is no shame about the body since no one's body is covered. The lack of mandatory military service in the States means that young males may not have many occasions to see other males' naked bodies unless they play a sport or have brothers at home. In many public schools, physical education classes have been eliminated.

The relevance of this for ET is the male's attitude toward the exposed but nonetheless covered and therefore simultaneously hidden in his life. Anything spoken that might prove to be embarrassing is associated with experiences of the covered sexed body of boyhood. In the consulting room, approaching the discussion of what he has kept to himself—in hiding and under cover—is therefore an especially delicate affair.

Admission of weaknesses also causes shame and is therefore discouraged if not forbidden in the world of stoic manliness. Only time and confidence in the therapeut can provide the conditions for an adolescent male to talk easily and openly about concerns related to his emotional life and on to the ultimate concerns. This holds especially for his sexual life and fantasies.

How best to respond to what is offered about the "unspeakable" by a male adolescent? Congratulating someone on having revealed something of himself is usually welcomed and seen as therapeutic in media representations of popular psychology. That something is now "out in the open" must mean a positive outcome. With males, it may be enough to hear that there is something "I want to keep to myself". Very well. It has been acknowledged. I don't probe. We can wait for another time when what yearns to be seen and heard but is known to be unheard-of, unspeakable and shameful to expose is allowed to appear. For example, coming to terms with his sexual orientation may be in existential focus, but it is not clear to him what his sexual identity is. How, then, can he compare it, for example, to the average expectable identity usually associated with his sex? Only when he has been given time to be clear what it is *that* he understands to be an issue for him do I move on to discussing with him the meaning of his choice of identity.

It is important to acknowledge what is revealed in confidence, but I do so without fanfare. Generally, I do not explore such admissions and allow the other an opportunity to assess the fact that he has said something he feared was going to be shocking. It is therapeutic in itself to have one's privacy respected. Having been open about what was thought to be entirely private and watching the therapeut take it in stride is therapeutic. On the other hand, the ultimate concerns that really bring the other to me are not private. They belong quite openly to all of us.

Place and Encounter

The place of encounter between therapeut and the other is generally of importance but especially so when working with adolescent males in ET. The décor is important, but more critical is the arrangement of bodies. I find that sitting directly across from a young man is not advisable. Generally, I sit at my desk and invite the young man to sit in a comfortable chair placed along the left side of my desk. He is seated about ten feet from a window and has to turn slightly to face me. The desk in part protects his body from my gaze. I am not between him and the door and the view outside gives him a sense of not being enclosed.

The door to my office is behind him. I find that most young men routinely close the door when they enter. If I answer the door, I indicate where he should sit and ask him whether he wants the door to remain open. Nearly always, he prefers that it be closed. It is closed but not locked.

I observe his body language closely and am sensitive to the social implications of male-to-male intimacy that most males—straight or gay—are burdened with in our culture. At my desk, we are close, but full physical openness, to which males are more sensitive literally and figuratively, is in that way avoided. I may push my chair back if he begins to wriggle in his. In general, it is more difficult for young males to remain in one position and place for long. This is related to the overall greater kineticism mentioned earlier. I expect a lot of movement.

The experience of place and lived time (Minkowski 1970) are related. Setting up such a place for encounter that is not confining affects the "velocity" of the lived time of our encounter. Male clients in general tend to want the consultation to be over as quickly as possible. I therefore sometimes say at the outset: "This won't take long". On the other hand, after our first meeting, that may be contraindicated if I sense it will take him a while to feel at ease with me. I also do not want him to feel rushed and therefore omit the standard: "We have an hour, you know, and I'll have to stop at. .. [and note the time]". The therapeutic action of ET occurs in the lived time of our encounter in the therapeutic setting. In general, the tradition of clearly carved-out periods of time in psychotherapy (the 45-minute "hour") makes flexibility difficult if more time is needed. But lived time must determine how much of the clock is used. Extending an hour may be necessary, even though this may be difficult to manage if my schedule is heavily booked. I therefore allow 30 minutes between appointments in case more time is needed. Eventually, however, we agree that "50 minutes" will usually have to do. Explicit limits (rules of engagement, if you will) and certainties are

valued by males. They tolerate and even appreciate the idea of rounds, innings, quarters, and periods.

I am also always prepared to stop things sooner than planned if I sense he has become more anxious than when he arrived and the anxiety is not productive, which it can be. In general—and everything I have to say here implies exceptions—males want something to be accomplished if they spend some time at it. They want a result and closure. I may therefore occasionally tentatively summarize or reformulate a conclusion he has reached, but I do not make too much of it.

Terseness and brevity can communicate as much and as well as a long disquisition since words can camouflage feelings and be deployed as a buffer between people. At the same time, I do not allow too much empty space with young men in the therapeutic situation. Silence can be threatening to young men especially since few words bear so much weight.

I always take the lead in any session. Psychoanalytic waiting is not tolerated by most adolescent males. The fundamental ambiguity of existence is an ultimate concern, yet precisely because young males covet certainties the vagueness of existence is an important ultimate concern for them. I try to end every session with a summary of what has surfaced and been seen. I often conclude by asking him where he is "heading" next and what his immediate plans are.

Present Orientation

Wilfred Bion (1977), a therapeut in the psychoanalytic tradition, described the approach to each session as "without memory, desire or understanding" of any earlier encounter. Ernesto Spinelli (1997) describes his existential analysis in part as maintaining an attitude of "unknowing", that is, openness to what something or someone means without making presuppositions about it. Both speak from the perspective of ET.

As I have argued, existence is in essence present-making. It is my impression that adolescent males are more focused in the immediate situation than their female age mates, and that includes what happens in the therapeutic setting. For that reason, they are perhaps better "candidates" for ET than females, for whom the future can have consequences of the sort to which males cannot be bound (pregnancy, commitment to caring for a helpless newborn for several years).

I am judicious about asking questions about his past, not because it is irrelevant but rather because of the goal of ET. Exceptions include learning

the names of siblings and other important persons. At a time when for a significant period of their early lives two out of three boys are likely to have been raised by a single parent—the mother—it is also important to know about the current family structure since most male adolescents are still living at home. I ask for a *first* name of a girlfriend or close friend.

Many young males are not especially interested in planning for the future much beyond the coming hours. This is another consequence of their present-centeredness but is also related to what motivates their well-known impulsiveness. I keep in mind that his apparent lack of commitment to the near future may indicate a sense of *freedom* rather than irresponsibility and indifference.

I assume that the session I am in is the only one I will have with him. Period. Toward the close of a session, I may ask: "So, are we finished here?" (implying "We *are* finished meeting after today"), or "Did you want to talk about something else?" (making the break less abrupt or seemingly arbitrary, which of course it is, but also indirectly offering a later time for meeting). I want him to leave with the impression that neither of us has dominated the situation, even though I clearly have responsibility for it. While not an ultimate concern, the clock dominates every aspect of everyday life in the technological West—and it works against the goal of ET.

I always shake his hand before he leaves since this is the customary physical gesture of emotional exchange between males in our culture, but also to assure him that physical contact is not prohibited between us.

Seemingly as an afterthought and after we have shaken hands, I may ask: "Do you want to talk any more?"—in this case meaning again next week or on some as yet unspecified day. I do not outline a "treatment plan" of a certain number of sessions. I leave that up to him. He will likely be decisive about when he has had enough. A "Yeah" in response to "Do you want to talk any more?" is not, of course, a guarantee that there will be another occasion to meet. In ET, this is not a matter of concern, given its sole aim, which is to make his present apparent to him.

Verbal Exchange

Males tend to be more terse than women, especially in physically and emotionally intimate contexts such as therapy. Monosyllabic responses are common. The reflective or mirroring style of Rogerian person-centered (client-centered) therapy is therefore not suitable for working with young men. Repeating what they have said is a needless review of the obvious.

Hearing "I hear what you are saying" is ludicrous and not reassuring to most young males. I have not specialized in working with children, but with adolescent males it is always in the back of my mind that children enact in play what they cannot (or will not) say. One can understand ET with young males as play with words instead of toys. Their overall more playful demeanor is evident even when talking about ultimate concerns.

Indirect communication—saying without naming—is especially effective with young males. This does not mean I attempt to talk with young men "guy-to-guy" or to be "cool" or suggest we are pals in a conspiracy against parents and the authorities. Nevertheless, candor and even bluntness are appreciated by young males.

I have suggested that alexithymia, which refers to the want of words to express emotions and thoughts, is probably not more common in boys, but rather that they simply say less. Pathologizing brevity may be less than helpful and better accounted for in terms of a tendency already mentioned for young males to be more laconic than their female counterparts. In general, English and most natural languages do not have an excess of words for the nuances of feeling, even physical sensations such as pain (sharp, burning, searing, dull) or the variety of pleasurable feelings, physical and emotional. A young man's vocabulary of emotions is probably as extensive as a girl's.

What, then, of the young man who seems tongue-tied when asked the generic feeling question: "So what's going on?" The expected reply is: "I don't know"—or a shrug. Lack of articulate verbal responsiveness in ET with young males should not be a source of discouragement. Here one of the most important considerations about working with adolescent males arises.

Punning and humor, and the use of idioms, slang and street language must not offend the therapeut. Sometimes I make that clear by repeating such language and then reformulating what has been said in more conventional terms. One judicious use of a four-letter word is often enough to make the point that any word is acceptable in the therapeutic setting, no matter how offensive it may be in the outside world or to the therapeut.

The classic four-letter words may be used to distance the therapeut and perhaps even frighten him. Again, I sometimes repeat the word to assure him that I am neither offended nor shocked by the use of such words in the effort to say something where, in general, words in any case fail most of us much of the time. My repeating such a word (once) may prime the pump for the elaboration of a feeling on the tip of his tongue or open the way to the discussion of an ultimate concern.

Most male clients are not unaware of the consequences of their feelings for the acts the feelings may motivate, especially those that may lead to

impulsive acts of self- or other-harming behavior. If I sense from a change in facial expression, posture, or body language that we have hit on a way into what he is feeling, I may use the opportunity to address an issue that has been close to expression but avoided up to that point. I may take the opportunity to "translate" the colloquialism, gesture, or posture as a way of clarifying for him what I believe he is feeling, but I am always cautious about wanting to appear to speak *for* him. He knows better than I do (or anyone else does) what he is feeling. It is always presumptuous to "say" for another person what is on his mind. In any case, we are always on the path to ultimate concerns, which are always adumbrated by strong feelings.

Any verbal expression of a strong feeling can be turned to therapeutic advantage even if at the same time it increases the volatility of the situation to some degree. Allowing the feeling may be a way of forestalling or defusing imminent action that might be dangerous to the person or others that the saying replaces. We recall the histories reported in newspapers of boys who had "gone silent" for long periods of time, only to break out of themselves with violent acts against others and typically in the end against themselves. Their blogs or private notebooks turn out to have been filled with tragically eloquent verbal expressions of fears, hates, longings, and wishes. They had the words but there was no one to safely utter them to.

Concluding Comments

1. Obviously, any of the personality or character features presented here as characteristic of young males may be found in young women in therapy, but currently they are far more common in males. The most important are grounded in anatomy, physiology, and evolution. It makes little difference, however, whether or not such features have such a basis since ET is directed to the ultimate concerns that are human. Yet gender hinders or enhances access to them and in different ways. Having said that, for better or worse, most males beginning in adolescence are still expected to take the lead in relationships, to be stoical, to control strong urges (especially sexual drives) and yet successfully deploy them on demand, and to express themselves on short notice physically rather than verbally. Being proactive rather than reactive contextualizes the relevance of ultimate concerns in certain ways.
2. ET with young males in the States—and, I would add, on the basis of conversations with colleagues this holds for Canadian, Australian, British, and European males as well—is best suited for them because its primary

goal is to make it possible for the person to recover and resume his present. The young male who is most attuned to life's ultimate concerns or who is blocked from considering them because of the social demands of manhood meets such crossroads as someone for whom the living present, where the ultimate concerns are always at stake, is both a mystery and a challenge. Our human inaccessibility to the lived present is more acutely felt by him. I have in mind here those young males who are precociously sensitive to the ultimate concerns discussed earlier. For some males, it is not until a life-threatening event has occurred or some personal loss has been experienced or the effects of aging loom that our ultimate concerns as human beings are foregrounded. They cannot be artificially introduced, but must arise from each individual's personal consciousness of them, existentially motivated.

3. I have not found significant differences in the response to ET in males who are White and those who are Black, affluent and well-educated or poor and undereducated, veterans of combat or the juvenile or adult criminal justice system, rural or urban, Christian or Jewish, straight or gay, or in between. In the end, existence is our common humanity.

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Angry Young Men: Interpersonal Formulation of Anger to Effect Change

Peter Cairns and Lawrence Howells

Introduction

Young men are particularly likely to present for help with anger difficulties. They may be referred by educational institutions, families, or they might come along themselves. They are often quite clear that the difficulty is with anger, that they suddenly explode, see a red mist, or can be fine one minute and raging the next. Clinically, it is a familiar presentation (Armbruster et al. 2004). In spite of the relative frequency of this presentation, however, the support available and the interventions offered fall significantly below that available for other presentations. The evidence and knowledge base lags significantly behind and, as a result, clinicians report less confidence and competence in this work, when compared to fear-based difficulties (Lachmund et al. 2005).

In this chapter we bring together the available knowledge and evidence in an attempt to better support young men presenting with anger problems. We draw on emotion science, gender and masculinity research, trauma and therapeutic research to try to bring some clarity to a neglected but highly important area.

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Why Are Young Men Angry?

We will begin by considering the reasons behind young men's anger, starting with exploring the impact and functions of anger, before looking at the relationship between anger and shame, and the psychological development of boys and men.

What Is Anger?

Anger is included as one of Aristotle's 14 emotions (1954), and alongside happiness, fear, and sadness as one of four basic emotions (Jack et al. 2014). Despite a theoretical acceptance of anger as a fundamental human emotion, anger is often labelled by society as 'toxic' or 'harmful' and many scientists have come to view anger as more of a liability than an asset (Izard 1991). Many scientific authors also appear to conflate aggression and anger, writing as though anger is responsible for the violence in the world and should somehow be eliminated (e.g. Tucker-Ladd 1996). These societal views risk reinforcing the difficulties with anger that young men face, an idea to which we will return later.

Anger is an emotion that is experienced relatively frequently and can last for periods of hours or days, but can also dissipate fairly quickly. It is experienced as hot and intense (Scherer and Wallbott 1994) as well as aversive; the majority of individuals report disliking the feeling of anger (Harmon-Jones 2004). Anger has a dramatic impact on the body that involves the activation of the sympathetic nervous system and is very similar to that seen in fear responses. This activation leads to increases in heart rate, respiration, muscle tension, and an attentional focus on threat. While the physiological processes underlying the experience of both anger and fear are similar, the felt sense is almost opposite: anger feels hot, whereas fear feels cold. Anger is associated with a great deal of thought in two main areas: past-focused thoughts about the cause of the anger and future-focused thoughts about action. The main behavioural impulses associated with anger are approach behaviours varying in intensity from a hardening of the body and words, through to extreme aggression and violence. It is important to note that aggression and anger are not interchangeable concepts. Whilst aggressive behaviour can sometimes be a component of the emotional experience of anger, anger can be experienced without aggression, and aggressive behaviour can be displayed in the absence of anger.

From an emotion science point of view, anger is, like all emotions, a functional, coordinating response to an environmental stimulus. Specifically, anger is one possible response to threat: it functions to protect. The other possible response to threat is fear; hence the fight or flight response (Cannon 1927). Anger is ordinarily a response to an interpersonal threat: the most commonly cited precursor to anger is a sense of being '*misled, betrayed, used, disappointed, hurt by others, or treated unjustly*' (Izard 1991, p. 235). The result is that anger protects individuals from the threat posed by others by gearing up the individual to counter the initial threat.

Anger and Shame

Interpersonal threats such as being poorly treated, undermined, or humiliated do not always result in anger, but can evoke other powerful emotions including shame. Shame is an aversive emotion that is linked to strong, negative self-evaluations, such as being flawed or defective in some way (Dearing and Tangney 2011). Due to the painful and self-focused nature of shame, individuals who are particularly prone to shame may be less likely to express these feelings, as they are so aversive (Tangney et al. 1996). Instead, common responses to shame include hiding away (Lewis 1971), or re-directing these feelings onto others through anger or aggressive behaviour (Zlomke and Hahn 2010; Scheff and Retzinger 1991).

Stronger feelings of shame, higher levels of shame-proneness, and greater shaming experiences have all been associated with greater levels of anger and aggressive behaviour towards others (Hundt and Holohan 2012; Aslund et al. 2009; Harper et al. 2005; Rand 2004). Other research has explored the relationship between anger and the capacity for empathy, or being able to understand the perspective, thoughts and feelings of others. Perhaps counter-intuitively, empathy and perspective-taking were the strongest predictors of self-reported anger in response to provocation, in a group of offenders (Day et al. 2012). This may suggest that people who are prone to anger are, in fact, better at accurately assessing the viewpoint of others. In turn, this may lead to a stronger focus on the negative judgments of others, thereby triggering uncomfortable feelings such as shame.

Angry feelings and the expression of anger may help to soothe and regulate feelings of shame (Bushman et al. 2001; Berkowitz and Harmon-Jones 2004). This may be particularly true in people who have experienced trauma and in whom the associations between anger and shame are particularly strong (Schoenleber et al. 2015). Conversely, Kaufman (1996) referred to

the 'shame-rage cycle', in which a shaming incident provokes anger and rage, which in turn elicits greater feelings of shame.

Anger and Male Development

There are significant gender differences in the experience and expression of anger: peer groups and adults appear generally less negative about overt expressions of anger in boys than in girls (Zahn-Waxler and Robinson 1995). Mothers have also been found to actively encourage boys (but not girls) to respond to provocations with anger and retaliation (Brody 1996; Zahn-Waxler and Robinson 1995). Furthermore, mothers are more likely to react warmly to boys when they react to provocations with anger than with sadness (Brody 1996; Fuchs and Thelen 1988). There are also generational differences: older people are significantly less likely to have a close friend or family member with anger difficulties, or report that they themselves struggle with managing angry feelings, than younger people ('Boiling Point' report, British Association of Anger Management 2008). Younger people are far more likely than older people to engage in aggressive behaviour that is driven by impulsive or explosive anger, rather than pre-planned acts driven by incentive or reward (Hecht et al. 2016; Connor et al. 2004).

These societal trends are thought to be driven by desired or valued male identities that revolve around demonstrating strengths, such as being athletic, competent, or individualistic; when these are violated strong negative feelings may arise (Lewis 1992). Relatedly, men may feel strong feelings of shame and discomfort in situations that require them to display feelings such as fear, or show intimacy (Schenk and Everingham 1995). These have sometimes been described as 'unwanted male identities', as they represent characteristics that undermine or clash with an internally-held male ideal and have been associated with a range of difficult feelings (e.g. Ferguson et al. 2000). Jakupcak et al. (2005) investigated predictors of anger and hostility in a group of 204 males, with fear of emotions predicting a small but significant amount of variance in overt anger expression.

Jakupcak and colleagues suggested that anger expression could be an effective means of reducing or managing painful emotions which, if successful, would be reinforced and used again as a strategy. It is suggested that many young boys are socialised to not express vulnerable emotions (e.g. Kuebli and Fivush 1992), or expect negative responses if they display emotion (e.g. Fuchs and Thelen 1988). Consequently, distressing or vulnerable emotions come to be experienced as shameful and to be feared

(Gilligan 1996). Men's fear of emotions was predictive of anger, hostility, reduced anger control and aggression within relationships (Jakupcak et al. 2005; Jakupcak 2003). The authors concluded that internalised male gender roles limited men's options for emotional expression and their ability to tolerate difficult or painful emotions.

Other research has highlighted the significance of 'gender role identities' in determining how other people are perceived in conflict situations, and the extent to which they respond with anger. Angry emotion and behaviour appears to be more likely when an individual's identity justifies or allows for such a response, with a strong masculine identity giving a greater 'cultural mandate' to respond in angry or aggressive ways (Coleman et al. 2009). It also appears that negative emotional events are more likely to be retained in memory and ruminated upon, which in turn increases the emotional experience of anger, when this was compatible with one's internalised perception of masculinity (Rusting and Nolen-Hoeksema 1998; Bushman et al. 2005; Bushman 2002).

Young men who have been exposed to negative influences within their families, such as chaotic or inconsistent discipline, are strongly influenced by these experiences in situations of conflict (Larkin et al. 1996). Larkin and colleagues compared young men (18–25 years) in role play situations that involved disagreement and conflict, who were from family backgrounds assessed as being either 'balanced' or 'extreme'. 'Extreme' families were described as having either excessively high or low levels of cohesion (e.g. family members being either enmeshed, or highly independent of each other), as well as either excessively high or low levels of flexibility (e.g. family members being either overly rigid, or chaotic and inconsistent). 'Balanced' families were defined as operating with moderate levels of cohesion and flexibility, qualities that have been associated with better communication and improved ability to cope with emotional issues and challenges (e.g. Olson 2000). Young men from 'extreme' families were seen to exhibit higher levels of state anger than those from 'balanced' families, and significantly more than young women from similar backgrounds (Larkin et al. 1996, 2011). Larkin et al.'s (2011) findings suggest that young men were more strongly influenced by exposure to negative family environments than young women, as reflected by their behaviour and feelings in conflict situations.

From another perspective, social learning theory suggests that young children learn about their own emotions by listening to how their parents talk about feelings, looking at how their parents react to their own emotions and imitating these emotional expressions (Bandura 1977; Eisenberg et al. 1998). It appears that some key factors that influence angry affect

and behaviour in young men can be traced back to some of their learning experiences within early social contexts. These may include experiences of family communication and relationships being extremely unclear, chaotic, and unpredictable, or of family rules being excessively rigid with little breathing space or 'room for manoeuvre'. When boys and young men have been taught few effective ways of managing challenging interpersonal situations, they are more likely to respond with angry feelings and actions. Parents often get caught up in responding to their child's anger in unhelpful ways that leave the young person feeling trapped or powerless, such as imposing strong, rigid, or non-negotiable boundaries. Over time, this can have the effect of disrupting communication and healthy patterns of interaction within the family, as well as doing little to reduce or contain the felt anger of the child or young adult (Currie 2008). Research has found that men are less likely than women to experience empathy and guilt, making them less likely to engage in behaviours aimed at reparation (Lutwak and Ferrari 1996; Zahn-Waxler et al. 1991). Lutwak et al. (2001) reported that in a sample of 265 college students, shame-proneness was related to both inward expression of anger and reduced anger control in men. The authors concluded that shame-prone males attempted to 'bottle up' unmanageable feelings (including anger) but remained at high risk of losing control of these feelings.

Others have suggested that anger may be an effective strategy for avoiding feelings of shame altogether, by guarding against these before they arise. For example, expressions of anger may enable respect from one's peer group, for example where the strong masculine ideal is valued, thereby promoting self-esteem and keeping feelings that are incompatible with a person's self-concept (such as shame) out of conscious awareness (Farmer and Andrews 2009). In a similar vein, Gilbert (1998) has argued that angry feelings enable people to move up the social hierarchy as they provide them with a powerful and valued identity. As such, expressions of anger may be seen as effective 'face-saving' strategies that promote a positive identity. There is a sense in which shame renders an individual passive and helpless, whilst anger brings back feelings of power and agency (Miller 1985).

Finally, research has indicated that people exposed to trauma of a violent nature, experience higher levels of anger and aggression (Jakupcak and Tull 2005). It appears that 'experiential avoidance' and 'emotional inexpressivity' are both significant predictors of anger and emotionally-dysregulated responding (Campbell-Sills et al. 2006; Feldner et al. 2003). The former refers to avoidance of an internal state (i.e. emotion), whereas the latter relates to the inhibition of the outward expression of an emotion.

It is suggested that suppression or avoidance of emotion (both the emotional experience and the emotional expression) may reduce distress in the short-term but prevent the processing of traumatic experience and result in greater emotional dysregulation longer-term (Tull et al. 2007).

In summary, there are a variety of reasons why young men are particularly likely to experience and express anger to a greater extent than other members of society. There are societally valued male identities that value strength and encourage the expression of anger in young men more so than other emotions. There are societal and family interactions that may lead to males having reduced access to effective means of resolving conflict and managing feelings. Finally, the presence of trauma, violent trauma in particular, is likely to significantly exacerbate these difficulties.

As a result, clinically, it is this population of young men who have been exposed to violent trauma, often very early in life, who are particularly likely to experience heightened levels of both shame and anger. They are likely to experience a variety of difficulties as a result, including difficulties with violent or aggressive behaviour, interpersonal difficulties, bullying, and criminal activity (Espelage and Swearer 2011; Schoenleber et al. 2015). They may also experience a range of potential emotional difficulties including sadness, worry, eating difficulties, school refusal, withdrawal, self-harm, or substance use. Despite this high level of need in young males, the accessing of help and support is much lower (Yousaf et al. 2015), which is likely to be one of the reasons for the much higher rates of suicide in this population (Pitman et al. 2012).

Anger and Traditional Models of Service

There are few psychiatric diagnoses that link directly to anger. Indeed, many young people frequently request help with anger only to be told that they are 'depressed'. This, clinical practice suggests, is deeply frustrating and invalidating for young people, and only tends to fuel problems with anger. At other times, clinicians in the UK are commonly heard to say that 'anger is not a mental health problem', that problems are 'behavioural' or that anger is 'comorbid'. Consistent with this are findings that the majority of people experiencing difficulties with anger have never received interventions targeting their anger (Kessler et al. 2006). Despite an apparent reluctance to classify anger as a disorder, adolescents, and young adults frequently present with anger difficulties (Armbruster et al. 2004). Clinicians also report frequently working with anger difficulties but report less confidence

and competence in this work, when compared to fear-based difficulties (Lachmund et al. 2005).

When young men are offered help, it is too often ineffective and ill-informed. This is perhaps unsurprising in light of a review in 2007, which found 185 references mentioning treatment and anger, compared with 6356 mentioning treatment and depression (DiGiuseppe and Tafrate 2007). The knowledge and evidence base to inform treatment of anger difficulties is extremely limited and is plagued by methodological issues around such basics as defining what constitutes an anger difficulty (Lee and DiGiuseppe 2017). Most young men will be offered "anger management" which is often extremely basic and is too often premised on an idea that anger is 'toxic' and should be eliminated, and by extension takes a judgemental and condescending attitude towards people who have anger difficulties.

The next part of this chapter aims to provide clinicians and young men with an understanding that validates their experience and provides some clear direction in terms of interventions that are likely to be beneficial and useful.

The Anger Trap

The anger trap (Howells 2018) is a psychological formulation based on cognitive behavioural therapy, but also informed by more relational models such as cognitive analytic therapy (e.g. Ryle and Kerr 2002). The anger trap is illustrated in Fig. 1 and is made up of two interlinking vicious cycles; the existence of each serves to prevent change in the other. The core of the two cycles is repeated experience of interpersonal conflict, appraisals characterised by interpersonal threat, and resultant anger and shame.

Difficulties with anger arise when the emotional response is no longer a helpful response to environmental stimuli but is disproportionate and over-estimated. In the anger trap, this is illustrated by appraisals of over-estimated interpersonal threat. A tendency to appraise situations in this way is particularly likely to result from early experiences of frequent conflict, abuse, humiliation, and trauma, as outlined earlier. Importantly, another common appraisal in anger is the sense that the anger and the associated behavioural responses are out of control; the individual is unable to control their own behaviour. These appraisals result in the experience of anger and shame. Interpersonal conflict, the two groups of appraisals, and anger and shame represent the core of the anger trap.

There are two possible behavioural responses to these emotional states. One is the outward expression of behaviour, in the form of aggression and

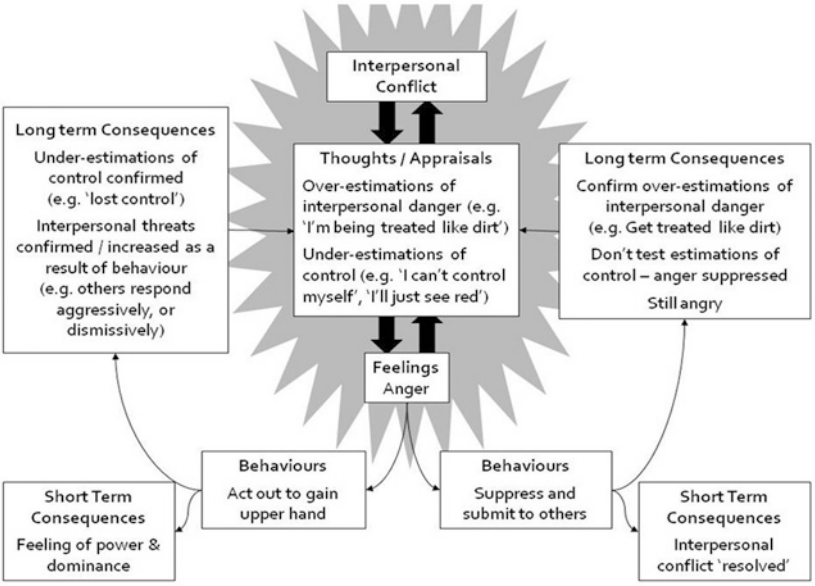

Fig. 1 Anger trap (Howells 2018) (Reproduced with kind permission from Taylor & Francis)

violence, the other is the suppression of emotion. Each of these behavioural responses forms one of the two vicious cycles around the trap.

The outward expression of anger in the form of aggression, either verbal or physical, is consistent with the behavioural urge of anger. Sometimes this outward expression is done in thought or fantasy: in a survey of college students, the majority of thoughts following an incident prompting anger were of revenge, attacking others and destruction (Izard 1991). Sometimes these thoughts can develop into fantasies of action and individuals might imagine screaming at people or being aggressive towards others, perhaps even have violent or murderous fantasies. In the short term, outward expression of anger results in a reduction in the feelings of shame so often associated with the precursors to anger. Young men often feel powerful and in control which is an almost opposite experience to the powerlessness they feel in relation to the eliciting event. This is a powerful maintaining factor in repeated episodes of aggression, even against an awareness of the more problematic long-term outcomes. In the longer term, outward expression of anger leads to one of two significant outcomes. One is an escalation in conflict, which serves to confirm the initial appraisals of interpersonal threat and a lack of control. Another outcome is an increase in shame as a result of the consequences of

the aggression (for example saying or doing things that are later regretted), or humiliation and devaluing by others. These serve to confirm the initial appraisals.

The suppression of anger, in which the young man 'walks away' or 'leaves it', avoids the potential for escalation or shame following the outward expression of anger. It is also often praised by others when young men are struggling with anger. However, in the longer term, the feelings remain and the young man still feels anger and shame following the precipitating event. Frequent suppression of anger and shame can also lead to interpersonal situations in which young men are taken advantage of or devalued as they do not stand up against this behaviour. As a result, the initial appraisals of interpersonal threat are confirmed.

The two vicious cycles of the anger trap can be labelled 'bottle up or explode' and both parts of the trap are always present, although one might be emphasised over the other. It is a powerful formulation as it places the experience of anger at the centre of the formulation and is based on an understanding of anger as an emotion that is ordinarily functional and helpful. In doing so, it also makes the links between anger and other emotions that are often more difficult for young men to experience and express, such as shame, fear, sadness, and guilt.

Intervention

One of the major challenges of working with angry young men is to reach the point of seeking a receiving help. There are well-documented barriers to male help-seeking (Yousaf et al. 2015) and once they reach services, the barriers continue. The anger trap can be used to inform decisions about early engagement as well as later intervention.

Early Engagement

The anger trap highlights the difficulties that young men face. Often young men present to services and experience assessments that are focused on their risk to others, the impact of their actions on others, and their level of remorse. Clinicians may also take overt measures to protect themselves from perceived threats, for example conducting assessments in pairs or refusing to visit the home. All of this is experienced as threatening and shaming by young men and fuels the trap. Sometimes this will result in appointments

characterised by tension and aggression, at other times young men might refuse to engage in the process at all. Often, both of these types of behaviour result in a lack of provision of support to the young man and he is left feeling devalued, rejected, and abandoned.

Our approach begins with an understanding and validation of the feelings and the associated behavioural responses, as outlined in the trap. Attempts are made to reduce the level of threat the young man is likely to feel from the beginning of the process. It is assumed that angry young men have already been through a long process of debate and inner conflict before seeking help (Yousaf et al. 2015) and so any request for help is taken seriously, even where the words or actions in the moment do not appear to support this. Interpersonal processes that might be experienced as threatening or shaming are kept to a minimum, which include avoiding direct lines of questioning, writing lots of things down, and using language associated with vulnerability. Potential Threats within early assessment sessions are kept to a minimum, one-to-one appointments are offered if possible, a confrontational stance in terms of room arrangement and clinician posture is avoided, care is taken to avoid questions that might be experienced as threatening or shaming and initially to stick to subject areas where the clinician can remain curious and interested. Over time, aspects of the anger trap can be brought into the conversation, including links between early history and types of appraisal, appraisals and emotion, emotion and behaviour. During this process, the focus remains on the young man themselves and on validating their experience, rather than switching position and asking about how others might feel (a line of questioning often used to determine remorse or regret, but which can be experienced as devaluing or shaming). Drawing the anger trap might take a number of sessions done in this way and represents a piece of collaboration between the young man and the clinician, and the bond of trust between them.

Feeling Angry

Once the anger trap is drawn, it can be used to begin the process of intervention, which is outlined in more detail in Howells (2018). Many clinicians operate under the misconception that whilst working with fear involves the experience of fear, working with anger should somehow involve its eradication. This leads to the kinds of ineffective interventions that young men have often experienced—anger management which is targeted towards eliminating the experience of anger as shameful and bad. In the context of

the anger trap, effective intervention for anger needs to involve exposure to anger-inducing situations and different behavioural responses. Over time, this leads to a modification of the appraisals of over-estimated threat, and hence reduced experience of anger and shame.

The process of exposure to the feelings of anger and responding differently usually requires some work around anger regulation in the moment, and some challenging of the appraisals around underestimates of control, so that young men learn both the skills to regulate their anger, and also learn that they can experience anger without losing control. Only then will they be willing to expose themselves to anger-inducing situations and better assess the interpersonal risk. The first stage of intervention involves the active regulation of anger, both upwards in intensity and downwards in intensity within the context of intervention. Clinicians can use a simple anger scale and use this to rate anger on a changing basis and to ensure that the intervention is carried out in a safe and contained way. Clinicians can then invite young men to think of recent events that made them feel angry, to focus their attention on the anger-inducing qualities of the events, to focus on the building tensions in their bodies, to notice any shifts in their thought processes, to think, perhaps about how they would have liked to respond. Behavioural experiments can be used to predict what young men think they might do if they get 7 out of 10 on the anger scale and then see whether they really do lash out or trash the room. This process can enable young men to learn that they can manage their responses to the emotional arousal produced by feeling angry.

Assessing Interpersonal Risk

Once young men understand the anger trap and have experience of feeling angry and regulating it differently, they can move on to more direct work on the appraisals of interpersonal threat that lead to anger and shame. There are a variety of different options to target the appraisals of interpersonal risk. One clear option, particularly in the case of young men who have experienced a great deal of trauma and abuse is to work on processing the memories of these events. This will involve experiencing the feelings, including anger, shame, rage, fear, sadness, etc. and re-evaluating these events against a more safe and secure present state (e.g. Ehlers 2010).

Alternatively, young men can be supported to use a whole variety of re-appraisal strategies commonly used in CBT in more current and present

situations. This might involve the use of thought records or continuum techniques (Padesky 1994). It might also involve behavioural tasks such as learning particular social skills, experimenting with different forms of communicating and interacting, including details such as posture and eye gaze, as well as developing skills and competence in particular areas (see Howells 2018, for more detail).

Most work with angry young men involves a variety of these different techniques, some work processing past events and some work on supporting them to better manage present situations. The key is that the work is based on an understanding of anger and related emotions that is used to validate the experience of young men and support them to make change in their lives.

Case Example

A 17-year-old male has been referred to the mental health service because of the concerns of one of his teachers at college. He has been talking to a tutor at college and has expressed thoughts of harming others, and of gaining pleasure from these thoughts. He has also spoken of fighting frequently. He lives with his mother and siblings, and at assessment it appears he is also frequently angry and aggressive in the home environment and will shout and bang doors. He attends the assessment with his mother, is tense and curt in the meeting, and talks freely of moments of aggression and fights with others, as well as talking in detail about his violent fantasies.

The staff of the service are worried about his risk to others, but on further investigation, it does not appear that there is a significant documented history and members of his family deny violence against them. The next appointment is with two senior clinicians and he again presents in an aggressive and uncooperative manner saying that he does not want any help, that everything is fine. The service plans to close.

A third meeting is offered for the young man and one clinician alone, who thinks that he is less likely to feel threatened on a one-to-one basis. In this meeting, the clinician begins by avoiding any potentially conflictual areas of conversation (for example 'what do you want to change?') and takes an interested and curious position. During the course of the meeting, the clinician gradually works to reference the ideas of the anger trap, avoiding putting pen to paper too soon. A link is made between early experiences of violence and a subsequent expectation of violence and attack from others. Anger and aggression is named as a helpful way of keeping others away. Care is taken to avoid language of vulnerability as much as possible: 'challenge' rather than 'struggle', 'tension' rather than 'fear'. Over time, the anger trap is drawn and the young man begins to talk about his early experiences, begins to process memories of being told to 'man up', and of early experiences of violence and abuse. He learns to talk more openly about his experiences, about his emotions, and learns practical ways of managing his emotions and managing social situations.

Conclusion

In this chapter, we have examined the reasons why young men should present with anger difficulties. We have highlighted the shortcomings of traditional approaches for this population, in spite of a high level of need. We have outlined a psychological formulation with anger at its core, which is designed to support the processes of validating the experiences of young men and supporting them to make change. A case example highlights the potential issues that angry young men face, along with some ideas about how these can be tackled.

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Improving the Mental Health and Well-Being of Excluded Young Men

Clare Holt, Sally Zlotowitz, Olive Moloney and Mark Chentite

Introduction

In writing this chapter we will lead you through a series of systems in order to share our understandings of what we believe impacts on, and can therefore improve, the mental health and well-being of excluded young men, particularly those who are affected by serious youth violence in their communities. The group of young men at the focus of this chapter may often be referred to as 'gang members', a term we see as problematic and critique (Section 'Prison and the Criminal Justice System').

To provide a context to the chapter, we wish to explicitly name some positions we take, and values we hold in our philosophy and practice when working with excluded young men. All the authors have worked at MAC-UK, a mental health charity, and are mental health practitioners who advocate political, community-based and co-production approaches, wherever we are working.

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a. *We wish to put those with lived experience at the forefront of our work.*

We start this chapter with the reflections of a young man who has directly experienced social exclusion and lived in communities affected by issues including serious youth violence, deprivation, and a poor fit with the current education and employment systems. Putting those with lived experience at the forefront of our work is crucial. The three female authors clearly are not socially excluded young men and so we do not wish to speak on behalf of them. We use Mark's commentary as a guide to unpick issues relating to the well-being of excluded young men, recognising Mark's voice as only one in a huge heterogeneous group. We take the stance that those with lived experience can offer insights and knowledge that the professional 'mental health and criminal justice systems' do not prioritise. Our thesis is that it is through working in partnership with those with lived experience that we can find solutions.

b. *We understand mental health as constituted by multiple systems interacting with each other and with individuals, including the structural arrangements of society.*

Our chapter draws on an ecological systems framework to promote the idea that to effectively improve the well-being and mental health of excluded young people, interventions and change need to occur at all levels (Bronfenbrenner 1979; see Fig. 1). We posit that mental health practitioners can and should intervene at all these levels and intervening in one alone is not enough; not least because we should be shifting towards a preventative health care system.

c. *We seek to remain critically aware, reflective of, and to challenge mental health practice, and our role as practitioners, in relation to reinforcing status quo power structures.*

The authors are aware of their own privilege as the majority are White middle-class females who might reinforce potentially oppressive processes and perspectives (Glynn 2013). We wish to distinguish this chapter from other papers about mental health and excluded young people by recognising and acknowledging the role of mental health practitioners in the maintenance of 'social control' and the socially unjust processes of the criminal justice system and at times the social care or mental health systems (Joseph 2007).

As Mark outlines below, the context in which young men find themselves can generate a need simply to survive their environments; the deprived and sometimes violent communities that young British men may grow up in. There are many sources of information about the ways in which the mental

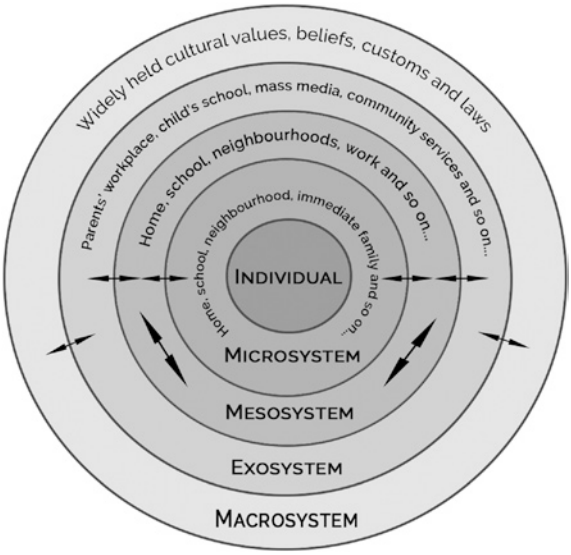

Fig. 1 Social ecological systems

health of excluded young people may be influenced by this need to survive afflictive environments (Public Health England 2015a; Beyond Youth Custody 2016); it will not be repeated within this chapter. In line with our positionality statement, our focus here is on the multiple levels of interactions that encompass a holistic perspective of mental health and well-being.

Issues, Solutions, Interventions and Ongoing Challenges Across the Systemic Levels

In keeping with an ecological systems model, we consider the different systems, where we see existing and potential solutions, and identify ongoing challenges. We start with Mark's thoughts and experiences as someone who speaks with the weighty knowledge of having lived experience of this world. His thinking, and the experiences he and other young men have been generous enough to share with us, are integral to the understandings we share.

The Microsystem

The microsystem is the smallest and most immediate environment in which an individual lives. It comprises the daily home, school, peer group or community environment. Interactions within the microsystem typically involve

personal relationships—with family, classmates, colleagues, teachers, caregivers—in which influences go back and forth. How these groups or individuals interact affects how an individual develops. Similarly, how an individual reacts to people in their microsystem also influences how they treat them in return. One of the most significant findings in Bronfenbrenner's (1979) study of ecological systems is that it is possible for siblings who find themselves within the same ecological system to still experience very different environments.

The Individual, from Mark's Perspective

Writing as someone who has seen and experienced first hand, as a perpetrator and victim, how serious youth violence can destroy and take lives, I am aware there are many challenges linking excluded and gang-affected youth with services aimed at supporting them. The imbalance of decision-making in deprived communities, alongside feelings of inequality and ambivalence, has led many young men to become what I call 3D: disenfranchised, disengaged and disaffected, a position that has an inevitable impact on mental health and well-being. I suggest that, amongst many other facets, the 3D's create and perpetuate a lack of trust with services and authorities; restricting the ability and willingness to seek help.

My first interaction with a support service took place in 2008. Recognising some of the shortcomings in existing services, a Clinical Psychologist was keen to build relationships with gang-affected males in my area. Upon her stating her intention to support a community, my community, in supporting itself, I became defensive and immediately untrusting. I felt that our abilities in supporting ourselves were being questioned by a middle-class professional who had no understanding that we had experienced a drive by shooting the previous night. Despite being spat at, swore at and essentially threatened, the Clinical Psychologist was still enthusiastically trying to engage with our group; in this way she convinced us she was well meaning and we had to respect that. The relationship developed through mutual trust and not an orthodox clinician—patient scenario, which would have felt unacceptable to me and my peers. We had natural conversations about well-being and discussed ways to try and improve the situation. I applied myself to the project and encouraged my peers to engage in the activities. Trust was built with the wider group and I essentially acted as a gatekeeper.

In my experience, there is a world that mainstream society hears about in sensationalised news reports and documentaries, which cannot begin to

capture the reality of our experiences. I suggest that many excluded youth feel unsafe and in constant anticipation of threat and danger. The reality of death is something that some young men must adapt to and deal with, and this may happen in different ways. As above, seeking out professional help can be very challenging for several reasons and alternative 'solutions' may include: a dependency on drugs and alcohol, misogynistic behaviour, a disregard towards their own and others' lives, a materialistic view of the world, and prioritisation of the here and now over the future. For excluded and marginalised young men, family structure is commonly fractured. Many peers were raised in single-parent households, and whilst appreciating the individuality of people's circumstance, family based experiences may impact unhelpfully upon mental health and well-being and may also impede a willingness to seek or accept professional support.

Education at that point in time felt like an obstruction as opposed to an opportunity and many of my peers passed through the education phase with haste. There was little interest in aspiring to particular careers, rather we wanted to emulate older peers who we regularly saw driving expensive cars and enjoying extensive financial resource; they didn't need to wait for anyone or anything, or so we thought at the time. Leaving the education system without GCSEs was just another reason to commit further to a daily cycle of illegitimate financial conquests to ensure you had 'p's in your pocket' and maintained a feeling of 'being a real man'.

Prison is another factor that weighs heavy on the well-being of many young men from areas and communities similar to my own. Short custodial sentences at a young age *can* act as a badge of honour and earn an underlying recognition of surviving a dangerous environment. Concurrent to this, the custodial environment can create and exacerbate a range of mental health and well-being needs. The longer sentences served by some young men can prove particularly challenging, and may be associated with broad-ranging battles with mental health and well-being.

In summary, a plethora of factors can mean that excluded and gang-affected youth experience increased mental health and well-being needs. Simultaneously, numerous factors create and maintain barriers between these young people and professionals in a variety of roles. I have noticed, through experience as a service user and practitioner that some professionals are reluctant to adopt unique and non-traditional approaches that are undoubtedly required to engage with this demographic. Whilst understandable for several different reasons, this reluctance, alongside the multitude of other factors introduced in this section, inevitably feeds into the cycle of young men's mental health and well-being needs remaining unmet.

The Family System

According to attachment theory, early experiences with a primary caregiver shape the development of an internal working model of relationships; a cognitive framework for understanding the self, world and others (Bowlby 1969). Multiple factors across different levels of influence can contribute to inconsistent or erratic caregiving and, experiences of being cared for and held in mind can be limited or even absent. In turn, these caregiving experiences can underpin an individual's model of self (e.g. unworthy, unlovable), others (e.g. not trustworthy, hostile) and the world (e.g. dangerous, unpredictable) in different, but largely unhelpful ways. The familial experiences of excluded young men *may* not promote the development of secure attachment.

In addition to individual factors (i.e. attachment styles), a multitude of other factors can and do disrupt the attachment process. For brevity, these can be summarised as Adverse Childhood Experiences (ACE's) and include: physical, emotional and sexual abuse; domestic violence; substance use; unmet mental health and well-being needs; parental separation; a parent being placed in custody. An extensive range of societal, political and community-based factors contribute to ACE's and, regardless of their cause, disruptions to early attachment have widespread implications in terms of attachment style, brain development, and the ability to recognise, regulate and respond to emotions and behaviour both in ourselves and others (Schore 2001).

It is suggested that many of the exclusionary influences that operate within and across the multiple systemic levels acknowledged within this chapter are experienced intergenerationally. Excluded young men may experience mandatory or unwanted contact between their family and professional agencies (e.g. social care, police) from a young age. These experiences will inevitably shape attitudes and beliefs regarding help-seeking, and may create multilayered barriers to engaging with services.

In summary, the family context experienced by some excluded youth may not provide the security, stability and consistency that supports optimal development across emotional, social, cognitive and behavioural domains. It is important to note that in isolation attachment theory provides a narrow and culturally biased perspective on how child–parent relations are, and should be formed. The extensive remit for a critique of the theory is acknowledged, however is beyond the scope of this chapter (Quinn and Mageo 2013).

Attempted Solutions

Between 2008 and 2011 the Department for Children, Schools and Families (now the Department for Education) funded the Parenting Early Intervention Programme (PEIP). Local authorities nationwide received PEIP funding to deliver evidence-based parenting programmes which aim to improve parents' skills, knowledge and confidence. A nationwide evaluation of the PEIP concluded that their positive effects upon parents' mental well-being and style of parenting, as well as on children's behaviour, are all key factors known to contribute to positive long-term child outcomes (Department of Education 2011). Evidence also indicates difficulties with access and successful completion of some parenting programmes, in particular for families in greatest need (Social Care Institute for Excellence 2009). The Social Mobility Commission emphasises the need for increased availability of universally accessible parenting interventions (2017).

A body of research has focussed specifically upon the impact of father–child interactions and relations upon social development (Frosch et al. 2001), behavioural development (Jaffee et al. 2003), emotion regulation (Roggman et al. 2004), and cognitive functioning (Gauvain et al. 2002). Recognising the pivotal role of fathers, the Expectant Father's programme provides practical guidance, advice and support for expectant and new fathers. It is unclear to what degree the one-day evidence-based programme provides accessible support across all demographic groups, and it is suggested that challenges regarding access remain.

Launched in October 2013, the '1001 critical days' manifesto focuses upon the period between conception and 2 years. Attempting to provide multifaceted support to families, a holistic, tiered approach spanning professional agencies was proposed. Additionally to universal access to generic support services, the tiered approach promotes identification of 'at-risk' families and suggests UK-based services provide access to: evidence-based interventions to support parent–child interaction, specialised mental health interventions for parents and antenatal classes that address emotional and physical aspects of parenthood (Public Health England 2015b). Whilst the manifesto successfully highlighted the window of opportunity to provide families with support during and subsequent to pregnancy, available information does not delineate the actual changes that have been achieved. It is evident that for some individuals and families, a range of needs remain outstanding before, during and after pregnancy.

In addition to universal initiatives, alternative interventions have been more targeted. Launched in 2012, the Troubled Families Programme (TFP) aimed to support families identified to have specific needs including: crime,

truancy, unemployment, mental health and domestic abuse. Recognising the need for a co-ordinated, multi-agency approach, the TFP identified key factors as crucial to 'success': a dedicated family worker; practical 'hands-on' support; a persistent, assertive and challenging approach; considering the family as a whole; common purpose and agreed action (Department for Communities and Local Government 2012). Government-funded evaluation has shown that phase one achieved positive outcomes at the level of individual families (e.g. obtaining employment) and service provision (e.g. coordinated cross-agency approach). Our critique of the TFP is its attribution of 'troubles' to the families themselves. Its agenda neglects the broader social, cultural and economic contributors to the disadvantages experienced by many families, all of which are discussed below.

Multisystemic therapy (MST) is an evidence-based model of intervention aimed at young people who are at risk of placement outside of the family home, in either custody or care placements. MST posits that all young people are embedded within multiple systems (family, peer, school, community) and the intervention aims to leverage protective factors across systems. MST's intensive, flexible and outreach approach is well-placed to meet the needs of excluded families who may be reluctant to engage with more traditional, clinic-based modes of intervention. Available evidence indicates that the present-focussed approach can help to avoid caregivers feeling judged or blamed (Tighe et al. 2012). MST has an extensive evidence base with young people aged 11–17 internationally and in the UK (Butler et al. 2011). However, MST is a costly licensed intervention; as austerity continues to impact on service provision, availability is likely to reduce and only a small proportion of suitable families will be reached.

The Education System

For some young men, like Mark, their relationship with the education system and environment is extremely negative (Khan et al. 2017); this can negatively reinforce other personal factors, and experiences within family and peer groups. Few alternative opportunities seem to be presented.

The expectations that schools and teachers hold for their students is well known to have an impact on their learning outcomes (Cooper and Good 1983). Evidence suggests that whilst the majority of teachers form initial expectations on the basis of viable information, and are able to adjust these expectations fluidly, a minority of teachers do hold unjustifiably low expectations for student achievement on the basis of factors such as race, gender,

appearance, or socioeconomic status (Wineburg 1987). The negative effects of differential teacher treatment on low-expectation students may be direct (less exposure to learning material) or indirect (treating students in ways that erode their learning motivation and sense of self-efficacy) (Cotton 1989).

In particular, for those from BAME backgrounds, behaviour and underlying intent, can be frequently misunderstood. Different pupils will perceive the same classroom differently and will be perceived differently (Ross and Nisbett 2011). This suggests,

> that we should guard against the assumption that a student who chronically underperforms or misbehaves has a low ability, a learning disorder, or a rebellious nature. Instead, we should consider what aspects of the classroom, both obvious and subtle, drive the student's behavior. (Cohen and Garcia 2014, p. 14)

Examining race in education over a period of 20 years, Gillborn et al. (2016) reflect that that despite a reduction of more than 50% in the proportion of young people permanently excluded from school, inequalities have remained, with Black Caribbean students being over 3 times or more likely to be excluded than White British peers. These findings are in line with qualitative research on the experiences of Black students, which portrays the relationship with school as frequently characterised by tension, mistrust, heightened disciplinary surveillance and low academic expectations on the part of schools (Gillborn 2008). Gillborn et al.'s (2016) data also refers to the failure of policy to address the needs of White working-class communities and points to the deracialisation of policy and politics—rather than seeing racism as an inevitable process which then allows policy to deal with it.

Within UK society, roles that are available to young people are flavoured by the neoliberal context in which we are living, that is through a lens of individualism and economic potential. Academic and sports success are both seen as valid ways of achieving this individual success, which limits the possibilities for those who may not conform. The fit of the current education system is not a good one for all young people, especially with the ever-increasing 'exam factory' experience of schooling, in which the curriculum is becoming increasingly more narrow (Hutchings 2015). For young men who have been discriminated against, come from backgrounds where expectations from the system are lower, and who have been excluded for learning needs and other reasons, the roles that are available to them are further narrowed and reduced, leaving some young men with the option of serious youth violence as their only means of survival, as described by Mark above. A system that promotes growth and learning can become limiting and damaging.

Attempted Solutions

Service provision in the UK is beginning to realise the possibilities of addressing well-being in schools, as well as racism and low expectations through the school system; the Home Office (2015) advocates for a mix of universal, targeted and specialist interventions.

Thinking beyond the school environment itself, the Home Office (2015) advise working with local partners and school councils, to achieve full understanding of how contextual/community issues affect behaviours in the school. They recommend that schools should have a system to target and respond to individual and group violence, and should work with the local community safety partnership. The guidelines highlight the importance of developing multi-agency responses and information sharing that is tailored to the individual *and* the context. Existing literature acknowledges that change is a process not an outcome (Cohen and Garcia 2014), implying that these recommendations may be particularly difficult to implement in a culture of accountability and risk management, or without the support, knowledge and experience of young people, grass-roots community organisations, faith leaders, elders and other influential community members.

Future in Mind and the Youth Select Committee report into children and young people's mental health both refer to the power of, and need for, facilitated peer support (Department of Education 2017). Surveying 1800 children and young people, and exploring the specific needs of different groups of vulnerable children and young people, a range of suggestions and recommendations for good practice were made: strong leadership and management support, clarity around safeguarding and confidentiality, supervision and support, training and information. Collaboration between schools and community settings can support schools to learn from good practice with regard to peer support (Department of Education 2017).

The Home Office (2015) impress upon school leaders and senior teams the importance of early intervention and the provision of support to develop social and emotional skills that young people need to meet their full potential, for example conflict resolution skills, managing transitions between establishments, understanding risky situations including violence and abuse, and recognising when to seek help. The Home Office (2015) has outlined an extensive resource of interventions targeted at reducing young people at risk and improving educational outcomes including: mentoring, anti-bullying programmes, improving social skills, involving parents and CBT. They show evidence of outcomes for reducing risk and improving education. Improved self-esteem, resilience and organisational ability are associated with whole school approaches (Clarke et al. 2015). Dealing directly with race and

racism, and its relationship to class, health, gender, sexuality and other areas of potential discrimination, is also acknowledged to be key (Gillborn et al. 2016). These interventions delivered uncritically and in isolation of context, may lead to teaching equality and equity when environments or communities may not be safe places in which to practice these, as Mark shows. We advocate here for thinking and engaging in a community-led approach, each time, to prevent further exclusion from employment and opportunities later in life.

Project Oracle (Belur 2013) studied London education-based interventions with young people not currently accessing employment, education or training, and identified four key factors in achieving successful and sustainable outcomes: referral (appropriate audience through agencies), hooking (incentive-based, intensive outreach), influencing (supporting and encouraging positive attitude change which can generalise) and facilitation (multimodal, facilitating tailored integrated transitions to further opportunities developed through good partnerships with ETE stakeholders). They noted that there is little robust evidence linking these interventions to longer-term outcomes. This may be because these interventions still target individuals and do not address their wider contexts, such as peers or community factors, which may limit effectiveness in the longer term.

Without explicitly acknowledging racism, discrimination, and other forces that impede individual's access to their educational right, well-intentioned interventions may reinforce existing power structures. Participatory approaches or providing equally valued alternatives are less explored.

The Peer System

During and after adolescence young men (and women) turn to peers for support, guidance, and advice in developing a sense of belonging and identity. Informal and formal help seeking from adults reduces, young people spend more time together and increasingly rely on each other (Dooley and Fitzgerald 2012). Young men who are excluded appear to be no different in this respect; available information highlights the important role of peers within antisocial behaviour but also the ways in which they protect and support each other.

As with any group, groupthink amongst excluded young men can lead to the valuation of hypermasculinity over other ways of 'being male', and as outlined by Mark, to behaviour that is misogynistic. Status and power may operate in a different way to prosocial groups with status being accrued if a

young man can demonstrate their management of: high levels of aggression and violence; high stress levels associated with evading police and the justice system; economic security and wealth; migration, asylum seeking or refugee status; historical traumas, discrimination and racism; personal traumas of witnessing and experiencing emotional and physical pain; protection of their peers without question. The prolonged daily accrual of these stressful experiences, can lead to an overload of 'toxic' stress leading to undermining physical and mental well-being (Khan et al. 2017); the reliance on peers for protection and support can be reinforced.

Attempted Solutions

For some social, emotional, spiritual, behavioural or mental health difficulties, groups are engineered in order to put people in contact with those who have faced similar issues and intend to assist individuals to overcome these issues together (e.g., Hearing Voices, DBT). Paradoxically, many mental health interventions for excluded young men separate them out in order to 'treat' or 'manage' their difficulties, removing their access not just to 'anti-social peers' but potentially to their only emotional support system. Some alternatives are outlined here with examples.

Tolan et al. (2008) found that overall, mentored young people, already displaying delinquent behaviour or at risk of future delinquency, displayed a lower likelihood of delinquency, aggression and drug use, and achieved better academic results than those who were not mentored. In terms of mental health, effects tended to be stronger when emotional support was a key part of the mentoring provision, and when the mentors were motivated to participate as part of their own professional development rather than simply volunteering. Jolliffe and Farrington (2007) found that mentoring significantly reduced subsequent offending for individuals who were at risk of offending or had been apprehended by the police, compared to those who were not mentored. The mentoring was part of a wider suite of interventions, and influences persisted only for the time of mentoring.

Peer support, 'involves people drawing on lived experience or shared characteristics to provide knowledge, experience, emotional assistance, practical help, and social interaction to help each other' (Graham and Rutherford 2016). Effective peer support is co-produced, asset-based and targeted towards better health, well-being and improved outcomes (Wood et al. 2016). There is evidence to suggest older peer to youth mentoring relationships in a youth offending context, may have comparable beneficial effects to adult–youth mentoring (DuBois et al. 2011). Peer support can help people feel more knowledgeable, confident and happy, and less isolated and alone

(NESTA & National Voices 2015). In mental health specifically, peer support was a key recommendation in the Five Year Forward View for Mental Health (NHS England 2016), with evidence that peer support is highly valued, especially by young people and British and BAME adults.

Accepting that exclusion is not solely applied to BAME young men, The Centre for Mental Health's 'Against the odds' report (2017), found that peer support projects' that implemented the Integrate approach developed at MAC-UK improved well-being of young black men because it: offered positive adult male role models in relatable black men who had been through and overcome adversity; provided culturally and psychologically informed safe spaces encouraging aspiration, openness, positive relationships with other young black men; engaging, creative opportunities that were strength-based; provided an experience of solidarity, unity and social commitment; conveyed a positive picture of black culture and heritage; and enabled some young men to mentor younger members of their community. Similarly, St Giles Trust SOS+ Project (school-based) and Peer Advisors (community and prison-based) are ex-offender, peer-led approaches to reducing (re) offending, increasing knowledge and supporting alternative choices. There is a risk that effects of peer mentoring can be reduced if insufficient support is provided (Karcher 2007); robust supervision systems can help to ensure deviant behaviour is not glamorised or modelled, and that a 'peer contagion' effect does not creep in (Dishion et al. 1999).

In summary, professionals may need support and or training to let go of expertise and to provide support to mentors and peers so that safety is maximised but discourses of professional 'rightness' are not perpetuated. Some mental health interventions, for example, Open Dialogue, might provide pointers in how to support professionals to do this (Holmesland et al. 2010).

Prison and the Criminal Justice System

The multiple strands of disadvantage experienced by excluded young men increase their likelihood of offending, coming into contact with the criminal justice system and receiving a prison sentence, e.g. pro-criminal peers, lack of opportunity for legitimate employment, traumatic experiences and some individual risk factors such as learning difficulties. There is also evidence to suggest that those from BAME backgrounds are significantly more likely to receive a custodial sentence in comparison to white peers (Ministry of Justice 2016). As outlined by Mark, if they do reach custody, this can have a significant impact upon their mental health and well-being.

Custody is shown to be ineffective in reducing offending behaviour (Marsh et al. 2009), and is particularly detrimental for developing adolescents (British Medical Association 2014). Therefore, the number of young people in custody in the UK is reducing with currently less than 1000 under 18 year olds in custody; a 66% decrease since year ending March 2006 (Youth Justice Board/Ministry of Justice 2017). Young people placed in custody have generally committed serious offences and represent the 'tip of an iceberg' in terms of complexity of need across multiple domains.

Mental health needs are three times more prevalent amongst under 18-year-olds in the youth justice system than amongst non-offending peers (Hagell 2002). Learning, neurodevelopmental and speech and language needs are also more prevalent (Centre for Mental Health 2010). Not only are young people in custody likely to experience a greater level of need across domains, they are also far less likely to have accessed support services for multiple reasons already discussed in this chapter. There is evidence that black and minority ethnic individuals are 40% more likely than white Britons to come into contact with mental health services through the criminal justice system, rather than through other referral sources (Kane 2014).

There is a wider critique of the criminal justice system for its inability to perform its own stated aims of reducing crime (Dorling et al. 2008), whilst being disproportionately focussed on those from lower socioeconomic classes (Reiman 2016). Indeed, it has been described and evidenced as merely a way of maintaining the social order and maintaining power over the less powerful (Moore and Roberts 2016). Yet prison has a huge detrimental impact on young men who end up within it.

Impact of Prison

Various contextual considerations impact the mental health and well-being of young people in custody. UK prison services are falling below expected standards regarding: safety, respect, purposeful activity and resettlement (HMCIP 2016). The prison environment can be immensely challenging; restriction of freedom and self-determination, isolation from family and peer support, and the exposure to conflict and violence are all highly influential. There is much evidence that austerity is perpetuating such challenges (Allen 2013). In addition, young people in custody are denied several opportunities that assist typical development in emotional, social and sexual domains (Howard League 2015). In short, young people in custody typically present with increased need across domains *and* incarceration in itself can impede mental health and well-being.

NHS England's 'principle of equivalence' stipulates that healthcare provided in custody should be equivalent to that in the community. The separation of custodial services for under and over 18s creates several challenges.

Placement types differ in many respects, not least in terms of the nature, breadth and availability of support services. In general the youth estate has a greater level of provision and it is commonplace that ongoing support cannot be provided following transition to the adult estate. Currently, there is a reliance on chronological age to determine transition to adult services. This prevents the application of individually tailored, developmentally informed interventions and can create discontinuity of care. Consequently, a young person's pre-existing beliefs about services and professionals can be reinforced, and crucially, their needs are likely to remain unmet. The organisation 'Transition to Adulthood' recognises the numerous challenges that can occur at points of transition; in line with developmental theories they promote the importance of developmental maturity, and not chronological age, when considering responses to, and interventions with, young people in custody.

The Wider Criminal Justice System

Although the criminal justice system is part of the exosystem, it is included here as it interacts with the prison system and therefore influences young people. Sociologist Patrick Williams and colleagues have problematised the use of the term 'gang' within UK discourse, arguing that an 'uncritical' acceptance of the label has led to inappropriate criminalisation and stigmatisation of young men from BAME communities (Smithson et al. 2013). They have argued that this has led to the harmful over-policing, intrusive intelligence-gathering and surveillance of these communities, reinforcing further social, racial and power inequalities (Williams 2015). The term gang has been compared to other racialised terms such as 'terrorist' or 'mugger' with the effect of 'Othering' young men and turning attention away from social and state oppression. Whilst Ansari (2015) describes the gradually increasing role of mental health practitioners in the lives of gang-involved young men as being part of an ever increasing 'risk management' and risk-averse criminal justice system.

Attempted Solutions

Based on a comprehensive review of mental health provision across the Children and Young Person Secure Estate (CYPSE), the Centre for Mental Health (2010) made several recommendations; these are discussed below alongside subsequent developments.

The review noted that entry to custody provides a unique opportunity for the identification of health needs, health promotion, and provision of tailored intervention for unmet health needs. The Youth Justice Board introduced the Comprehensive Health Assessment Tool (CHAT), a screening assessment of physical health, substance use, mental health and neurodisability.

The CHAT represents an improvement to historical practice that was inconsistent between establishments, and less inclusive across a range of needs. However, the CHAT is a narrow and individually focussed assessment tool that is defined by psychiatric diagnoses and classifications, and does not provide optimal opportunities for engagement and relationship building.

A recent (2015–2016) partnership agreement between NHS England, the Youth Justice Board (YJB) and Public Health England (PHE) set out joint commitment to the delivery of healthcare services across the CYPSE in England. This collaboration places great emphasis on *all* staff across agencies being trained and supported in a consistent way to best meet the needs of young people in custody. Underpinned by developmental and attachment theory, and trauma informed ways of working, the integrated care framework (SECURE STAIRS) represents a move away from individualised approaches to mental health and well-being and recognises that the environment and the relationships within it (rather than specialist in-reach services) are the primary agents of change for young people in custody. The premise of this service development is highly encouraging; the programme is in its early stages of implementation and encompasses different methods of evaluation to be monitored over time and across establishments.

In line with the recommendation for regional strategy (Centre for Mental Health 2010) there have been changes in local commissioning across the UK. As one example, the mental health provision at HMYOI Cookham Wood expanded significantly in 2014 when funding was increased to support the development of a multidisciplinary Child and Adolescent Mental Health Service (CAMHS), the Health and Well-Being Team (HWBT). The HWBT consists of a range of professionals and uniquely a Peer Support Worker with personal experience of criminal justice and/or mental health services. This team adopts a 'whole prison approach' that enables health promotion and prevention activities, in addition to more reactive individual and group intervention. Some of the other key features of the HWBT's practice are in line with recommendations of the Centre for Mental Health (2010). For example, the team places an emphasis on youth participation, basing its group work programme on the ideas and experiences of young people. The team employs service-user representatives who adopt several roles and responsibilities (e.g. group co-facilitation, research design), and act as a 'bridge' between their peers and the team, promoting and increasing access. The HWBT employs a flexible approach to direct clinical intervention, prioritising the development of a trusting, therapeutic relationship over and above specific clinical 'goals'. The work of the HWBT is yet to be formally evaluated in terms of short- and long-term outcomes. As emphasised

throughout this chapter, the multiple levels of systemic influence create a complex picture, and a focus on the individual continues to prevail.

Resettlement planning remains one of the largest challenges inherent in delivering custodial services. The NHS England strategic direction paper (2016) emphasises the importance of continuity of care before, during and after custody, highlighting the increases in need and vulnerability that can occur at any transition point and recognising the need for changes to current commissioning. With some exceptions, current service structures generally prevent the continuity of care that is pivotal to facilitating and maintaining trusting, working relationships with young people and therefore optimal outcomes.

Ongoing Challenges

The emotional impact of being placed in custody cannot be underestimated. In practice, the 'opportunity' for therapeutic engagement that can be afforded by a young person's placement in custody can become focussed on ameliorating the day to day distress and providing support to navigate life in custody, as opposed to focussing on other needs. Services for young people in custody almost exclusively adopt an individual approach to assessment and intervention. Broader societal, economical and community-based influences are largely neglected and consequently the 'problem(s)' is/are located within the young person. Whilst attempts may be made to include family and other members of a young person's network, broad-ranging barriers can make this difficult. As mental health practitioners we must also engage with critical criminology which considers how the 'youth crime problem' is socially constructed across certain periods of history (much like how the DSM has been constructed differently across time).

The Exosystem

The exosystem encompasses the linkages that exist between two or more settings. Other people and places which an individual may not directly interact with but may still have an effect on them, comprise the exosystem. Such places and people may include: parents' workplaces, the larger neighbourhood, and extended family members.

Systems of Broader Communities and Neighbourhoods

Communities and neighbourhoods influence young people's experiences in many ways (see Zlotowitz 2010 or Kagan et al. 2011, for overviews).

For example, a deprived neighbourhood can have fewer institutional resources that can support well-being, as well as contain more exposure to social and environmental stressors, like general crime or fear of crime, drugs and violence and residential instability (Shinn and Toohey 2003; Haynie et al. 2006). Evidence suggests that neighbourhood disadvantage increases daily stress, making people in them more vulnerable to negative events and negatively affecting social relationships (Cutrona et al. 2006). Research in the US notes the similarity of the levels of trauma symptoms between children living in war zones and children living in inner cities (Garbarino and Kostelny 1997).

In some neighbourhoods there is less informal social control which can deter criminality (Haynie et al. 2006). For BAME young people, living in neighbourhoods that are majority white and with a lower median income can lead to higher chances of experiencing psychological distress (Wight et al. 2005). The 'middle-class rod' theory explains that status within neighbourhoods is constructed through the 'middle class' urban lens, in which people are judged by their attainment, ambition, 'individual responsibility' and capacity to cultivate skills (Cohen 1955). This lens privileges some groups over others and contributes to young people developing their own 'code of the street' in which they generate their own status hierarchy through which they can progress (Anderson 1999; Brezina et al. 2004). Research has shown that 'deviant' behaviour is related to negative feelings and low self-worth in the social context of inequality (Pals and Kaplan 2013).

There are multiple community concepts which affect people's well-being and are linked to the experience of their communities; for example, social cohesion, social capital and collective efficacy (Mckenzie 2008; Orford 2008). These community-level factors are recognised within community psychology interventions, but often neglected by clinical psychology and other individual approaches to mental health and well-being. These factors also speak to the concept of 'social exclusion'. One theoretical position (Burchardt et al. 1999) outlines four dimensions of social inclusion:

1. having enough income to be able to purchase the goods and services required for a good quality of life;
2. having opportunities for a good standard of employment;
3. having opportunities to vote and engage in elections and local and national policy-making processes;
4. a positive social support network and different types of social relationships.

It is possible to imagine how these dimensions are not present for '3D' young men and the ways in which this can impact their well-being. Generally, a sense of participation and control over one's life and in the

wider community is crucial to well-being and good mental health (Public Health England 2018; Marmot and Bell 2012), this overlaps with the concept of 'empowerment' as crucial to well-being at both an individual and community level (Public Health England 2018). Within service responses to mental ill-health, there is little encouragement for young people to participate in local political processes or how to get involved in local issues affecting them, such as community housing or planning decisions. In London for example, young people living in council housing may be affected by planning and development processes that some groups have termed 'social cleansing', but otherwise known as 'regeneration' (Minton 2017). These are regeneration processes in which local authorities partner with private development companies in order to demolish what may be referred to as 'problem estates' and become luxury, unaffordable flats; with evidence that many of the original tenants are displaced to the outskirts of the city away from their social support networks and community ties (Minton 2017). When such development happens with little sense of control over the processes for the residents this will impact on their well-being. Another example of this lack of control over community decision-making, is the closure of youth centres in communities as a result of austerity policies (Berry 2017).

Attempted Solutions

We argue that to develop effective and preventative solutions to the mental health of excluded young people we should be engaging with communities directly. By developing community-led approaches, a wider range of ideas are developed that are often more sophisticated in their capacity to generate wider systemic change, taking the focus off individual young men and families, instead putting a spotlight on structural and asset-based approaches.

Community-Led Interventions

South Africa is particularly rich in community-led approaches to issues such as violence prevention, excluded youth and community well-being with its unique context of the post-Apartheid landscape. However, these enriching examples frequently remain unheard in the UK and Western Europe due to the marginalisation of non-European/non-American research and practice (Seedat and Lazarus 2014), mirroring the experience of the BAME communities of young people in the UK. Instead the UK knowledge production around what constitutes the evidence-base of mental health interventions remains limited to academics residing in structurally rich universities. Liberation and community psychology are both approaches critical of the individualising of traditional mental health support and neglect of deep

historical social contextual factors, including colonisation and slavery. Such interventions might support peace-building (i.e. violence reduction) as a way of improving the health of young men. Ratele and Suffla (2010) argue that consciousness-raising around issues such as male identities and masculinity, interpersonal and structural levels of violence are important components of such interventions:

> Ultimately, peace action with men must translate anti-violence work into a psychological, cultural, societal, political and economic process …The framework for peace action with men is located within a theoretical landscape that distinguishes between peacemaking (which is associated with conflict resolution) and peacebuilding (which is focused more on the alleviation of structural violence, the development of social justice and long-term structural equity). (Ratele and Suffla 2010, unpaginated)

One such example, is the community-led SCRATCHMAPS project outlined by Lazarus and colleagues (2012). In SCRATCHMAPS the religious and spiritual assets of the community are harnessed by that community to support violence prevention and wider well-being. Like in the UK, young men are at highest risk of being both victims and perpetrators of violent crimes, including homicide (Lazarus et al. 2012). The project used a community-based participatory research framework throughout to engage local community members to co-design and co-deliver a series of training, research and actions to generate a sense of safety and peace in their community. The long-term project harnesses the community's religious leaders' influence in the community and involves community members completing asset maps, working within primary schools and holding community researcher led workshops to create change at an individual, relationship, community and societal level. The project draws on the values inherent within faith-based networks, such as: pluralism, inclusion, peacemaking, justice, forgiveness, healing, sovereignty and atonement. The emphasis on participation and harnessing the knowledge of communities has led to individual and collective empowerment (Lazarus et al. 2012).

As referred to by Mark earlier, the multi-agency partnership projects and services of MAC-UK also draw on a community-level analysis (see Zlotowitz et al. 2016; Durcan et al. 2017). MAC-UK offers a service redesign intervention for statutory services (called 'INTEGRATE') that transforms them to become more accessible, relevant and multilevel. INTEGRATE is a set of service design principles which harness lived experience and co-production, demanding more community-led solutions. Evaluations report well-being

benefits at the individual, peer group and community level with an emphasis on social change and peer support that works to prevent the future exclusion of the next generation.

The Macrosystem

The macrosystem is the largest and most distant collection of people and places to an individual that still exercises significant influence on them. It is composed of cultural patterns and values, specifically an individual's dominant beliefs and ideas, as well as political and economic systems. Individuals living in neoliberal areas, for example, will experience a different kind of development than children in other economic systems.

Economic and Political Systems

Neoliberalism dominates our economic and political systems in the UK and the global North more widely. This involves policies which encourage free markets, deregulation and reducing state 'intervention' in all sectors of society, including gradually the NHS and healthcare sector, as well as the criminal justice sector. Mental health professionals and their concomitant talking therapy formulations, interventions and services rarely name this all-encompassing context and societal structures as a contributing factor to young people's experience. Yet, since 2010, excluded young people and their families are at the painful end of the UK's response to the financial crash caused by neoliberal systems: the implementation of austerity policies. Evidence has demonstrated a disproportionate impact of these policies on BAME communities, women and other relatively less powerful groups in society (Runnymede Trust Report 2012; Women's Budget Group and Runnymede Trust 2017). Indeed, there is clear evidence of rising mental health problems within this social context (Barr et al. 2015; Marmot 2015), including rising suicide rate, and rising poverty (Joseph Rowntree Foundation 2017). As poverty and inequality rises, evidence suggests that distress rises and other social problems increase (Wilkinson and Pickett 2009).

Michael Marmot and the Institute of Health Equity's recent analysis shows the number of families living below the minimum income standard has risen by 2 million since 2008/2009 (from 9 million to 11 million families). This is the minimum standard required for the basics of decent housing, transport, nutrition etc. The system is rigged towards wealth

racing upwards, not trickling down. For instance, Oxfam's (2016) report analysed data from Credit Suisse and found that the richest 10% of the UK population own over half of the country's total wealth, with the top 1% owning nearly a quarter (23%). The poorest 20% share just 0.8% of the UK's wealth between them. These structural inequalities affect the young men residing in these communities and have both direct and indirect impact on their well-being and mental health.

Potential Solutions

It is essential that through our 'interventions' we are not reinforcing how power is maintained and legitimised by the powerful without questioning. There are always opportunities to do this in partnership with young people themselves and engaging alongside them in policy work and civic engagement. Drawing on the lived experience of people from marginalised communities to shape policy, social conditions and systems is part of a community and liberation psychology approach (Martín-Baró 1994; Afuape and Hughes 2015). Community psychology approaches work to transform the social conditions that create exclusion (transformative), going beyond just helping individuals (ameliorative). For example, policies or social action that tackle structural inequalities or institutional racism. Within MAC-UK's projects and partnership projects there have been clear examples of engaging with policy-makers to challenge business as usual approaches to serious youth violence. Indeed, there are approaches to justice which encourage us to think about 'social harm'—which would include the harm done by corporations, workplaces, tax evasion, ecological damage or fraud. And there are models developing on how we move towards transformative approaches to justice, such as the framework 'Justice Matters' (2017).

Conclusion

Our vision is to revise the role and remit of mental health practitioners in improving the mental health of excluded young men. As mental health practitioners we must engage with critical criminology which considers how the 'youth crime problem' is socially constructed across certain periods of history. It is essential that through our 'interventions' we are not reinforcing how power is maintained and legitimised by the powerful *without questioning*. There are always opportunities to do this in partnership with young people themselves and engaging alongside them in policy work and civic engagement. Given the analyses presented by both Mark and the literature

as described above, we argue that the criminalisation of many '3D' young men, especially young men from BAME communities, contributes to the demise of their well-being. This is despite the fact that empirically, the criminal justice system is ineffective at preventing reoffending and remains a deeply politically driven system which doesn't account for social power (Moore and Roberts 2016). Drawing on the lived experience of people from marginalised communities to shape policy, social conditions and systems is part of a community and liberation psychology approach (Martín-Baró 1994; Afuape and Hughes 2015). It is imperative that the mental health system accounts for and considers all the systemic and structural issues contributing to these young men's experiences. With this in mind, we should be working towards social transformation by changing the conditions that lead to '3D' living, through policy change, activism or other forms of collective action, alongside supporting individuals and joining together on a journey towards social change.

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Help-Seeking Among Men for Mental Health Problems

June S. L. Brown, Ilyas Sagar-Ouriaghli and Luke Sullivan

In this chapter, we will first review the current situation regarding the mental health of men. We will then review help-seeking among men and women before describing important factors which may contribute to men being less likely to seek help from mental health professionals. We will then go on to describe recent positive work that has been carried out on male help-seeking and suggest some ways forward.

The Mental Health of Men and Boys

The pattern of mental health problems among males changes with age. During early years, it is estimated that 11% of boys experience diagnosable mental health problems compared to 8% of girls (Green et al. 2005). The most common problems are developmental difficulties, including autistic spectrum disorders, specific learning disabilities and speech, language and communication problems (Kraemer 2000; MHF 2010). Boys are four times more likely to be

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diagnosed with behavioural and social difficulties including conduct disorder; and are three times more likely to be given the label of attention deficit hyperactivity disorder (NICE 2006).

However, in adult life, this pattern appears to switch as men are less likely to be diagnosed with a mental health problem, and prevalence rates of anxiety and depression are found to be higher in women (NHS Information Centre 2009). In the United Kingdom (UK), the Acute National Morbidity Survey 2007 (NHS Information Centre 2009) found that one in eight men compared to one in five women met the diagnostic criteria for a common mental health problem, whereas men are more likely to have what may be called 'externalising' problems like drug and alcohol problems.

Another sign that the mental health of men is not as good as it could be is to do with suicide. Suicide rates have been consistently reported to be higher in men compared to women since records began, with very few exceptions (Haggett 2015; WHO 2017). Suicide remains the most common cause of death in men under the age of 35 and remains at record levels among middle-aged men (45–49 years) (Office for National Statistics 2014). In the UK, men currently make up 78% of all suicides (Men's Minds Matter 2017), which is consistent with suicide rates across other high-income countries (WHO 2017). It is estimated that half of all those who commit suicide may also suffer from depression (MHF 2010), although many men who take their own lives do not have identifiable mental health problems.

Psychological treatments usually involve talking about problems and learning new ways of handling the presenting problems. It is important to note that while most users of Improving Access to Psychological Therapy (IAPT) services in the UK are female, no overall gender disparity in service use was found when taking into account the lower prevalence of depression and anxiety among men in IAPT services in the UK. However, the pathway into the service may be different as it has been found that fewer of the GP referrals were men compared to self-referrals, whereby men were able to refer themselves directly into the service (Brown et al. 2014).

A major problem is that men do not always use the health systems that are provided. Men do not always use traditional services (Conrad and White 2010), and may be reluctant to seek help from professionals when faced with mental and physical health problems, this being the case even before taking their own lives (Sullivan et al. 2015). In the instances where men do engage in treatment, some studies have found men to be more likely to drop-out (Cottone et al. 2002).

Secondly, mental health problems may underlie other more social problems such as homelessness, and forensic problems. Men make up 94% of the prison population and 90% of prisoners are believed to have a mental health

problem of some kind (Prison Reform Trust 2005). Similarly, it is estimated that 85% of rough sleepers in London are men (St. Mungos 2016), making up the vast majority of homeless people, where the rates of mental illness are high (Gill et al. 1996). The most frequently reported reasons for male homelessness are: relationship breakdown, substance misuse and leaving an institution (e.g. prison, care or hospital).

Help-Seeking

Help-seeking occurs when people are faced with problems that demand more resources than they alone can provide. In its broadest sense, it can be defined as any communication that occurs about a problem aimed at eliciting advice, support and assistance during times of distress and difficulty. People can therefore seek help from a range of places and people including friends, families, colleagues or neighbours. It is not just confined to seeking help from professionals and agencies.

Seeking help from health professionals for mental health (or formal help-seeking) generally occurs much less frequently than other forms of more informal help-seeking and occurs towards the end of the help-seeking journey (Timlin-Scalera et al. 2003). Bebbington (2000) noted that only 30% of people with a mental health problem in the UK had consulted a mental health professional. Additionally, this is consistent with the pattern in six European countries where only one in four adults with a mental health problem consulted mental health services (ESEMeD/MHEDEA 2000 Investigators 2004). Thus, only about 30% of people with mental disorders receive treatment (Kessler et al. 2005).

One of the most common findings in the help-seeking literature shows that males are less likely to seek help for mental and physical health problems than females (Addis and Mahalik 2003). Further, men of different ages, nationalities and ethnic backgrounds seek help from mental health services less frequently than women from comparative groups (Addis and Mahalik 2003).

While sex differences are helpful in highlighting men's underutilisation of services, they tell us very little about within-group differences or the underlying biological, psychological, or cultural processes (Addis and Mahalik 2003). Having said this, many authors claim that men's help-seeking behaviour can be directly related to the social construction and cultural representations of masculinities (Courtenay 2009). Indeed, it would appear that psychological and social factors have the greatest impact on men's help-seeking behaviours (Doyal et al. 2003; Courtenay 2009).

Despite this, there appears to be some processes that are shared by both men and women which reduces their likelihood to seek help. None the less, males are notably worse at seeking help for psychological support when compared to their female counterparts. We shall now briefly discuss factors that affect help-seeking among both genders before focusing on specific factors that are relevant to men.

Factors Affecting Help-Seeking Among Males and Females

There are a variety of factors that stop people seeking help. The most common reason people do not seek help is that they feel they can deal with the problems on their own (Meltzer et al. 2003). This has been consistently found, among young people (Rickwood et al. 2007), older people (Lawrence et al. 2006) and adults with diagnosable mental health problems who do not seek help (Savage et al. 2016). How people perceive their problems or their 'illness perceptions' also impacts on help-seeking behaviour (Leong and Zachar 1999; Edwards et al. 2007) as does a person's 'locus of control' (Fischer 1970). Although severity of problems did predict help-seeking, perceived need (Mojtabai et al. 2002) was seen to have a greater influence on whether someone sought help or not compared to their psychiatric symptoms. Perceived need was found to be related to sociodemographic factors (gender, younger people) and attitudes.

A commonly cited reason for people not seeking help is stigma which has been found to be the fourth most common reason for not seeking help (Clement et al. 2015). An influential review on stigma found that treatment stigma (stigma associated with seeking treatment for mental ill health) and self-stigma (holding stigmatising views about oneself and feeling shame) were the most strongly related stigma barriers to help-seeking (Clement et al. 2015). A meta-analysis of help-seeking in a college population similarly found anticipated benefits of treatment and self-stigma to be the two main obstacles (Nam et al. 2013). The threat to an individual's self-worth and how the person perceives the act of seeking help is also of importance (Vogel et al. 2006). Other factors, such as race, ethnicity, cultural background and sexual orientation are also likely to intersect with gender to influence help-seeking behaviour, but these have received more limited attention.

Let us now look at factors that make help-seeking more difficult for men.

Masculinity in the Context of Help-Seeking

Masculine Gender Role Socialisation

Gender-role socialisation theories posit that social environments teach men and women distinct sex-type behaviours and attitudes that influence how they see themselves in relation to their gender and how they perceive the expectations for their behaviour (Mansfield et al. 2003). Masculine scripts promote strength, independence, invulnerability and winning, therefore making it difficult for a man conforming to traditional masculine norms to seek help for mental health problems which involves relying on others, admitting and recognising that there may be a problem and addressing emotional difficulties (Sullivan et al. 2015).

Emslie et al. (2006) compared male and female experiences of depression and their treatment preferences in a qualitative study, and reported the contradiction between depressive symptoms and masculine ideals. Feelings associated with depression, such as shame and weakness contradicted masculine ideals of control, stoicism, strength and success. This makes seeking help difficult, as some men would expect to be ridiculed by other men for 'weakness' if they opened up about emotional difficulties (Emslie et al. 2006).

In a recent review, Seidler et al. (2016) reinforced the importance of masculinity and concluded that conformity to traditional masculine norms has a threefold effect on men experiencing depression, affecting firstly, how they experience depression, secondly, attitudes about and actual help-seeking, and thirdly, how they manage their symptoms. However, the review also highlighted that the type of help men with 'masculine' norms chose or were offered was important. The type of social support was found to be important in moderating the effect of these attitudes (Houle et al. 2008). Men preferred talking to a close other, typically their mother or female partner with the weakest preference being for a male friend (Lane and Addis 2005). Furthermore, men preferred therapy approaches that were more practical and problem-focussed rather than just involved talking about their feelings (Emslie et al. 2007).

Masculine Emotions and Male Development

Male gender role socialisation may mean that boys are socialised to minimise, ignore or lack awareness of their emotional experience and as a consequence may become less able to recognise or process their emotions in

later life (Sullivan 2011; Sullivan et al. 2015). From an early age, caregivers appear to conform to cultural gender norms and unwittingly respond differently to boys and girls, subtly reinforcing gender consistent expressions of emotion (Fivush et al. 2000).

Male clients may assume that they will be expected to talk about emotions and explore the emotional context of their life experience during psychological work (Mahalik et al. 2003). Gender role socialisation seems to encourage boys and men to ignore and devalue emotions and many men may believe that feelings are unnecessary and better left unexplored (Mahalik et al. 2003).

O'Neil (1981) hypothesised that some men develop restrictive emotionality, which refers to difficulties in self-disclosure, recognising feelings and processing the complexities of interpersonal life. Large-scale self-report surveys with undergraduate students in the US have supported this hypothesis by showing that restrictive emotionality is a predictor of men's negative attitudes towards psychological help-seeking (Lane and Addis 2005).

Furthermore, the socialisation of men to not discuss or be aware of their emotions or feelings can result in other difficulties. For instance, alexithymia is hypothesised to be a common and widespread condition in men, whereby one experiences the inability to put emotions into words (Levant 1998). Subsequently, this inability to identify and recognise emotions may leave men at greater risk of poorer health outcomes and increased somatisation of psychological problems. More importantly, emotions are central to forming relationships.

Masculine Intimacy in Close Relationships/Self-Reliance

There is evidence to show that men tend to interact less intimately than women do and overall their relationships are less intimate, particularly with the same sex (Reis 1998). This may be due to disruptions in early attachment relationships (Diamond 2004) and/or connected to emotional developmental opportunities during childhood. Indeed, men often report having fewer social support networks than women (Pevalin and Rose 2003), which may be related to an avoidance or difficulty forming close attachments (MHF 2006). Additionally, focus groups carried out by Ritchie (1999) found that young men from the UK had difficulty accessing confiding relationships with male friends for emotional difficulties.

Associated with intimacy is the masculine ideology of independence, which may signify a discomfort with needing assistance from others, including

health care professionals (Mahalik et al. 2003). In the development of the Barriers to Help-Seeking Scale, Mansfield et al. (2005) found that within a sample of 537 undergraduate men in the US, those who reported more self-reliance showed less willingness to seek psychological help. They concluded that self-reliance was an important psychological process related to lower help-seeking in men.

Johnson et al. (2012) suggest that men's reluctance to seek help could be addressed by nurturing genuine connections between depressed men and health professionals, promoting acceptance of 'guarded vulnerability' until trust is established and working with men as equals in a partnership.

Masculine Coping Styles

When men experience problems, masculine norms can lead to social withdrawal, increased work hours, alcohol and substance abuse and anger-fuelled conflict to cope. Some even mention suicide as a brave masculine attempt to re-gain control (Emslie et al. 2006; Oliffe et al. 2012). This helps explain to why men with depression are more likely to cope by drinking alcohol or taking part in sporting activities, whereas women are more likely to find ways to express their emotions, and to believe more in religion (Angst et al. 2002).

As a result, gender role socialisation on how to manage mental health problems may reflect the difference in symptom profiles between men and women, with men demonstrating more acting-out behaviours, lower impulse control, more risk-taking and substance misuse, more anger, irritability, aggression and antisocial behaviour, and women showing more overt signs of sadness, tearfulness, appetite and sleep disturbance, worthlessness and guilt (Angst et al. 2002). This may help explain the patterns of service use seen in men and boys described earlier.

Other Contributory Factors to Help-Seeking

Beliefs About Mental Illness

A number of studies have explored the relationship between beliefs about depression and help-seeking behaviour and compared these between males and females. A systematic review of 71 quantitative and qualitative studies found that females were more likely than males to attribute depression to

medical or biological causes, as opposed to non-biological, psychological, or environmental causes (Prins et al. 2008). Research findings also suggest that men might not believe depression or anxiety to be as serious as women do, in terms of length or severity of problems (Edwards et al. 2007). It might therefore be hypothesised that men perceive less need for treatment in health services but this hypothesis has not been formally tested.

Expectations of Treatment

There is some evidence that females have more positive attitudes towards mental health care than males (Mackenzie et al. 2006). In the systematic review conducted by Prins et al. (2008), when compared with women, men expressed less confidence in mental health professionals, were more likely to think that antidepressant medication was addictive and appeared more concerned with the costs and side effects of treatment (Prins et al. 2008).

There appears to be heterogeneity within males about what they want from professionals (Emslie et al. 2006). Expected satisfaction with treatment has been shown to correlate with the likelihood of having a depression-related outpatient visit over a 6-month follow-up period (Fortney et al. 1998). However, findings relating to the relationship between perceived need for treatment and help-seeking behaviour have been inconsistent (Lin and Parikh 1999; Fortney et al. 1998).

Finally, a recent study by House and colleagues (House et al. 2018) using a Q methodology compared men who had and had not sought help. They found that while all men held the view that depression should be something that was dealt with in private, those men who actually sought help believed more strongly that treatment could be effective.

Frequency of Contact with Other Services

Men come into contact with health services less frequently than women do, as the latter attend more often for family planning and perinatal appointments. This gives medical professionals fewer chances to recognise signs of depression in men and offer support. However, when men do see the doctor, they are more likely to describe physical than emotional symptoms (Galdas et al. 2005) which can make underlying or concurrent depression difficult to identify.

Recent Interventions for Men

Public Health Campaigns

Public health campaigns in the UK by leading UK charities including the Campaign Against Living Miserably (CALM), Samaritans, Rethink, Men's Health Forum and Men's Minds Matter have focused on raising awareness of the issues faced by men, sought to legitimise and redefine help-seeking as a strength, and encouraged men to open up and support one another with problems where they exist. Although difficult to measure directly the effectiveness of public health campaigns, they do directly address men about a previously invisible problem which has made it more open.

Interventions to Engage Men

There have only been a few successful evaluated interventions to encourage help-seeking among men.

When attempting to engage men Pollard (2016) talks about the importance of gender-sensitive language. He suggests using terms such as 'stress' rather than 'mental wellbeing' because it externalises the problem and may be more acceptable to men. He also suggested that men should feel in control of the service rather than be expected to fit in and feel disempowered. In an intervention aimed at sleep, Archer et al. (2009) marketed the intervention to men using a physical symptom which was successful in engaging men to the insomnia workshops.

While Rochlen et al. (2006) found few benefits of a National Institute of Health (NIH) male-sensitive brochure, Hammer and Vogel (2010) found that a specifically tailored male sensitive brochure improved help-seeking attitudes and reduced self-stigma among 1397 depressed men who had not sought help. Similarly, an outreach brochure (McFall et al. 2000), designed to increase mental health service enrolment for veterans diagnosed with post-traumatic stress disorder, significantly improved the likelihood of scheduling an appointment with a service, presenting to the initial intake appointment, and attending at least one follow-up treatment session.

Reframing help-seeking as a sign of strength and as a preventative action has been suggested as a way of increasing help-seeking. Indeed, more flexible masculine ways of coping have been described (Kiselica and Englar-Carlson 2010) such as seeking help to maintain the role of looking after others (Emslie et al. 2006).

While not evaluated, helplines seem to be effective in engaging men and are an effective source of support for people in times of need. The charity, Samaritans, improved their engagement of male callers by training staff in how to speak to male callers. These frontline sources of support may also be the first place that men test out what it might be like to talk about a psychological difficulty. A positive experience of using helplines may impact on whether someone goes any further into their help-seeking journey.

Interventions

It has been suggested that men have a preference for short-term, directive goal-oriented, action-focused interventions based on problem-solving strategies, emphasising the practical utility of CBT over other forms of 'just talking' therapies (Emslie et al. 2007; Kingerlee et al. 2014).

In the only successful treatment study published so far, Primack et al. (2010) did find large positive changes on depression and increases in social support following an 8 session CBT group treatment including masculine norm discussions for six depressed men in a pre-post study. However, there were no significant effects on conformity to male norms and there were mixed results for self-stigma.

However, it is also important to note that there are recent community initiatives that seem to be successfully engaging men. 'Men's sheds' have been expanding with about four new sheds opening each week. These are places where older—as well as younger—men can meet and share practical skills, learn informally and work on community projects. Although originally set up to combat loneliness, they are also places where mental health issues can be addressed. Culph and colleagues found that depression scores were significantly reduced as a result of attending (Culph et al. 2015).

There is some evidence indicating that men who seek help are staying in treatment and are also improving (Kingdom, in preparation). However, there may still be difficulties with some cultural groups, such as men from black and ethnic minority groups who are more likely to drop-out after assessment (Kingdom, in preparation).

The setting can make a difference. Hunt and colleagues reported on a RCT for a gender sensitised programme (FFIT) for weight loss for 747 male football fans (aged 35–65) run in football clubs (Hunt et al. 2014). This was run because of the poor take-up of men in weight loss programmes. Here, the intervention group received a weight management booklet and received a weekly weight loss programme delivered by

community coaches for 12 weeks. At one-year follow-up, the intervention group lost significantly more weight compared to the waitlist control group. Running the programme in social settings, such as sports clubs and workplaces helps to engage men.

Finally, the content of the programme can be important. Robertson et al. (2014) in a weight management programme for men reported that men preferred more factual information and more emphasis on physical activity.

Some Ways Forward

We shall attempt to highlight some key clinical and research considerations when developing interventions for men. Particular emphasis should be placed on the way interventions are marketed to men, gender sensitivity to the male experience and, the execution and delivery of evidence-based interventions.

Marketing of Interventions to Men & Treatment Stigma

There is some evidence to suggest that men are more willing to access helplines and online text support. This appears to be particularly important when a gender sensitive approach is used. Services designed specifically for men, such as CALM, Men's Health Forum and Men's Minds Matter have been successful in engaging men in mental health conversations, partly due to the gender sensitive language used and their non-psychiatric focus. The language around marketing these initiatives is likely to be a crucial factor as many men do not identify with a mental illness model.

There is evidence highlighting that men will seek help if it is accessible, appropriate and engaging (Spendelow 2014). Thus, the combination of easy access helplines/online text support, a non-psychiatric focus and male appropriate language appear to improve engagement while offering a confidential and distal form of informal support. This probably creates a positive first impression of help-seeking, gives information about potential treatment options and helps men decide on what steps they would like to take next.

It appears men may have different, possibly erroneous, ideas of what psychological treatment comprises. Providing factual information is therefore important and will help to avoid any misconceived ideas, improve understanding of the available services and contribute towards reducing treatment stigma (Robertson et al. 2014). Once help-seekers get to know more

about the efficacy of psychological therapy services, the perceived benefits of help-seeking may then outweigh the negatives (House et al. 2018). Additionally, adaptations to the delivery of services may also make them attractive. Interventions that do not conform to traditional 'talking' therapy such as using physical and/or leisure activities can also appear to be engaging and effective (Kingerlee et al. 2014).

Using concepts men use could be very helpful. Results from a large European study indicate that men often attribute depressive symptoms to work stress (Angst et al. 2002) or physical illnesses, particularly heart and blood pressure problems, whereas women attribute depression to relationship problems or illness/death in the family (Angst et al. 2002). The tendency to somatise psychological experience may occur more frequently in men, as it is likely to be linked to poor emotional awareness. Thus, marketing interventions that address these concerns may also improve engagement.

Masculinities & Self-Stigma

Men who could benefit from psychological support may choose not to pursue it because many aspects conflict with dominant masculine gender roles (Sullivan 2011; Sullivan et al. 2015). Identifying with having a psychological problem is likely to be self-stigmatising and entwined within a relationship to masculine ideals. Psychological therapies often emphasise traits such as emotional expression, introspection, intimacy and acknowledgement of vulnerability which may be alien and threatening to some men. There may be fears about performance, control and mastery of the therapy, questions about the utility of such approaches or fears about what might be uncovered. These terms may not yet be part of a familiar vocabulary for many men and work may need to occur before we get to this stage of intervention.

Psycho-educational material aimed at men is likely to be important for increasing awareness of psychological difficulties, developing a psychological vocabulary and for introducing key concepts and ideas. Combining psycho-education with non-stigmatising approaches such as Acceptance and Commitment Therapy has been shown to be more successful in reducing self-stigma generally, for both psychologically flexible and inflexible participants than psycho-education alone (Masuda et al. 2007). A lighter touch may be required before moving deeper into the psychological world of men in order to reduce possible anxieties.

Services can adopt 'male-sensitive frameworks' that are more sensitive to the needs of diverse men (Englar-Carlson and Kiselica 2013).

One aspect emphasised by Pollard (2016) is the need to help men feel in control of the service offered by empowering men to choose their preferred treatment plan (e.g. Cheshire et al. 2016). Another example would be services that adopt 'male positive' attitudes and be more accepting about male distress. This framework could be beneficial for reducing feelings of shame and self-stigma, reaching marginalised groups, encouraging help-seeking and improving treatment engagement.

Developing Male Appropriate Interventions and Improving Treatment Engagement

Wholesale changes to existing evidence-based practices are unlikely to be needed to meet the needs of men. What is more likely required is a gender sensitive approach in the delivery of the intervention and sensitive engagement at the right entry point for different men in their psychological journey. By doing so we are likely to improve men's engagement with the available evidence-based therapies.

Men's preference for short-term, problem-focused goal-oriented interventions should not be ignored. However, the dynamic interpersonal context and men's relationship to emotional experience should not be discounted as a potential focus for change. Indeed, social and emotional isolation may underlie many of the difficulties men experience and is likely to be a valuable focus for change. However, some work may need to be done prior to reaching this point.

Conclusions

Two types of intervention may help men seek help. Firstly, engaging men to perceive treatment as a possible viable option is essential to enable them to access professional support. Secondly, ensuring that the support they do receive is appropriate to their needs will help to reduce treatment drop-out.

Recent developments indicate some positive signs of change as more men seem to be willing to access help in different settings. There are also signs that they do not always drop-out of treatment once they decide to seek help.

There is still a need for future research about effective ways of marketing interventions to men alongside evaluating the uptake to and outcomes from existing and newer interventions such as practical interventions with factual information, men only groups and physical/leisure activity-type formats.

In summary, there are factors that make it more difficult for men to seek help for their mental health problems. However, there are also recent clinical and research developments in terms of public health campaigns, approaches to engaging men into seeking help, as well as the development of gender-sensitive interventions. These are all positive developments that could be helpful to men with mental health problems in improving their help-seeking.

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Counselling Male Military Personnel and Veterans: Addressing Challenges and Enhancing Engagement

Duncan Shields and Marvin Westwood

Introduction

One of the gifts of feminist research and practice has been the insistence that the mental health field recognize intersections of gender, diagnosis and clinical interventions. Yet while the key role of gender socialization in women's experience and recovery from mental health challenges such as trauma has been extensively studied, relatively little attention has been paid to the influence of gender socialization in male's mental health experiences, and on the experiences of male veterans specifically (Braswell and Kushner 2012; Brooks 2010; Fox and Pease 2012; Jordan 2004; Shields et al. 2017). Despite this lack of attention, historically, hyper-masculine gender norms have been explicitly used by the military to socialize soldiers into an idealized culture of "warrior masculinity," presenting the soldier as the ideal of the strong and stoic male (Barrett 1996; Fox and Pease 2012; Hinojosa 2010; Keats 2010; Keegan 1994). Against the backdrop of these military masculine norms, veterans may remain silent about their service-related stress injuries and other life or mental health challenges lest they be shamed (Shields 2016).

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Therapists are in an ideal position to help veteran clients rewrite the rules of masculinity to recognize the battle for the heart and mind as valid, courageous and a sign of strength. Doing so restores dignity to the individual, is an act of social justice, and brings to light inherent capacities and convictions that enhance veterans' ability to resolve the difficulties they face. A culturally safe, gender-informed approach to veterans' counselling can contribute to more accessible, relevant and effective services (individual and group) that respect veterans' existing courageous and agentic helping and healing efforts.

Military Masculinity

Various researchers have noted that in military training, a particular type of "traditional" masculine gender role is extended or emphasized in a hypermasculine military cultural norm in order to prepare soldiers for combat and inculcate values of selfless sacrifice for the group (Brooks 2010; Fox and Pease 2012; Hale 2012; Higate 2000, 2001; Morgan 1994; Westwood et al. 2012). The historical emphasis of the military on this subtype of masculine ideals underscores the adaptive and functional nature of these norms within certain contexts. The masculine gender precept requiring soldiers to confront particular aspects of human biology and suppress them, to override and disregard biological signals to run in fear or to cry out in grief or pain, is amplified in military enculturation to help soldiers continue to act and survive in battle (Basham 2008; Fowler 2010; Mejia 2005). This pressure and expectation that military personnel be able to detach from emotional and physiological response, and continue to push on and fight, is captured and reinforced in often repeated infantry credos such as "suck it up and soldier on."

This kind of message captures the drive to minimize emotions that could damage morale, and also underpins a "robust pride in ship, regiment, or squadron" (Higate 2001). As shared narratives, they contribute to a sense of "masculine unity" that is a "cementing principle," and prerequisite to belonging, in military life (Harrison 2003, p. 75). Gabriel (1988) noting this link between stoicism, agency and belonging, catalogued the desired outcome of military training as a high standard of self-discipline and emotional control; a valued group identity; and the development of a strong "warrior" persona that is aggressive, dominant, and risk-taking, and that precludes experience or expression of "weakness." Military training emphasizes domination over one's body and the external world, a neglect of physical needs and health, limited emotional expression, and allegiance to and self-sacrifice for one's

buddies (Brooks 2010; Higate 2006; Keegan 1994; Shields 2016). Selfless sacrifice, perhaps, represents the ultimate expression of belonging, teamwork, and agentic stoicism—the ability to override the needs of the body and the self, even into death, in service of mission and team.

Such masculine ideologies play a central role in military training and culture, tending to transcend the diversity of military life, and set standards of accepted behavior across service types for both men and women. The centrality of this gender messaging to the military identity, however, has important implications for veterans' and serving military members' experience of mental health challenges, on stigma and on the meanings given to contact with mental health professionals and systems of care (Brooks 2010; Shields 2016). Paradoxically, identification with hyper-masculine ideals may not only contribute to soldiers' strength and bond, but also create vulnerability to shame in the face of overwhelming experiences, or mental health or physical health challenges (Gabriel 1988).

Abject Identity: Mental Health and the Fall from Masculine Grace

Military enculturation and training, by continually referencing or invoking the accepted gendered norm, establishes itself as an accepted "timeless truth" for its own members. What is acceptable is further defined by all of the behaviors that are "repudiated" or considered unacceptable and looked down upon by the group (Butler 2006). Military training, in emphasizing and exaggerating masculine norms, invokes both masculine ideals and abjections in order to define military cultural norms and define who belongs and who does not (Fox and Pease 2012). "Belonging" is not an automatic process, but rather is dependent upon acceptable masculine performance and ongoing conformity to others' expectations and their approval (Whitehead and Barrett 2001). The centrality of performance testing in the military, and the need to "measure up," heightens this dependence on the esteem and estimation of others (Barrett 1996).

This dependence on the validation and acceptance of others is by no means unique to military expressions of masculinity. For example, White (1997) observed that manhood generally does not appear to be self-reliant and autonomous; it depends chronically on the estimation of others, and is vulnerable to attack by ridicule, shaming, subordination and the "dishonor" of being seen as feminine. This ever-present existence of the spectre of failed masculinity results in what Pascoe (2012) refers to as "compulsive" masculinity, in

which role compliance must be continually proven, abject identity defended against, and success never attainable in any permanent way. The nature of manhood then appears to be "precarious," as masculine status is hard won and easily lost (Vandello and Bosson 2013). The struggle and conflict of manhood is not just about achieving the ideals, but also struggling against an ever-present threat of falling into the abject identity of failed masculinity.

During initial enculturation into military service and continuing throughout service, conformity to acceptable military masculine norms is policed, both internally by the individual, and in social interactions that establish hierarchies of status and power. This process creates and reaffirms a "threatening spectre" of failed gender, which must be continually guarded against. From early training, recruits who cannot keep up with others or who exhibit sensitivity to the harsh demands, environments or treatment are subjected to a variety of shaming, gendered insults such as faggot, pussy, or wimp (Fox and Pease 2012).

Against this backdrop of masculine military norms, reinforced in recruitment and training, veterans who experience lingering effects of trauma or other mental health challenges, or who fail to uphold or perform within the accepted norms, may begin to narrate their symptoms and any mental health diagnosis as "failure" or weakness—a fall from masculine grace (Pascoe 2012; Shields et al. 2017). Previously granted membership among "warriors," those considered the military masculine ideal, these veterans may experience their mental health challenges as a collapse "from hero to zero," into the abject identity of "unfit," "disordered," and "abnormal." Symptoms of mental health challenges signal vulnerability, attract stigma, and directly threaten masculine ideals (Oliffe and Phillips 2008).

For men who comply with these military masculine ideals, the presence of "clinically significant distress or impairment in social, occupational, or other important areas of functioning," characteristic of most diagnostic categories (American Psychiatric Association 2013), confronts the individual with evidence of the loss of mastery over one's body and experiences—a source and reason for shame. A dominant cultural model of self-reliant masculinity complicates the experience of mental health issues and may serve as an oppressive force that marginalizes and stigmatizes veterans who experience distress.

Military training that links identity and belonging to agency and stoicism may inadvertently precipitate veterans' thwarted sense of belonging and a sense of burdensomeness to their team or community. These two states, along with the comfort with lethality gained from the nature of military work, make up the three essential conditions for suicidality identified in Joiner's (2005) interpersonal theory of suicide. Under these conditions,

suicide may present as the last and final act available to demonstrate personal agency—a self-sacrificing solution that may seem honorable in the face of the perception that one has failed as a soldier and become a burden to one's family and peers (Shields 2016).

Thus, the very qualities that are highly valued within the military context, and which may aid in the performance of tasks in times of conflict, may exacerbate and exaggerate emotional, behavioral, and relational difficulties after deployment. The need to maintain the appearance of stoic competence makes it more difficult for these clients to admit they have problems, seek professional help, or have faith in the efficacy of treatment (Brooks 2010; Jakupcak et al. 2014; Yousaf et al. 2015). A diagnosis, and the gendered stigma it brings, may itself become a central barrier to treatment access and engagement. The resulting "code of silent stoicism" isolates military personnel during times of distress and, paradoxically, perpetuates a myth that real soldiers neither ask for nor need help.

A Clash of Cultures: Therapeutic Versus Military Culture

Perhaps not surprisingly, numerous studies and surveys show that clients with high conformity to masculine gender norms such as these are less likely to seek counselling, and/or drop out early. Some researchers have suggested that this is partly due to a conflict between masculine and therapeutic norms (Addis and Mahalik 2003; Brooks 2010; Englar-Carlson and Stevens 2006; Owen et al. 2010). For instance, Brooks (2010) argues that traditional male socialization predisposes these clients to hide private experience, maintain personal control, appear stoic, present the self as invincible, and value action over introspection. In contrast to these norms, traditional counselling approaches tend to favor clients who self-disclose, relinquish control, recognize and express emotion, introspect, experience vulnerability, and admit failure and/or ignorance.

Brooks (2010, p. 34) contends that, "While the creation and the development of the psychotherapy establishment has been historically dominated by men, it has largely failed to develop models of therapy that are more harmonious with unique masculine ways of experiencing emotional pain and coping with distress." Within the military masculine culture, there exists a stigma associated with seeking mental health care and therefore both male and female military personnel are discouraged, sometimes actively, from doing so. Many may also fear that seeking help is "career suicide" if they are

no longer seen as "fighting fit" (Linford 2013). This cultural backdrop may exacerbate fear of stigmatization with regards to help-seeking, particularly in the early stages of contact with the mental health system. This suggests that the relatively unstudied clinical feature of shame in men's mental health concerns is a particularly powerful, preoccupying, and overwhelming source of emotional conflict and a barrier to service uptake.

Traditional methods of therapy have often failed to attract or interest these clients, and caution needs to be exercised to ensure that the client is not blamed for this failure (Brooks 2010). For feminist researchers, the development of new understandings of femininity have been a central feature of responses to women traumatized by rape, abuse, and domestic violence. There, a rich research literature demonstrates the importance of social constructions of gender on both women's experience of trauma and in developing gender-sensitive approaches to respond to it (Burstow 2003; Butler 2006; Harvey et al. 2000; Herman 1997). The colonization of male veterans' experience of their mental health challenges with military masculine role norms, and the problems that ensue, shows a parallel need for such scholarship and a change to our approach.

In the face of these larger hyper-masculine sociocultural contexts and pressures, how do we successfully engage veterans and leverage the strengths and values inherent in their worldview in the service of therapy? If, for example, PTSD disrupts the ability of the individual to form safe social attachments (Herman 1997), and masculine socialization may engender shame reactions that exacerbate a shift toward isolation (Brooks 2010), how do male veterans negotiate culturally safe spaces to form therapeutic alliances or other relationships where they can renegotiate overly constrictive and self-defeating masculine role expectations? In the following sections, we will explore avenues for culturally appropriate approaches that can help veterans form safe social bonds, take control, and engage more actively in therapy.

Reframing Therapy

Making counselling "culturally safe" for military clients calls for clinicians to be able to acknowledge, respect, and value differences that arise from traditional masculine gender roles and military cultural norms—to become culturally competent. In order to work effectively and ethically with this population, careful attention needs to be paid to the attitudes and therapeutic structural barriers that can make it difficult for this population to begin counselling and to benefit from it.

Essential to any satisfactory therapeutic outcome is the formation of a "Helping Alliance" that begins with meeting the client where they are. This way of looking at counselling encourages the clinician, regardless of his or her own cultural background and gender roles, to communicate and practice in ways that respect and take into account the cultural, political, linguistic and spiritual realities of the people with whom they are working (Brown 2008). It also behooves the counsellor to not only meet the military client on their own terms, but also to be sensitive to frame the work to be done together within the context of the clients existing values and belief systems.

Military social norms and values can be readily leveraged as assets to enhance engagement and propel the process of change. Soldiers are explicitly taught particular values in their training and are expected to live up to them in everything they do. Counselling can be consciously retooled to leverage these values. Some of these explicit values adapted from military training include:

Courage: Military personnel must face fear, danger or adversity. This is a matter of enduring physical and emotional duress and at times risking personal safety. Courage may also be required in the long, slow process of continuing to "do the right thing," even if taking those actions are not popular with others. (Sample questions: Tell me about a time when you had to act and complete a task despite fear, danger or adversity? How does your current situation call for courage from you? What does it mean to face and actively struggle with these problems with all of your courage?). Expressing feelings can be redefined as "courageous," the "hard thing to do," as "men's work." Paradoxically, the very expression of emotional life that was previously stigmatized becomes reconstrued as a form of agency—the hero's path. In courageous and bold self-assertion against the judgment of others, therapy can assist in the building of a parallel meaning structure in which the strongest men are able to feel and speak their truths (Michaels 2011). "Only the toughest belong here. We're in a battle. That battle is not done alone. You never go to battle alone."

Commitment: Military personnel fulfill their obligations, taking pride in tackling the hard challenge and doing the tough work. They must resist the temptation to take the easy way or "shortcuts" that might undermine the integrity of the final product or outcome. (Sample questions: What is one thing you did, or were part of, that makes you proud of being in the military? What is the toughest thing you had to do while serving in the military? How did that affect you then? How does it affect you today? What commitments do you need to hold firm to now? Who are you committed to as you make changes in your life today?)

Loyalty and Selfless Service: Military personnel put the welfare of others, the nation, the military, and their team before their own. They commit to go a little further, endure a little longer, and look a little closer to see how they can add to the effort. Loyalty and service to others requires these clients to consider the impact of their behavior not only on themselves, but also on their family, their team, and their community (Sample questions: When were you expected to work for the good of the whole group regardless of the cost to you? Could you tell me about that? Who relies on you today? There are a lot of military personnel who suffer in silence and who have not been able to take the step forward to get help—If you could model something for them by how you approach your own struggles and your own counselling, what would that be?)

Integrity: Integrity calls on clients to assume accountability for their behavior and to take steps to enhance or recover personal "fitness" and well-being. Assist the client to identify what part they have played in the events that lead them to counselling and what part belongs to others, or the military. (Sample questions: What helped you in your decision to come here today? Many service members don't show up in counselling to do the work that you've stepped up to do. How do you keep connected to the integrity that you've shown in your commitment to do the work that you need to do?)

In order to demonstrate that counselling is relevant and helpful to military clients, the process can be recast so that it capitalizes on these military values and is seen as a relevant means to help clients align more closely with their own value system. It can be beneficial to help the clients see that their personal courage will be tested—counselling is not for the faint of heart. Commitment is required in the face of setbacks and they will be called on to give 110% because counselling will not be an easy way. They will be held accountable for their behavior and called upon to do and give their very best. As one military client observed, "sitting in the bar is a lot easier than being in here." Or as another described counselling, "This is a battle for the heart and mind." These core values and sensibilities can be honored and integrated into specific approaches to counselling. The following further considerations will allow counsellors to tailor their work to capitalize on, rather than work against, the dominant military culture:

1. Use a strength-based approach. For these clients to engage in therapy, clinicians needed to attend to issues of cultural "safety" and appropriateness in order for safe social bonds to develop. By first creating conditions of safety and recognizing resources and strength, the courage and capacity needed to explore vulnerability and emotional content can emerge. When a

counsellor actively seeks and acknowledges the client's strengths, the client feels respected and recognized for his or her competence. Clients need to be given the space to inform counsellors about themselves and what competencies underpin who they are or were. A counsellor needs to be aware that clients may worry or feel anxious that they will be judged or that counselling may uncover all their weaknesses. For that reason, they may work to correct this perception or clients may have difficulty dropping the "mask of competence" they have assembled to compensate for feeling out of control. It is also beneficial to explore values that are also a kind of strength.

As clinicians, we may need to more explicitly communicate our belief in our client's intrinsic strength and frame our therapeutic environment and interventions in ways that first recognize and support notions of competence and skill. It may be helpful to explicitly recast therapeutic activities within masculine role norms, or even as proof of compliance to military masculine norms. (Sample questions: What does it mean to you to be in military service? What motivated you to sign up? What is one of the things you most enjoyed, most valued? Take me through a challenging day when you were proud of how you handled yourself—What were you saying to yourself? How did you "carry" yourself physically? What did you do? This must have been difficult to come here and many don't have the strength to start this work. What do you draw on to start this work?)

2. Be goal oriented and "hit the ground running." Initially, these clients may be uncomfortable with introspective discussions and may prefer focusing on approaches that emphasize more immediate relevance and action. It is frequently beneficial to apply cognitively oriented approaches and/or self-regulation, relaxation or simple mindfulness exercises in the early stages of the work due to the concrete nature of the skills and the ability to demonstrate small gains immediately. (Sample questions: If you could take away something useful from todays meeting, what would you like to have more insight into, or new skills to start to address?)

3. Educate. Action-focused skills training or activities tap into a familiar learning style reinforced in military training and service. A counsellor can provide specific information on relevant areas of concern, such as the psychobiology of trauma, effective communication skills, specific self-regulation techniques, and other skill-based or problem-solving tools.

4. Ensure safety by augmenting their control. One military client who came for counselling was quickly tearful when he started telling his story and clearly quite embarrassed about his "breakdown." By interrupting his storytelling and teaching a self-regulation technique, he learned immediately and first hand that the consultation would give him reliable tools to stay in control.

This is important as early disclosure can be overwhelming and, if it occurs before the establishment of trust, can result in embarrassment for the client and precipitate early termination. By then using the opportunity to discuss how the body "releases" and reregulates itself through tears, the grief that tears signal can be normalized and the courage required to "let go" of tears and acknowledge hurt or loss can be acknowledged. For significantly traumatized clients, establishing grounding skills early in counselling allows them to discuss difficult trigger events without becoming hyper-aroused or dissociating.

5. Explore their issues within a structure and with pacing. Utilizing structured storytelling assignments is one example of giving the client a sense of personal control as he or she can choose what they want to and do not want to talk about. Adhering to masculine gender roles may result in a client feeling uncomfortable or incompetent in the area of emotional self-disclosure and self-reflection normally expected by the counsellor. It becomes easier to focus attention on feelings and expression of inner states once the client has first established themselves in a place of strength. It is important to create safety first, build rapport and then facilitate introspection and self-examination. Note that this is a contrast to how counsellors are normally taught to use relationship building skills emphasizing insight, emotion and self-reflection in the initial stage. A counsellor should be mindful that for many personnel who have been through military socialization, emotions may be funneled toward anger until they learn to expand their vocabulary of emotion and acquire the skills for expressing them.

6. Draw their attention to their body sensations. Use somatic awareness and physical sensations as a way to expand emotional identification and expression. Despite the fact that many clients with high masculine gender conformity have a diminished range of emotional expression and may not be able to access and describe their emotions, they still experience the physiological effects in their bodies. These clients may experience emotions as a general feeling of frustration or anger, and tension in the body. You can assist clients to expand awareness and insight by helping them identify emotional themes in their stories and begin to focus on and label body sensations. Focusing on sensations in the body helps clients identify internal states and yet does not maroon them in the unfamiliar territory of emotion where they may lack language to describe their experience.

Culturally competent counselling with military members, as in any effective counselling, begins with making a connection with the client, establishing the therapeutic alliance essential for the process of helping to begin. Without a successful interpersonal connection and a shared understanding

of how their work will be approached, the client will not feel understood, and will likely remain disengaged, and isolated with their problem. This also extends to negotiating an agreement about the nature of the issues at stake, how to address them, or establishing a shared understanding of how change occurs. It is important for the counsellor and client to agree on an approach. In military terms, this could be conceptualized as defining objectives and a plan of attack acceptable to both of them. Regardless of the cultural and gender lens of the counsellor, the clinician must provide explanations and interventions that are consistent with the client's perspective and point of view. In short, the counsellor must work collaboratively with the client to establish safety, trust and a felt sense of having some personal control so they are willing to move out of their current comfort zone and into the foreign territory of counselling. Through changes in framing, language, and metaphor, therapy can be made more "culturally appropriate" for those who conform to military masculine norms, and this may be helpful in, or indeed a prerequisite to, establishment of a helping alliance.

Working in Groups—The Veterans Transition Program (VTP)

There are opportunities and advantages for utilizing group-based counselling approaches with this particular population. The following case study, which describes working in groups, incorporates many of the cross-cultural competencies and perspective presented.

The group approach presented here draws on the inherent capabilities present in any military group and leverages the preexisting respect and trust for other military personnel in a "soldiers helping soldiers" model. When we ask soldiers, what got them through their most difficult experiences in their service, they typically say that they trust and rely on: (a) their equipment and technology; (b) their training; and (c) the soldier beside them. Counsellors can work with them in the same way by giving them the tools, the training, and the support they need.

Bringing soldiers together in a group offers an efficient mechanism to teach skills but also presents a unique opportunity for them to obtain support from the social group for which they have the most respect and with which they have the most cohesion. Validation received from a group of fellow soldiers has far more credibility than validation from a counsellor—even a counsellor within the military.

The group approach is a culturally appropriate intervention for working with soldiers for all of the reasons outlined previously. Most soldiers are group trained, group experienced, and group ready, as this is the context of their daily work and has been since day one of their military experience.

A Case for the Group: Soldiers Helping Soldiers

A number of researchers have recommended approaching the treatment of traumatized combat veterans with group approaches as the benefits are considerable (Coalson 1995; Greene et al. 2004; Ruzek et al. 2001; Shea et al. 2009; Van der Kolk 1987). Van der Kolk et al. (1996) suggested that veteran groups inherently include built-in peer input, the potential for interpersonal support, and the benefits of social regulation. They also stressed the value of the group for trauma work with veterans.

Group counselling is an effective first-line treatment for many clients with PTSD. An encouraging, mutually supportive environment is commonly experienced as empowering for the participants (Van der Kolk 1987). Group-based therapeutic approaches offer additional therapeutic support beyond what is possible in individually oriented clinical therapies. The advantages of group-based therapies are summarized by Foa et al. (2000), Ford and Stewart (1999), Rozynko and Dondershine (1991), and Ruzek et al. (2001). In particular, the group setting serves to counteract and confront the socially avoidant and self-isolating tendencies of traumatized individuals (Fontana and Rosenheck 2001; Greene et al. 2004). Carefully planned and facilitated groups can provide a structured and safe environment for promoting self-awareness, emotional expression, and cognitive reframing to aid coping and symptom reduction.

Setting Up and Conducting the Group

The Veterans' Transition Program (VTP) focuses on: (a) creating a safe, cohesive environment where soldiers can experience mutual support, understanding from others who have "been there," and process their reactions; (b) normalizing soldiers' military experiences overseas and the difficulties with reentry back to civilian life; (c) offering critical knowledge to understand trauma and its origins, symptoms, impact on self and others along with provision of specific relational and self-regulation strategies for trauma symptom management; (d) reducing the symptoms of the operational

stress injuries arising from their military experiences; (e) teaching interpersonal communication skills to help manage difficult interactions or enhance relationships with others (e.g. spouses, friends, coworkers); (f) helping soldiers generate life goals and learn how to initiate career exploration; and (g) involving spouses and other family members in family awareness evenings.

These components of the VTP are conducted in a structured fashion in order to reduce reactivation, promote increased trust formation, and permit greater self-awareness, self-disclosure, emotional expression, and cognitive reframing. The groups involve veterans only, unlike many trauma recovery groups in which veterans are expected to join with civilians.

The group facilitation team typically consists of two professional clinicians (i.e., a combination of psychologists, counsellors and a physician with doctoral-level training in psychology) assisted by two soldiers paraprofessionally trained in basic communication, and group skills. They model caring and supportive behavior and engage in the expected behavioral outcomes of the program (Alcock et al. 2001). Veterans report that they trust others who have had similar experiences and the witnessing and validation from other soldiers is an essential component in the repair of war-related traumas.

Six to eight veterans meet for approximately 80 hours in a residential program occurring over an 8–12-week period. Consistent with military nomenclature, participants refer to the program as a "course" rather than a counselling group. The terms counselling or psychotherapy are often seen as stigmatizing to the veterans and can discourage others from joining the group. Research has demonstrated that military personnel are cautious about revealing information to others regarding a possible "weakness," such as a psychologically based injury (Rosebush 1998).

Following the first phase of establishing a solid working group, the counsellors begin to assist individuals to address symptoms and begin the work of trauma repair. This is accomplished by having the member share life-narratives through a group-based life review process (Birren and Birren 1996; Birren and Deutchman 1991). In this process participants write short autobiographical accounts on preselected themes in both civilian and military life. These stories are read aloud to the group by each participant. After each story has been read, others respond to what they have heard without making any judgment, interpretation, or giving advice. Rather, they speak about how the story affected them. The goal of this work is to simply and clearly let the speaker know that their story was heard and understood (Birren and Birren 1996; Birren and Deutchman 1991).

Participants practice identifying and disclosing the personal impact of listening to another person's story. By coaching participants to stay out of advice giving, soldiers have the opportunity to practice identifying and verbalizing personal impact, and the participants who are reading their own story to the group have the experience of being heard and understood by their peers. The facilitators are very active in this stage of the group process, modeling the communication skills and checking how feedback is received by the storyteller.

It is important to give the implicit and explicit message that disclosure of difficult personal information is respected as a sign of strength and is not seen as a signal of weakness or as a need for advice and assistance. An example of this occurs when a member is able to disclose feelings of threat or fear when under attack and with this disclosure hears from others that they too had similar feelings but were afraid to disclose those emotions until they witnessed the courage of another soldier to do so. Hearing the reactions of others to one's story can help normalize difficult feelings such as anger, guilt and shame. Sharing common military experiences in particular promotes trust and greater group cohesiveness (Corey 1990).

The use of life review is a relatively low-risk method to initiate self-disclosure as it allows individuals to engage and disclose at their own pace. This narrative method is a semi-structured, topical, group approach to the life review. Participants receive selected themes with guided-response questions so that they can write a 1.5-page story on the themes. The first one used is called the "Branching Points of One's Life" which asks participants to identify critical events across their lifespan beginning in childhood through to the present that have helped shape who they are today. This narrative process helps to highlight strengths and capabilities that have been shown to decrease depressive symptoms (Birren and Birren 1996; Birren and Deutchman 1991; De Vries et al. 1995; Rife 1998). The second life review theme targets critical events in their military service, and is used as a structured form of written, traumatic exposure, that can then provide a framework for sharing traumatic events within the group.

Once the group members have told their individual narratives they are ready to enact critical life events through the therapeutic enactment (TE) process. Therapeutic enactment is a highly structured intervention in which participants are able to externalize memories of traumatic events by enlisting other group members into the controlled, paced enactment of specific trauma events in a form of traumatic exposure work (Westwood and Wilensky 2005). The soldiers refer to this process as "dropping the baggage." Through the enactment process, group members are able to confront their

triggers, practice self-regulation skills in real time, and come to new understandings of the events that they have experienced and their reactions to those events.

To maintain a feeling of safety and in order to remain grounded through the enactment process, group members are taught emotional self-regulation skills. This prevents them from moving into hyper-activation (i.e., heightened anxiety response) or hypo-activation (i.e., decreased sympathetic nervous system responding). By attending to ways of regulating the psychological responses of the client, the counsellors work to keep them within the "window of tolerance" (Ogden and Minton 2000, p. 7). Through active expression of emotion (verbally, emotionally, and somatically) while describing the event for the group, the person doing the enactment integrates the trauma reactions into the narrative. This enables the individual to make sense of what occurred and promotes cognitive reintegration. Participants are able to successfully integrate their reactions at a thinking, feeling, and experiencing level, thereby helping to develop a story of coherence versus confusion and reactivity (Herman 1997).

The process follows a distinct number of steps. (a) In the planning phase, the counsellor and group member work together to plan a critical event to be enacted. (b) In the enactment phase, group members are asked to take on the key roles of significant others who were part of the event or act as witnesses to the enacted event. Techniques such as "doubling" and "role reversal" are used to help the soldier access and express the feelings and negative cognitions attached to the problematic event. (c) The enactment phase is completed by having members who took roles and the witnesses tell what they experienced, what they observed and how the enactment affected them personally. Completion of this process deepens trust among members and further strengthens group cohesiveness and support.

Group Case Demonstration

Greg, a 24-year-old sapper (combat engineer), begins to read his story to the group outlining a critical incident related to his combat experience. He explains that he has been having a lot of bad dreams and intrusive thoughts related to the death of his buddy Don, that occurred during his last tour in Afghanistan. He reports that he cannot sleep as he sees Don's face coming into focus in his nightmare after which he wakes up. It is clear to the team leaders that Greg's symptoms of trauma are tied to this incident as Greg has stated that it really should have been him that died and not Don. Greg had asked Don to drive that day because Greg was drinking the night before and was hung over. Don said he'd be glad to cover for his buddy and drive that day. They drove over an explosive device that struck the driver's side of the vehicle. Don was severely

injured and unable to get out of the driver's seat. Within minutes his side of the vehicle was engulfed by flames. Greg tried to pull him out, but couldn't due to the heat. He had to get out himself to save his own life.

Greg recalls that when the improvised explosive device exploded, he was initially unsure if Don was still alive. He felt he had not deserved to survive as he felt tremendous guilt in setting up the death of his mate by asking him to drive. He carried this guilt and shame for 2 years. In the group, he wanted to recreate the scenario of this explosion again. He wanted to do so in a way that could slow the events down so he could show and explain to the group what happened and how he had tried to save Don but couldn't. Following the steps of reenactment, Greg and the leader began to show the group what had happened by selecting someone to take the role of Don and someone to play Greg's part (as a double) in the reenactment of the two men in the vehicle on that day. The rest of the group witnessed what occurred that day.

After the enactment of that scene, the leaders ask Greg if he would like to talk to the soldier playing the part of his buddy Don to tell him directly what he wished he could have said at the time of attack. Most importantly Greg wanted Don to know how much he missed him, how guilty he felt about asking him to drive, and how it should really have been him that died. Greg added that he wished he could have died instead of Don and that his life is hardly worth living with the knowledge that Don would still be alive if Greg hadn't asked him to drive.

Participating in the reenactment permitted Greg to grieve and express some of the pain he had carried for 2 years. In addition, the enactment helped Greg hear from other soldiers who were the only credible people who could reassure him that what had happened was not his fault and that asking his buddy to drive was something each of them would have done or volunteered to do as a way of backing up a buddy when asked to do so. The soldier playing the role of Don said, "I knew what I was doing when I agreed to drive, I would have done the same thing as you did if the roles had been reversed. It's just the luck of the draw and we knew this was a possibility when we signed up. And Greg, there is one more thing—I need you to live and to live your life fully, otherwise it's as though two of us died that day. Can you do that?"

Hearing the input and reactions from others, conveying understanding and validation of what he felt and what he had done, gave Greg the permission he needed to complete a cognitive restructuring of his trauma narrative that let him to let go of the regret and shame that had troubled him for the past years. In addition, the other guys reminded Greg that he did the right thing by not going back into the vehicle to try to pull him out as he would have died also. A key memory also emerged during the enactment that Greg had forgotten. During the fire, ammunition had started to explode that had forced him to retreat.

In the end, Greg is invited to say goodbye to Don. He tells Don what he most valued about him and what he will carry with him in his memory. After he said all there is to say, Greg bends down to cover Don's body with a sheet. This registers an end and closure as he stands up, gives a final salute of respect to his friend, and walks away. This completes an unfinished grief reaction that has contributed to Greg's posttraumatic stress symptoms.

As part of the follow-up several months later, Greg reported that he feels lighter and that his nightmares of Don's face have stopped completely. He is pleased to add that he is sleeping through the night.

The group TE has been investigated and shown to be well suited to the treatment of combat-related traumas because it is action oriented, requires low verbal expression, involves the support of many others, provides validation and normalization from peers and has an established support group base for follow-up treatment (Black 2003; Cave 2003; Coalson 1995; Cox et al. 2014; Ragsdale et al. 1996; Westwood et al. 2002).

Having worked to confront and integrate traumatic memories, participants begin to shift their focus to their future goals and plans (family, school, work, etc.). Consolidating new learning and creating clear achievable goals and objectives for the future is part of the third phase of the VTP. This final phase could be referred to as a type of post-traumatic growth phase as described by Tadeschi and Calhoun (2004). Participants are encouraged to discuss and generate life goals including initiating possible career paths not previously considered. The group ends with members setting up a post group network of communication with one another.

Research demonstrates that there are significant gains for members who have completed the VTP, including a reduction of trauma symptoms, decreased depression and higher levels of self-esteem (Westwood et al. 2010). Once trauma-related symptoms are reduced, there is less life interference and an increased ability to respond to and plan for future life tasks within the family and at work (Westwood et al. 2010). Qualitative outcome studies reinforce the value of the group as a place where clients can be validated by others who have "been there." Member to member support strengthens clients' sense of confidence to move forward. Increased skills and knowledge about how to navigate in the civilian world allow them to be better prepared and more effective in the work world. Finally, there are considerable benefits in relationships with their spouses and children (McLean 2005).

Conclusion

Although traditional approaches to counselling have sometimes devalued or been critical of clients with high conformity to masculine gender norms, counselling can be retooled to take advantage of unique masculine language, values, and ways of experiencing emotional pain and coping with distress. Therapists are in an ideal position to help veteran clients rewrite the rules of masculinity to recognize the "battle for the heart and mind" through therapy as valid, courageous and a sign of strength. Understanding how therapy can be an asset to veterans as they seek to align their lives more closely with their own value system can contribute to more accessible, relevant and

effective services that respect veterans' existing courageous and agentic helping and healing efforts. As with all populations, the foundation for effective work with military clients is built upon the existence of high regard and profound respect for the "other."

The benefits of group work for all client groups have been addressed by several researchers (for example, Yalom 1995). Bringing military clients together to "drop baggage" is particularly appropriate given their lives are typically lived in groups and they are very accustomed to the value of helping others in their group. We invite counsellors to embrace a different approach to entering the process. We advocate adapting language and interventions so as to mirror the values which already exist in this clientele. These can be integrated into existing helping models to promote change for the military client.

While the need to maintain the appearance of stoic competence may make it more difficult for these clients to enter counselling, once engaged these clients bring a formidable work ethic and energy to the challenge. Making counselling "culturally safe" for military clients calls for clinicians to embrace the strengths inherent in traditional masculine gender roles and military cultural norms, while helping clients break free of the code of silent stoicism that isolates them when they are in pain. When empowered and equipped to escape the long tradition of masculine silence and take personal responsibility for their lives, they do not fail to engage in the work that they need to do. Given that these veterans are husbands, fathers, and sons who belong to and affect families and communities, the social costs of poor treatment access and outcomes are high. When military clients can access therapeutic modalities that allow them to heal from a position of strength, they emerge with dedication and drive to contribute back to their communities.

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Hope in the Face of Despair: An Acceptance and Commitment Therapy Approach to Working with Suicidal Ideation in Men

André Bolster and Azi Berzengi

Meet Sean

Sean is a 42-year-old male who recently lost his job following unexpected redundancies in the supermarket that he had been working in. Living alone since separating from his ex-partner, Hannah, Sean only sees his children, Zoe (14) and James (8), for a few hours on a Saturday afternoon. As much as Sean appreciates seeing his daughter and son, he is growing increasingly frustrated that Zoe's visits are becoming less frequent since she got a boyfriend and James is spending an increasing amount of time playing videogames. Although Sean and Hannah do not have much contact with one another, he feels very upset that her new partner, Martin, will be moving in with her and the children soon. Feeling down about his current circumstances, Sean tends to spend most of his time browsing day-time TV, smoking cannabis, surfing the internet, and watching pornography. While Sean regularly fantasises about meeting someone, the opportunity has not arisen because he spends most of his time in his flat. Feeling increasingly hopeless about the future, Sean has been questioning the point in continuing to live, believing that his children would be better off without him, particularly now that Martin is moving in and taking over his role as a father.

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Despite wanting to reach out for help, Sean has been struggling to confide in his friend, Peter, about his problems because he fears judgement for being 'weak' and 'failing' to live up to his perceived responsibilities as a man.

Sean's thoughts of ending his life mirror those of many other men. To suggest that all suicides are driven by a perceived lack of meaning and purpose in life would, however, be oversimplistic. For some historic indigenous people, suicide was seen as the ultimate act of life affirmation because it was believed to offer a pathway to the eternal (Lifton 1979). In stark contrast to this life-affirming view of suicide, throughout most of its history, the Judaeo-Christian tradition in the West has largely condemned suicide as an unforgivable 'sin' (Choron 1972). Given the extensive role that martyrdom played in the early beginnings of the Christian faith (Colt 1991), one could be forgiven for wondering why this 'sinful' view of suicide came to dominate so much of Western history (Marks 2003). Indeed, it was only in 1961—over 1500 years after St. Augustine of Hippo (353–430) first published his treatise on the 'sinfulness' of suicide—that the UK government decriminalised the act, so that those who did not succeed in their attempt were no longer at risk of being prosecuted for it.

While the meaning of suicide has varied across different cultures and historical periods, in his book *The Suicidal Mind* Edwin Shneidman (1996) proposes that all suicidal acts, irrespective of their form, serve a common function: they *offer a solution to a perceived problem*. In the case of the aforementioned indigenous people, for example, suicide was seen to provide a solution to the problem of death by promising immortality to those who were willing to sacrifice themselves for the good of the tribe (Lifton 1979). Christ's willingness to sacrifice himself on the cross and the martyrdom that based itself on his example could likewise be understood as attempts to 'salvage' humankind from its own 'sinfulness.' Reflecting on this problem-solving function of suicide, Shneidman (1996, p. 158) bleakly speculates on the function of most suicides in the modern world:

> There are some suicides in which the idea of reunion with departed loved ones, in heaven or some other peaceful haven, is in the mind of the suicidal person. But most suicides… are disappointingly secular. The destination (or concern) is not to *go* anywhere except *away*. The goal is to stop the flow of intolerable consciousness; not to continue in an afterlife or an eternity.

It is this nihilistic form of suicide with which we are primarily concerned in this chapter.

Specifically, we aim to explore how Acceptance and Commitment Therapy (ACT; Hayes et al. 2012) might help suicidal men gripped by a sense of despair to find hope in the face of their suffering—a suffering which might seem so unbearable that self-extinction might appear like the only viable course of action. Our reason for focussing on suicidality in men is that men are two to three times more likely than women to die by suicide every year (Office for National Statistics; ONS 2017; World Health Organisation 2014). Although the reasons for this gender difference are complex, a growing area of interest is exploring whether men are more likely to die by suicide because dominant views of masculinity in society discourage them from accepting their emotional vulnerability and consequently seeking help for it at times of crisis (see Rasmussen et al. 2018; Seager and Wilkins 2014; and this volume). With the aim of contributing to this literature, we draw on the unique philosophy of science (Hayes et al. 1988) and theory of language and cognition (Hayes et al. 2001) underlying ACT to consider how the construction of male identity might account for this increased risk of suicide among men in the first place. Following the exposition of these ideas, we then examine the therapeutic potential of ACT for addressing suicidal ideation in men. To illustrate how we would work with a suicidal man using ACT, we provide a detailed example of how we would work with Sean to help him overcome his suicidal ideation by showing him that, no matter what challenges he was confronted by, it was always possible for him to find meaning in the face of his difficulties.

Functional Contextualism: The Philosophy of Science Behind ACT

Despite numerous mental health campaigns to encourage men to talk about their feelings (e.g., Campaign Against Living Miserably; CALM), the idea of the tough and stoic male has arguably remained the dominant view of masculinity in the UK (Haggett 2014). Although adverts on TV and the internet encourage men to open up about their feelings as a way of looking after their mental health, many men, like Sean, still find it difficult to confide in their friends and relatives, or indeed health professionals in general, about their personal struggles, given that they see such behaviour as being antithetical to 'being a man' (Williams et al. 2014). This constraining image of masculinity, however, was not always at the forefront of British society. While it was considered virtuous and wise for men to express their

emotional vulnerability in Georgian times, this 'cult of sensibility' was subsequently replaced by a 'cult of toughness,' centred on power and control, as the demands of Victorian imperialism and capitalism came to define the idea of what it means to be a man (Haggett 2014).

The fact that 'being a man' has meant different things across different places and times suggests that essentialist views of gender—the idea that men and women differ from each other because of fixed and inherent differences in their nature—should be treated with caution. Many traditional models of male psychology have nevertheless been based on such essentialist views of masculinity (Addis et al. 2010). These essentialist views have in turn been founded on a philosophy of science known as *elemental realism*. Based on the root metaphor of the machine, elemental realist doctrines often liken the universe to a giant clock composed of discernable parts that mechanically interact with one another. According to this perspective, each part of the clock can be studied in isolation from its constituent parts. For instance, a cog can be distinguished from a spring, a spring can be distinguished from the pendulum, the pendulum can be distinguished from the clock hands, and so on. As can be seen in this example, a fundamental assumption of elemental realism is that there is a *correspondence* between the words that we use and the objects that they are meant to refer to. For example, an elemental realist would assume that the word 'clock' was referring to an actual object composed of *real elements*—'cogs,' 'springs,' etc.—that are essential to its nature. So far, so good.

Now imagine if one of these parts were suddenly to be removed from the clock, say for example, its hour-hand were to be taken off, so that one could no longer accurately read the time. Without this *essential* part, an elemental realist would consider the clock to be 'faulty' on the assumption that it could no longer carry out its *essential* function of telling the time. Seen from this perspective, one might also be tempted to conclude that the clock was *inherently* 'dysfunctional,' 'bad,' or 'broken.' The philosophy of science underpinning ACT, however, would offer an alternative point of view: from a functional contextualist perspective, it would not be possible to conclude that the clock was *intrinsically* 'faulty' as such a judgment would depend on the context in which it was found. For example, if someone wanted to play a practical joke on their work colleague, then a clock with no hour-dial might be considered 'perfect' for serving that *function* in that particular *context*. Similarly, if one were suddenly to run out of wood for a fire, then under desperate circumstances the 'faulty clock' might suddenly transform into an 'excellent source of fuel' for heating one's home.

Given that the function of an object can vary across different contexts, *functional contextualism* does not assume that objects have an essential nature. Instead of assuming any direct correspondence between words and their referents, a functional contextualist would focus on the *pragmatic* value of a particular word or idea—that is to say, the degree to which it helped one to take effective action based on one's goals at a particular place and time. If, for example, one were planning to direct a horror movie, then the previously 'faulty clock' might suddenly become an 'excellent prop' for setting a gothic ambience in a scene.

Extending this pragmatic perspective to narratives and ideas about male identity, a functional contextualist would refuse to attribute a priori ontological status to terms such as 'man' or 'manly.' Instead of being concerned with the ontological truth of a statement such as 'men don't cry,' a functional contextualist would ask whether holding onto this idea was working for a man at a particular place and time. If his intent was to avoid the ridicule of an insensitive peer, then a man might certainly conclude that the idea that 'men don't cry' was working for him. If, however, holding onto this idea was leading him to conceive of suicide as his only option for dealing with his distress, then the idea might not be considered to be working for him after all. Before considering the clinical application of this philosophy for addressing suicidality in men, we will consider the role that language plays in the formation of male identity and how this in turn might contribute to the increased risk of suicide among men.

Relational Frame Theory: The Role of Language in the Formation of Male Identity

Relational frame theory (RFT; Hayes et al. 2001) is a theory of language and cognition that is rooted in functional contextualism; it is also the theory upon which ACT is based (Hayes et al. 2012). While a complete account of RFT is beyond the scope of this chapter (see Hayes et al. 2001 for a comprehensive overview), a brief introduction to the key ideas of the theory will be provided to highlight the fundamental role that language plays in the construction of male identity (Addis et al. 2010; Sylvester and Hayes 2010).

RFT is founded on the simple but not obvious, observation that human beings are the only creature capable of *deriving relations* between objects *without any direct training in those relations*. For example, if we were to tell you that 'John is Mark's brother,' then you would instantly be able to derive

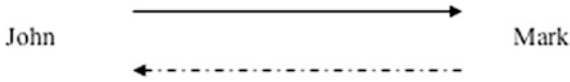

Fig. 1 If you learn that 'John is Mark's brother', you can derive the relation that 'Mark is John's brother' (shown by the dotted line) without any direct training

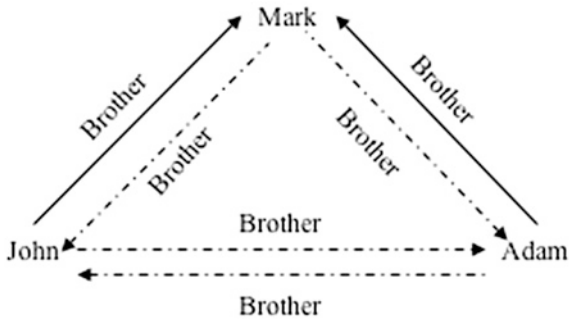

Fig. 2 If you learn that 'John is Mark's brother' and 'Adam is Mark's brother,' then you can derive that 'John is Adam's brother' (shown by the dotted lines) without any direct training

that 'Mark is John's brother' without us having to explicitly inform you of this fact (see Fig. 1).

In addition to being able to derive such mutual relationships between objects, human beings are capable of deriving further relationships between objects by combining their mutual relationships. For instance, if we were to tell you that 'John is Mark's brother' and 'Adam is Mark's brother,' then you would immediately be able to derive that 'John is Adam's brother' without necessarily having to be told this (see Fig. 2). What is especially interesting about this capacity for relating objects in mutual and combinatorial ways is that *the resulting derived relations can influence the way we respond to the things specified in those relations*. Returning to our example, if you did not like John due to some transgression that he might have committed against you in the past, then it is possible that you might also not like Mark and Adam after realising that they were related to John.

While human beings with adequately developed language skills are capable of deriving such relations between objects, non-human animals and pre-verbal human infants do not demonstrate such a capacity. Indeed, research on human infant development suggests that the ability to derive mutual and combinatorial relationships between objects is acquired through an extensive learning history in early childhood during which a parent or

Table 1 The main categories of relational frames typically learnt in childhood

Type of frame	Example
Coordination	'A is the same as B'
Distinction	'A is different to B'
Opposition	'A is opposite to B'
Comparison	'A is more/less, better/worse, bigger/smaller than B
Hierarchical	'A is part of B'
Temporal	'A is before/after B'
Spatial	'A is above/below, in front of/behind of, inside of/outside of B'
Causal	'If A, then B'
Deictic	'I-you'… 'now-then'… 'here-there'

caretaker repeatedly reinforces the *bidirectional relationship between words and their referents*—that is, if a word stands for its referent, then the referent stands for the word (Lipkens et al. 1993). For example, imagine that a parent first shows a rubber duck to a child, names it in their presence by saying 'this is a duckie,' and then reinforces any orientation that the infant makes towards the object. Following this initial exposure to the rubber duck, a parent might then ask the child 'where's the duckie' while prompting them in the direction of the rubber duck and then reinforcing any orientation they make towards it. Through such repeated experiences of *bidirectional learning*, RFT proposes that children come to learn *general operants* for relating objects in particular ways. For instance, in the aforementioned example, the child would be said to have learnt to relate two objects in a *relational frame of coordination* because they had learnt *to coordinate* the word 'duckie' with the rubber duck, and vice versa. RFT metaphorically compares such general operants to *relational frames* because just as a picture frame can hold different pictures, so a relational frame can stipulate the relation between different objects. For example, using a frame of coordination, a child can learn not only that 'duckie' stands for rubber duck but also that 'mama' refers to mother, 'bow wow' to dog, 'biscuit' to treat, and so on.

A list of the main relational frames typically learnt in childhood is shown in Table 1 (Hayes et al. 2001). As can be seen from the list, a child typically learns to apply different relational frames depending on the relationship between objects they wish to specify. For example, if a young boy wanted to assert his difference or opposition to his younger sister, then he might employ a relational frame of *distinction* or *opposition* to state that 'boys are *different* or *opposite* to girls.' Similarly, if the boy wanted to declare his superiority to his sister, he could use a relational frame of *comparison* to state that 'boys are *better* than girls.' Drawing on the same relational frame of comparison, the boy might also wish to point out that he is 'taller,' 'stronger,' 'older,'

'smarter,' or simply 'better' than his younger sister in numerous other ways. If the boy was feeling less cantankerous towards his sister, then he could adopt a *hierarchical* relational frame to highlight that 'boys and girls are both *part of* the same human race.' If the boy continued to be in a hostile mood towards his sister, however, then he could draw on a *temporal* relational frame to brag that he was born 'before' her or a *spatial* relational frame to boast that he is "above" her in terms of his physical height. In a related vein, the boy might employ *causal* and *deitic*[1] relational frames to assert his authority over his sister by exclaiming: '*you* have to do as *I* say *because* mum said so.' As can be seen from these examples, *simple relational frames can be combined to create complex relational networks* that gradually weave together the narrative and identity of the child.

Of all the frames listed in Table 1, the deictic frame is arguably the most central for identity formation because it involves specifying relations between objects *from the perspective of the speaker* ('I-you,' 'here-there,' 'now-then'). This perspective is central to the formation of our identities because, while the contents and processes of our experiences are always changing, our *sense of perspective* remains unchanged. Consider, for instance, how you can still identify with your younger self in childhood even though the physical atoms and social narratives composing you have changed over time. Although your body and mind has been altered by a lifetime of experiences, there remains a *continuity of consciousness* between your 'I-here-now' and the 'I-there-then' of your childhood. It is upon this *first person perspective* that our identity is built, specifically through different relational frames combining with one another to form our self-narratives. Far from offering us an elemental realist perspective of our 'true nature,' however, *the stories that we come to tell ourselves are heavily influenced by the verbal community we grow up in*.

Nowhere is this perhaps more evident than in the case of gendered social learning where, depending on the historical time, geographical location, cultural milieu, and specific family situation, a child may be told different things about what it means to be 'a boy' or 'a girl.' As mounting evidence suggests, the cumulative effect of such learning on the sexes can be considerable (Fine 2017). For instance, the child may be told that 'blue is for boys' and 'pink is for girls.' Although such a specified relation between colour and gender are completely arbitrary, the relational frames that coordinate 'blue' with 'boys' and 'pink' with 'girls' can come to be *seen as reflections of reality by being non-arbitrarily reinforced by the verbal community* in which the child

[1]Coming from the Greek *deiknunai* (to show), the term 'deictic' refers to a word or expression whose meaning or referent is dependent on the context in which it is used (e.g., I, here, now).

grows up. A boy, for example, may come to believe that 'blue *really* is for boys' and 'pink *really* is for girls' by being praised for wearing a blue item of clothing and ridiculed for choosing a pink one. Through such repeated experiences of differential reinforcement, children may also come to *frame ideas of masculinity and feminity in opposition to one another*, thereby leading them to see qualities associated with one gender to be contradictory to the other. For instance, if a young male is taught that 'women are vulnerable, irrational, and emotional,' then through a process of oppositional framing, he may come to believe that 'men are strong, rational, and emotionless.' In a similar vein, if a man is taught to equate feminity with help-seeking behaviour, then he may conclude that such behaviour is antithetical 'to being a man' (Sylvester and Hayes 2010).

The implications of such processes can be far-reaching. While holding onto such beliefs may be functional in settings where help-seeking behaviour by men would be met with rejection, such rigid and inflexible constructions of male identity can, in our experience, also lead to a narrowing of men's behavioural choices in the context of emotional suffering. In extreme cases, we suggest that this can lead emotionally vulnerable men to conceive of suicide as their only option for dealing with their distress. Before considering ways of addressing this in the clinical setting, it is helpful to briefly explore how RFT can actually account for this problem-solving function of suicide in the first place.

Take a moment to imagine a young suicidal man who is experiencing such intense feelings of despair that it is difficult for him to conceive of an optimistic future. Given his situation, this man might think to himself 'I will always feel hopeless; there is therefore no point in going on.' While this imagined future *might* reflect a real possibility, note how it is through language, specifically through the combination of different relational frames, that the man is able to conceive of suicide as a logical solution to his perceived problems. Notice, for example, how the man's belief—'I will always feel hopeless'—consists of a deictic frame of 'I-here-now' being brought into a frame of coordination with a deictic frame of 'I-there-then' in the future. Both of these deictic frames, in turn, are brought into a frame of coordination with the grim experience of always feeling 'hopeless;' that is, the deictic frames of 'I-here-now' and 'I-there-then' are both brought into a frame of coordination with 'hopeless.' Based on this pessimistic construction of the future, the man next draws on a causal frame (highlighted by the word 'therefore') to conclude that *if* he 'will always feel hopeless' *then* 'there is no point in [him] going on' (see Table 2). As can be seen from this brief analysis, *it is through the process of relational framing that suicide becomes conceivable as a logical course of action*.

Table 2 Relational frames involved in the construction of the following suicidal thought: 'I will always feel hopeless; there is therefore no point in going on'

Type of frame	Example
Deictic	'I-here-now'… 'I-there-then'
Coordination	'I-here-now' (present) = hopeless = 'I-there-then' (future)
Causal	'If I-there-then' = hopeless (in future) … then there is no point in 'I- here-now' carrying on (in the present)

Reflecting on this process, Wilson et al. (2001) suggest that most suicidal ideation seems to consist of an over-extension of the following problem-solving formula: 'now bad, do X, later better.' While the 'X' in this equation could stand for a number of different avoidance strategies, including drinking alcohol, taking drugs, or watching pornography, at the most extreme end of the avoidance spectrum suicide can be conceived as the ultimate attempt to move from the 'now bad' to the 'later better,' especially when the emotional pain that one is attempting to overcome is perceived to be *intolerable, interminable, and inescapable* (Chiles and Strosahl 2005). Though perfectly logical in some respects, the trouble with this problem-solving mode of mind is that 'it can readily address every human problem except the limits of verbal problem solving itself' (Hayes et al. 2012, p. 57). Given these limitations of the problem-solving mind, we next explore how ACT might be used to address such suicidal ideation in men.

Promoting Psychological Flexibility in Men Through ACT

ACT is a third-wave mindfulness-based behavioural therapy that has been shown to be effective in addressing a wide range of presenting problems, including depression, anxiety, OCD, anorexia, psychosis, substance misuse, chronic pain, and terminal-illness-related stress (Hayes et al. 2012). Instead of focussing on symptom reduction, however, ACT aims to help us to live a meaningful and fulfilling life by encouraging us to *drop the struggle with our unwanted internal experiences*. For many men, this is a completely new perspective, antithetical to their own cultural conditioning. Recognising that pain is a natural and unavoidable part of life, ACT notes that it is in fact the ongoing attempt to rid ourselves of unwanted experiences that leads to the development of psychological problems in the first place. Consider, for instance, how Sean had been browsing daytime TV, smoking cannabis, surfing the internet, and watching pornography on a daily basis. From an

ACT perspective, these behaviours could be understood as attempts by Sean to escape his underlying sense of despair. Although these behaviours might have been giving him temporary relief from his troubles, they were unlikely to eliminate, or even ameliorate, his emotional pain in the long-term.

While ACT acknowledges that not all attempts to control our inner world are necessarily problematic, it is the extent to which these *experiential avoidance* strategies pull us away from the things that we value that is the criteria by which to judge whether a particular behaviour is working for us or not. For example, if Sean's TV, cannabis, internet, and pornography use was not interfering with his ability to live a meaningful and fulfilling life, then these behaviours would not be deemed problematic. As Sean, however, had been contemplating taking his own life, we would ask him to consider whether these attempts at coping were actually working for him in terms of helping him live the life that he wanted. If Sean were to recognise that they were not, we would aim to help him to be more *psychologically flexible* in how he was dealing with his current circumstances.

According to ACT, psychological flexibility is the ability to be present and open to our moment-to-moment experience in such a way as to facilitate meaningful engagement with life. To explore how we might begin to help Sean to become more psychologically flexible, we will now go over the six core processes that ACT postulates to underlie such psychological flexibility: (1) values, (2) contacting the present moment, (3) defusion, (4) acceptance, (5) self-as-context, and (6) committed action (see Fig. 3).

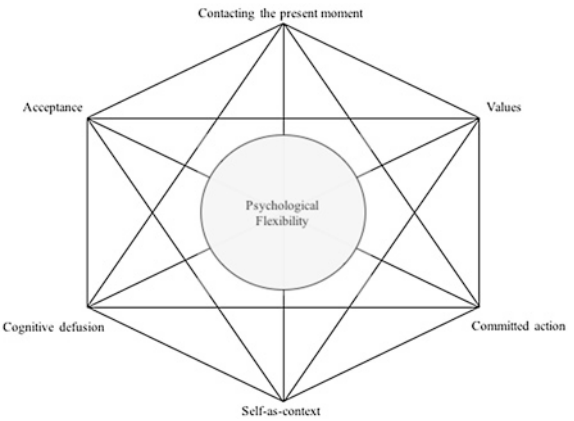

Fig. 3 The 'hexaflex': this diagram is so called because the six core processes comprising the *hexagon* are postulated to work together to promote psychological *flexibility* (We would like to thank Professor Steven C. Hayes for kindly allowing us to reproduce this diagram)

The diagram depicted in Fig. 3 is commonly referred to as the 'hexaflex' because the six core processes comprising the *hexagon* all work together to promote psychological *flexibility*. While we have decided to start our illustration with a focus on values, it is important to point out that ACT does not adhere to a strict protocol in terms of where to begin on the hexaflex. To the contrary, ACT advocates that therapists be *flexible* when working towards increasing their clients' psychological flexibility by encouraging them to 'dance' around the hexaflex as guided by the subtle 'rhythm' and 'melody' of the therapeutic encounter.

Values: Knowing What Matters

As you may recall, Sean had been feeling hopeless about the future because he had been feeling increasingly distant from his children, Zoe and James. Sean's growing sense of isolation was compounded by concerns that he would eventually be displaced in his role as a father by Hannah's new partner, Martin. Indeed, one reason why Sean had been contemplating ending his own life was because he was wondering whether Zoe and James would be better off without him. To add to his deepening sense of alienation, Sean had been spending most of his time in his flat, browsing daytime TV, smoking cannabis, surfing the internet, and watching pornography. As much as Sean wanted to be able to reach out to Peter for support, he feared doing so in case it exposed him as being inadequate as a man.

Given his growing sense of despair, Sean's suicidal ideation could be understood as his verbal problem-solving mind *trying* to help him by proposing suicide as a logical solution to his problems. After all, if Sean were dead, he would no longer have to feel the agonising loneliness and growing sense of hopelessness that was leading him to think of killing himself in the first place. As logical as this might seem, we would begin our work with Sean by getting him to reflect on whether ridding himself of his emotional distress was a prerequisite to him being able to move forward with his life, especially considering that *the depth and intensity of his psychological pain was directly related to the amount he valued certain things in his life*. For example, if Sean did not *care* about his relationship with his children or *value* his role as a father, then he would unlikely feel upset about Martin moving into the family home. Similarly, if intimate relationships were not *important* to Sean, then he would unlikely *care* about being single. By helping Sean to see such connections between his values and his pain, we would aim to help him understand that living a meaningful life did not necessarily entail him having to rid himself of his painful internal experiences. To the contrary, we

would hope to help Sean *honour* his pain by supporting him to reconnect with what was most important to him in life and to take action on it in the face of his difficulties.

To this end, a crucial part of our work would focus on helping Sean to clarify what mattered to him in life. For example, what sort of father did he wish to be to Zoe and James? Similarly, what sort of friendship did he want to have with Peter? And what about his hopes and ambitions for his brief time on the planet: if he only had a short time left to live, would browsing daytime TV, smoking cannabis, surfing the internet, and watching pornography really be what he wanted to do? By helping Sean to clarify his values through questions such as this, we would hope to help him see that, no matter what the circumstances he found himself in, it was always possible for him to remain true to what was most important to him in life.

According to a common metaphor in ACT, values are like a compass because they can give us a sense of direction when we are feeling lost in life. If a value represents our chosen direction, *goals* are the *destinations* that lead us in that desired direction. Thus, after helping Sean to clarify what was most important to him, we would next ask him what goals he could set himself to start bringing his values to life. For example, if Sean told us that he wanted to be more connected to Zoe and James, then we would ask him what sort of things he might be able to *do* to transform this into a reality. Could he perhaps set aside some time every week to give Zoe a phone call if she preferred to spend her Saturdays with her boyfriend? Likewise, would he consider joining in when James was playing his computer games or, even better, could he think of alternative fun activities that they could do together? If he was concerned about opening up to Peter, what if anything might he be able to share with him as a first step to closing the gulf between them? After establishing what goals were most important for Sean to focus on, we would next explore what barriers were standing in the way of him taking action on them and then consider ways for him to overcome these. As a starting point, we would aim to help Sean to come more in contact with the present moment because this is, ultimately, where all of our actions take place.

Contacting the Present Moment: Being in the Here and Now

To be fully in contact with the present moment means attending to what is happening in the here and now with an attitude of openness and curiosity. As human beings, we find it extremely difficult to remain connected

to our moment-to-moment experience because we can easily get caught up with what is going on in our minds. One reason why we struggle to stay in contact with the present moment is because the 'verbal chatter' in our heads tends to take us away from the here and now by leading us to ruminate about the past, worry about the future, or imagine hypothetical scenarios that may or not happen. Consider, for example, how Sean was capable of imagining being rejected by Peter without actually first reaching out to him for support. While Sean's capacity to anticipate this scenario enabled him to prepare for imagined threats or dangers, it also came at the cost of him losing touch with his immediate surroundings.

To help Sean interact more effectively with the here and now, an important aspect our work would focus on developing his ability to notice his experience in the present moment. As bringing attention to his internal experiences could prove too threatening as a starting point, however, we would likely begin by teaching Sean how *to ground himself in the here and now* by asking him to observe what he could notice outside of himself using his senses. For instance, at the beginning of a session, we might invite Sean to take a moment to look around and notice five things that he could see, to close his eyes and to notice four things that he could hear, and to pause and notice three things that he could sense against his body; for example, the floor beneath his feet, the chair against his body, and the clothes against his skin. After Sean had an opportunity to familiarise himself with this grounding exercise, we might next invite him to take a few deep breaths and to notice the sensations involved in the act of breathing; for instance, the changes in the temperature of the air as it flowed in and out of his nostrils, the rise and fall of his chest and shoulders with each in-breath and outbreath, and the differences in effort between inhaling and exhaling. As Sean became more aware and open to these aspects of his internal experience, we would start to invite him to bring an attitude of openness and curiosity to anything else that he might be experiencing, including any difficult thoughts, feelings, images, memories, sensations, and urges that might be showing up for him during a session.

By helping Sean to become more aware of these aspects of his experience, *our goal would be to help him begin to engage and interact more fully with his moment-to-moment experience, so that he could start taking more effective action on his values*. For example, if Sean noticed his mind telling him to pretend that everything was okay as he reached out to Peter for support, instead of allowing this thought to take him away from his valued course of action, we would hope that he would be able to start to notice and allow the thought to be there without necessarily having to let it influence

his behaviour. As the verbal chatter in our heads can be very seductive, we would next aim to teach Sean how to step back from the contents of his mind when it was taking him away from what he valued.

Defusion: Stepping Back from Unhelpful Thoughts

Recall that one reason why Sean was struggling to reach out for support was because he *thought* that Peter might judge him as being 'weak' if he were to open up to him about his difficulties. Based on the aforementioned literature on RFT, we would hypothesise that one reason why Sean was struggling to seek help from Peter was because he had developed a relational network in which expressing emotional vulnerability was framed in opposition to being a man. Given this, we would expect thoughts like 'men don't cry,' 'I must be strong,' or 'I cannot show weakness' as acting as a barrier to Sean confiding in Peter about his problems. Instead of getting into a debate with Sean about the ontological truth or otherwise of these ideas, consistent with functional contextual principles, *we would ask him whether buying into these thoughts was taking him further or closer to what he valued*. For example, if Sean believed that buying into the idea that 'expressing vulnerability is a sign of weakness' was helping him to have the sort of friendship that he wanted with Peter, then we would not challenge him on this point. As the idea, however, appeared to be taking him away from his friendship with Peter by leading him into social isolation, we would invite Sean to reflect on the *effects* of him holding onto it. If Sean were gradually able to recognise that holding onto this idea was leading him to withdraw from Peter and risking *taking him away from everything that he valued* by leading him to see suicide as the only logical solution to his problems, we would start to teach him to step back from his thoughts when they were being unhelpful in this way. Importantly, however, we would only start to move our work in this direction if Sean himself was able to recognise the *value* of doing so.

To help Sean begin to step back from his thoughts, we would introduce him to some basic defusion techniques, the purpose of which would be *to help him distance himself from his 'chattering mind' when it was being unhelpful*. At its core, defusion involves looking at our thoughts with a sense of dispassionate curiosity and recognising them for what they are: a stream of words passing through our head that may or may not be helpful, depending on the situation we find ourselves in. Defusion is so called because it is the opposite of fusion—a state in which we are fused, entangled, or caught

up with our thoughts because we respond to them as though they were literal truths. One way that we might help Sean to start holding his thoughts more lightly would be by getting him to label his thoughts *as thoughts* as they arose in session. For example, if Sean were to express the thought that reaching out to Peter would be a sign of weakness, we would encourage him to first notice that thought and then to label it as a thought by adding 'my mind is having the thought that…' as a prefix to it. To facilitate Sean's capacity to recognise his thoughts as thoughts, we might also share certain observations with him in session, such as 'I'm noticing that your mind is having the thought that…' By continuously labelling Sean's thoughts in this way, our aim would be to help Sean to learn to step back from his thoughts when they were being unhelpful and getting in the way of him taking effective action based on his values.

Another strategy that we might use to help Sean with this could include him learning to relate to his thoughts as though they were leaves on a stream that will move on if simply allowed to come and go at their own pace. Alternatively, we might invite Sean to relate to his mind as though it were a separate entity from himself; for example, an overly helpful friend who might mean well but whose suggestions might not always be helpful in every given situation. At such times, we might encourage Sean simply to acknowledge and thank his mind for the suggestion without engaging in any further dialogue with it. Whichever defusion techniques we were to introduce to Sean, the primary aim would be to help him to unhook or disentangle himself from his 'chattering mind' when it was preventing him from moving towards the things that he valued in life.

Acceptance: Noticing and Allowing Difficult Internal Experiences

While the mere *thought* of rejection was enough to prevent Sean from reaching out to Peter for support, we would be curious to explore other potential barriers standing in the way of him asking for help. For example, alongside his thoughts, it is likely that Sean would have also been experiencing strong *feelings* of anxiety about wanting to turn to Peter for support; *memories* of having his emotional vulnerability rejected by others in the past; and *intrusive images* of Peter judging him in the way that he feared. As a consequence of these painful internal experiences, it is likely that Sean would have also been experiencing an *urge* to stay away from Peter. To help Sean overcome

these internal barriers, we would encourage him to *notice* these aspects of his experience without judgement and to see if he could *allow* them to be there *in the service of what he valued*.

To illustrate the rationale for this to Sean, we could invite him to engage in a literal tug of war with us in session, during which we would ask him to imagine that we were one of the difficult internal experiences—say his anxiety, for example—that he was wanting to get rid of. While engaged in this tug of war with us, we would encourage Sean to reflect on what he noticed as he got into a battle with us. Specifically, we would aim to help Sean notice how *fighting his anxiety only added extra tension and stress to the emotional discomfort that was already there*. Based on this insight, we would hope to help Sean see that by learning to *accept* his anxiety, the pain that he already felt did not have to be exacerbated by any further struggle with it. Indeed, for many men in clinical practice, who have been socialised to 'give up' or 'give in' under almost any circumstance, this moment of acceptance can bring great and welcome relief.

Given the above, we would aim to help Sean to practice being *open* and *compassionate* with his unwanted internal experiences, instead of struggling to alter them. For example, while inviting Sean to adopt a more accepting attitude towards his anxiety, we would be very clear with him that acceptance did not necessarily imply that he had to like what he was experiencing; instead it required him *to be open and willing to experience whatever was there in the service of what he valued*. To help Sean make space for his anxiety, we would encourage him to notice where it was located in his body—for instance, in the form of 'butterflies' in his stomach, tightness in his chest, or tension in his muscles—and then to gently breathe into and out from it, all the while seeing if he could just allow it to be there. By encouraging Sean to embrace his uncomfortable inner experiences in this way, our goal would be to help him to overcome any internal barriers that were standing in the way of him reaching out to Peter for support.

Self-as-Context: Connecting with the Unchanging Aspect of Our Experience

While we would hope that Sean would become better at noticing and allowing his uncomfortable inner experiences as our work progressed, we would remain conscious that he might not feel able to contain *all of* them based on his narrow conception of what it meant to be a man. For example, if

Sean were to buy into the idea that 'men don't cry,' then this would immediately limit his ability to be open to his emotional vulnerability. Drawing on the literature on RFT, we would see this self-limiting perspective as deriving from Sean's overidentification with fixed and rigid ideas of masculinity.

In order to help Sean go beyond this narrow view of himself, we would aim to help him relate to his experience from the perspective of the *self-as-context* which, theoretically speaking, is constructed through the 'I-here-now' deictic frame upon which our identity is based (see Table 1). In contrast to the conceptualised self, which represents the narratives that shape and constrain our identity, the self-as-context refers to the 'I-here-now'-ness of our experience—*that locus or perspective within our conscious awareness that remains unchanged* no matter what thoughts, feelings, images, memories, sensations, and urges we might be experiencing.

To gain an experiential sense of the self-as-context, sit in silence for a moment and notice what your mind is saying about our brief overview of the *idea* of the self-as-context so far. As you sit in silence, notice your thoughts and see if you can also notice *the perspective from which you are noticing* the thoughts that are currently running through your mind. Notice that although your thoughts are ever-changing (e.g., 'what are they talking about… this isn't making any sense… couldn't they explain things more clearly…'), the 'I-here-now' *perspective* from which you observe your changing thoughts itself remains unchanged. This unchanging perspective from which we observe the changing contents of our consciousness is known as the self-as-context because it provides *the context through which we experience our inner and outer world*.

Therapeutically speaking, the self-as-context is an important aspect of our experience because it represents the part of ourselves that remains unchanged in the face of the ever-changing contents of our consciousness, including any uncomfortable thoughts, feelings, images, memories, sensations, and urges that we might be experiencing. Just as a chess board is unaffected by the battle that ensues between the black and white pieces on top of it, our self-as-context remains unchanged by any painful internal events that we may be experiencing. The therapeutic relevance of this unchanging perspective within ourselves is that it gives us a *stable point* from which we can engage more effectively with our experience. Seeing our consciousness as the sky and our ever-changing internal experiences as the weather offers another helpful way to understand this unchanging aspect of our experience: in the same way that the sky remains unharmed no matter if there is a snow storm, a hurricane, or drought, the perspective from which we perceive our internal

experiences remains unchanged regardless of the depth and intensity of what we may be experiencing.

Through the use of experiential exercises and metaphors such as this, we would aim to help Sean to appreciate that, contrary to what his rigid and fixed self-narrative was suggesting, *there was an aspect of himself that was limitless and boundless in terms of the uncomfortable inner experiences that he could contain*. Through encouraging Sean to connect with this transcendent aspect of himself, our goal would be to help him weather any emotional storm, including the intense feelings of anxiety that he would likely experience while reaching out to Peter for support.

Committed Action: Doing What Matters

Our work with Sean would be incomplete if we did not support him to take this final step because, as already discussed, the ultimate aim of our work would be to help him to *take action* on what was most important to him in life. Thus, instead of just encouraging Sean to reflect on the deeper sense of connection that he wanted in his friendship with Peter, we would encourage him to do whatever it took to bring this value to life, even if doing so brought up pain and discomfort. To facilitate Sean to reach out to Peter for support, we would ask him to identify the necessary steps that he would have to take to turn his goal into a reality; for example, getting in touch with Peter, arranging where to meet up with him, and planning what to say to him. Having identified these steps, we would next ask Sean to consider any internal barriers that might get in the way of him carrying them out; for instance, anxiety about opening up to Peter and an accompanying urge to pretend that everything was okay. Lastly, we would ask Sean to think about which of the aforementioned processes—values, contacting the present moment, defusion, acceptance, and self-as-context—he could draw on to help him overcome these internal barriers. For example, to help Sean find the strength to reach out to Peter for support, we would encourage him to reflect on *why* it was important to him to do so. Similarly, we would encourage Sean to consider whether grounding himself in the here and now, stepping back from his chattering mind when it was being unhelpful, making room for his uncomfortable feelings in the service of his values, and relating to his internal experiences as if he were the sky and not the weather, could help him to deal with these internal barriers. By asking Sean to consider all of these things, our goal would be to enable him to do what he needed to

do to strengthen and deepen his friendship with Peter. For those men, who have, like Sean, entrenched themselves in ever more deeply in isolation, such social reconnection can be profoundly important.

Building on this, we could apply the same formula to support Sean to take action on other things that were important to him in life, such as his wish to experience a greater sense of intimacy in his relationship with his children. By supporting Sean to bring his values to life, our ultimate aim would be to help him to find hope in the face of his despair by showing him that no matter what depth or intensity his emotional pain took on, it was always possible for him to honour his pain by remaining true to what was most important to him in life and taking action on it. Indeed, it is our clinical experience that for men, like Sean, who are questioning the meaning of their existence, learning to become more psychologically flexible by detaching from overvalued ideas about masculinity and reconnecting with what matters can be deeply transformative and, in many cases, life-saving. Based on this observation, we believe that ACT offers an extremely helpful approach for working with suicidal ideation in men. Given that the theory of language and cognition upon which ACT is based also offers intriguing insights into the construction of male identity and how this may lead to an increased risk of suicide among men, we hope that the ideas contained in this chapter will provide inspiration for clinical innovations and future research into this pressing area of concern.

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Practising Eye Movement Desensitisation and Reprocessing (EMDR) with Male Civilians and Male Veterans

Roger Kingerlee

Introduction: What Is EMDR?

Eye movement desensitisation and reprocessing (EMDR) is a relatively recently developed psychotherapy (Shapiro 1989; Shapiro 2017). Since its development, initially in the United States and subsequently internationally, a large amount of empirical evidence has accrued for the efficacy of EMDR (EMDR Institute 2017a). This has resulted in the inclusion of EMDR in international treatment guidelines for PTSD, including in the UK (e.g. NICE 2005)—and the evermore widespread use of EMDR in the UK and globally.

EMDR is currently conceptualised, in its standard form, as an eight-phase intervention in which the work is prepared, a traumatic memory is identified, and then targeted for adaptive information processing (EMDR Institute 2017b; Shapiro 2017; Shapiro 2007).

In the first phase of treatment, the client is subject to a detailed psychological assessment, with particular reference to experiences of psychological trauma and their possible sequelae.

In the second phase of treatment, therapist and client focus on identifying and/or enhancing the client's coping and self-stabilizing skills so as to ensure that they will manage any heightened affect during or after trauma processing.

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In phases three to six, therapist and client identify the most vivid, representative image associated with the trauma; the negative, self-referencing belief (the 'negative cognition'—NC) linked to it, and any associated emotions and bodily sensations. The client will also be helped to identify a preferred belief (the 'positive cognition'—PC) about the self that could be linked to the memory. The validity of the preferred, positive, belief is rated quantitatively (the 'validity of cognition' [VOC] rating), as are the associated emotions (the 'subjective units of disturbance' (SUDS) rating). Then, arguably at the core of EMDR is the reprocessing of the memory. While bringing the agreed image to mind, combined with the negative belief and any attendant emotions or sensations, the client is presented with a bilateral stimulus. Often (bizarre as it can seem to the layperson new to EMDR) the therapist will move their hand bilaterally for 20–30s before the client to facilitate visual tracking. Other methods of bilateral stimulation (BLS) may be used effectively, including bilateral taps or machine-generated sounds, machine-generated light, or electronic buzzers. The client is asked to notice what happens. These procedures tend to facilitate movement through the traumatic memory at question—often swiftly—towards its conclusion, such that the emotional distress associated with it is reduced.

When no further distress appears to be linked to the target memory, the client is asked to bring the positive belief to mind, and again to engage in eye movements or other BLS. This procedure tends to increase confidence in the positive belief. A check is also made of the client's bodily sensations. If any negative sensations are noted, they are processed in the above manner using BLS. If, on the other hand, the bodily sensations are positive, these are enhanced with further BLS.

During the active, trauma reprocessing element of EMDR, it is believed—while the mechanisms responsible are not fully understood (e.g. Greenwald and Shapiro 2010; Solomon and Shapiro 2008)—that the traumatic memories are reprocessed such that they become less distressing. In clinical practice, this phase can take anything from a few minutes (less than three minutes, in the researcher's experience) of BLS, to three, four or, very rarely, more full, 90-minute processing sessions devoted to the same memory (which is sometimes but not often the case).

In the seventh phase, the session is safely closed. If the target memory has not been fully processed (such that no disturbance is associated with it), a stabilising, previously established 'safe place exercise' will be used. The client may also be asked to keep a note of any emerging traumatic material prior to the next session, and is likely to be encouraged to use any previously identified means of self-stabilisation (e.g. mindfulness meditation, a commonly used example).

In the eighth phase, a review of progress in the period since the last session, and of any psychological matters arising, is conducted (EMDR Institute 2017b).

Given intervention with EMDR—as the empirical literature suggests—clients often come to recover to a greater or lesser degree, depending on other variables such as personal history and complexity of trauma. In many cases, it should be noted, it is well-recognised among clinicians that EMDR can produce quite remarkable results in short order. Often, client progress will be visible in the form of reduced distress linked to the memory or memories, coupled with changes in belief about self—as well as spontaneous behavioural and personal change (EMDR Institute 2017b).

In simpler clinical situations, EMDR is used as a stand-alone treatment for post-traumatic stress disorder (PTSD) in particular and psychological trauma generally. Over the last decade especially, researchers have begun to produce promising clinical results by beginning to apply EMDR to issues beyond PTSD, including such diverse matters as body dysmorphic disorder (Brown et al. 1997), borderline personality disorder (Brown and Shapiro 2006), depression (e.g. Wood et al. 2018; Gauhar 2016; Bae et al. 2008), panic disorder (Fernandez and Faretta 2007), dissociative disorders (Knipe 2015), and chronic phantom limb pain (de Roos et al. 2010). Clinicians internationally are beginning to experiment very cautiously, and apparently effectively, with EMDR in what were traditionally thought to be no-go areas including (pharmacologically well-controlled) bipolar disorder and schizophrenia, when traumatic memories are part of these conditions, as they very often are (Miller 2015).

EMDR in Practice: A Brief Case Example

As an illustration of how EMDR can work in practice, consider the following.

In this situation, a middle-aged man was suffering from severe PTSD, severe secondary anxiety, and depression as a direct consequence of a prolonged assault that made day-to-day functioning difficult or impossible. Once stable enough to tolerate actual trauma processing, around 6 sessions of BLS were performed with client consent over about 3 months, nested within an overall intervention of 18 months. The use of EMDR Therapy focused on four difficult memories, all different aspects of the assault.

The man, as is very commonly the case, experienced the EMDR sessions as difficult. But the distress associated with the memories soon began to lift very significantly. By the end of treatment, the client and his family felt that the man's psychological functioning was better than it had been since the index incident some years previously. This improvement was associated with spontaneous behavioural change (notably exploring the urban environment much

more freely than before), an eventual return to work and, interestingly, not only the elimination of highly distressing nightmares (which is commonly observed as an effect of treatment) but a key change in the narrative course of one nightmare which—post-EMDR—acquired a positive, reality-based ending for the first time.

Explaining EMDR

Since the inception of EMDR in 1989, it has—reminiscent of many other scientific breakthroughs over recent centuries (e.g. Waterfield 2002)—been at the centre of various, and sometimes bitter, controversies about how, and even if, it works.

To take a prominent example, it has been claimed that EMDR, in essence, is more or less identical in mechanism to traditional exposure-based ways of working with trauma—in the UK most notably trauma-focused cognitive behavioural therapy (TF-CBT). According to this argument, what is new (bilateral stimulation) is not effective, and what is effective (psychological exposure) is not new. Dismantling studies (e.g. Lee et al. 2006) have not settled this matter, though there is recent, noteworthy experimental evidence that eye movements can reduce the vividness and associated emotional charge of a trauma memory (Lilley et al. 2009).

The debate around EMDR is still live. Lines of work, for example, have examined the possible neuropsychological (e.g. Propper et al. 2007) and neurological correlates of EMDR (e.g. Ohtani et al. 2009). In a recent attempt to integrate such diverse findings into what they term the Adaptive Information Processing (AIP) model, Solomon and Shapiro (2008) locate EMDR partly within currently dominant information processing theories. Specifically, Solomon and Shapiro (2008) argue that at its core, EMDR is consistent with neurobiological theories of reconsolidation of memory (e.g. Suzuki et al. 2004), according to which a memory, once accessed, becomes labile before being stored in an altered—and potentially more adaptive—form. Partly on this basis, Solomon and Shapiro (2008) argue that physiologically stored memory networks are a principal source of psychopathology. The processing of hitherto unprocessed traumatic memories, moreover, is predicted to lead to a reduction of symptomology. Indeed, in clinical practice with EMDR, this prediction is often to a greater or lesser degree correct. Appealing and credible though the AIP Model may be, however, there is little scientific doubt that, as with some other psychological and medical phenomena, the practice of EMDR remains some considerable distance ahead of our understanding of the phenomenon. Nevertheless, it is indubitably

the case that steps are being made in this direction. As Knipe (2015) points out, taken together, recent research around the clinical use of focused sets of BLS seems to suggest that conscious experience is influenced and adaptively changed by BLS; and that the retrieval of key information from memory may be affected. As one example here, empirical research has established that BLS increases the capacity for distancing and/or noticing (e.g. Lee and Cuijpers 2014) in people—a frequently observed phenomenon—as EMDR proceeds.

Various, and it must be said persuasive, lines of research into EMDR continue. However, ongoing unresolved issues in this area, perhaps combined with their own understandable resistance to novelty, have left some established institutions and individuals sceptical about EMDR—and certainly reluctant to embrace it.

Despite the controversies and even confusion around EMDR, what is not in doubt is its clinical efficacy. Whether or not it is—as some argue, for instance—'the same' as traditional TF-CBT, or a type of TF-CBT, EMDR is demonstrably effective, as an ever-growing number of randomised clinical trials (RCTs) from 1995 onwards attest (e.g. De Bont 2016; de Roos 2011; Van der Kolk et al. 2007).

Male Development, Male Psychologies, and EMDR

As clinical practice and research over recent decades has begun to show, male development and male psychologies are far from untroubled. As outlined in the first section of this volume, while the nature of psychological sex differences remain debateable, the behavioural differences between the sexes, on average, in certain domains at least, are not: take suicide. Men are, all too often, damaged, and damaging—both to themselves and to others. Frequently subject to less than optimal—or even 'good enough'—care and treatment themselves early on in life, their issues can be unhelpfully acted out, both as they develop, and during maturity. As we will see, EMDR can be an exceptionally useful tool with which to address these issues.

Various factors impact on male development. As a growing body of work is starting to show, there are subtle neurological, neuropsychological, and hormonal differences between the sexes that can—over time and in interaction with other factors—affect the developing male (Kingerlee 2012). Combined with these, there are considerable psychological pressures on boys

and men, the cumulative effect of which is to produce a bias away from psychological reflection and disclosure of emotional distress. There is at least some evidence that, for instance, higher male social status confers benefits in, among other things, health and mating opportunities (Sidanius and Pratto 1999). As such, higher social status in males may be (and demonstrably is) striven for at both conscious and unconscious levels. But this may mitigate against emotional disclosure.

A further layer to this argument has been provided by research in cognitive psychology. It has been established that the human mind has various types of information processing mechanisms. Some of these are 'fast', automatic, and impressionistic; some are 'slow', conscious, and deliberate. The workings of these leave no life domain untouched, as human experience is processed by the mind with systematic—and often unconscious—biases (Kahneman 2011).

One such bias relevant here may be that of deception and self-deception. On the basis of experimental evidence from both animals and humans, Trivers (2011) suggests that, in order to gain or maintain status in the social and sexual hierarchy, animals and humans commonly use deceit in their relationships with others—and with themselves. Trivers (2011) argues, moreover, that humans particularly may have evolved to deceive themselves at times, in order to deceive others more effectively. These ideas may be particularly pertinent to human males, with their tendency (as Trivers terms it) towards self-inflation. According to this line of thought, increased social status confers such benefits (including sexual) to men that they frequently go to enormous lengths to impress others. This entails powerful psychological processes of deceit and self-deception—for example the systematic screening out of unwanted information by the mind. As well as adducing persuasive evidence from the animal and human kingdoms, Trivers (2011) gives many amusing examples of how he himself has deceived himself and others—with the aim, in effect, of raising his status in the eyes of others, but also to his own cost (when his ill-advised attempts to impress backfire).

While Trivers's (2011) ideas about deception are being explored by researchers in the biological sciences, they probably have relevance to human male psychology—and may be relevant here. Specifically, the cognitive mechanisms described by Trivers (2011) may further help explain male tendencies to disavow one's own male psychological experience on the one hand and, when life is difficult, not seek help on the other. In other words, in order to gain or maintain their own social status, some men may tend to disregard or otherwise downplay their own vulnerabilities and the associated memories—since these could send them tumbling in the pecking

order. In effect, men doctor the narrative of their lives, amplifying notions of strength, silencing any senses, or stories, of vulnerability. It is well-established that men find help-seeking problematic (Addis and Mahalik 2003). These mechanisms may help explain why. In effect, from Trivers' (2011) perspective, faced with difficult psychological experiences, boys and men may be prone to deceive themselves and others that—at times—they do not need help.

This line of thinking opens up a new vista in terms of enabling men to be more honest with themselves and others—perhaps in environments that are known to be therapeutically safe, so facilitating useful intervention. It also gives further reason to believe that, all too often—subject to various systematic cognitive biases (Kahneman 2011) whose default is to privilege male stories of strength over realism and vulnerability, men's psychological view of themselves is, in one way or another—and even though men are not conscious of it—quite impoverished.

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From the current perspective, then, it may well be that, from an early stage in boys' lives, various developmental, cultural, and psychological forces are at work that, taken together, leave developing many males prone to a restrictive stance towards their own emotional life. This may have two consequences with regard to doing EMDR with men.

First, clinical practice suggests that given their less empathic early development, sometimes coupled with tough socialisation processes (for example during military training), many civilian and veteran men have little or even no awareness of the traumatic or quasi-traumatic nature of the earlier parts of their lives. As an illustration, it is common to meet men at mid-life who are aware—on a conscious level—that their father was 'strict'. But only close examination, often via EMDR, reveals the true psychological picture—all too often a story of chronic psychological and physical pain inflicted by a parent. In such situations, it may well be that the combination of neurological, psychological, cultural, and social factors—perhaps amplified by later harsh male socialization processes—have led to the full narrative meaning of life-episodes, and the memories of them, not to be acknowledged, or to be ignored, or otherwise dismissed. Perhaps because of this, male clients are sometimes surprised to be informed that their unempathic early treatment by their caregivers may in fact be a significant issue now. In line with this, some men exploring these aspects of their past often need to learn a new vocabulary, emotional and otherwise, to understand it, as therapy continues.

Also, as prominent scholars in the field have observed, men at midlife or older frequently tend to experience depressive states, some of them chronic, as a response to minor and major losses in life (Cochran and Rabinowitz 1996, 2000). A similar pattern is often noted. Owing to the developmental and other forces acting on the man, the meaning of the loss itself (perhaps of a partner, or of good health) has been downplayed, to the point of not being understood. A significant loss, of course, may also reactivate earlier life difficulties and traumas of which, as noted above, the man may not be fully cognizant. Given all of which, the man in question may present initially with a chronic, diffuse sense of ill-being, itself ill-understood.

In such cases where the various pressures on male consciousness have, over the years, mitigated against a full understanding of the man's experience, EMDR has a key role to play. Working with the adaptive networks of memory, lines of difficult and/or traumatic experiences are easily traced with EMDR. More often than not, in EMDR practice with men, new light is shed on what may have appeared to be a simple, one-dimensional issue. In such psychological matters as elsewhere in life, very often, all is not what it initially seems—and new, richer, and more accurate narratives emerge (Kahneman 2011).

Second, it is well-understood that owing to the various pressures on male consciousness not to acknowledge vulnerability, men tend to shear off into avoidance behaviours—rather than reflect on the issues in hand in a psychological way. Kingerlee (2012) suggests that for many men, when psychological distress comes into awareness, the reflection abandonment mechanism (RAM) kicks in, leading the individual male to undertake an avoidance behaviour. These, as day-to-day clinical practice with men shows, can include such issues as substance use (to manage mood), externalising behaviours as acting out, anger, and violence, as well as more subtle types of avoidance like humour, and/or never taking anything seriously. In short, some men in distress can become disconnected, from others, from services, and from themselves. This possibility—and that of eventual reconnection via a phased process—is expressed in the Male Connection Continuum (Table 1; see Kingerlee et al., this volume).

Here, too, there are opportunities for the clinician using EMDR. As Knipe (2015) has demonstrated, avoidance defences may themselves be skilfully targeted so as to reveal, and eventually resolve, the hidden underlying issues which, of course, may have gone unidentified by the man in question for many years, or even decades. Often, this can lead men to reconnect both with themselves, and others.

Table 1 The male connection continuum

Disconnection: The man is disconnected and isolated, outside the remit of services. Barriers to the external and internal worlds are in place
Behavioural Connection: The man changes his behaviour in the direction of connection, for example visiting his GP, exploring help online, or attending a helpful activity like a Men's Shed. The barrier to the external world has been lifted. The barrier to the internal world remains in place. Psychologically, the man remains defended
Emotional Connection: The man begins to connect emotionally with others, individuals and/or a service. The man is also in emotional contact with himself. The barriers to the internal and external worlds are lifted
Reconnection: The man shows signs of being fully reconnected to others, and to himself. Recovery and change processes are well underway

To sum up: the male consciousness with which we are presented in the consulting room has been, and is, subject to various pressures—often invisible and unidentified. This can leave some men who are suffering psychologically unclear about the meaning of their current or past experiences—and psychologically distant from them. In extreme cases, men can present with severe psychological symptoms, but with little or no idea what has caused them, and with no narrative to explain them—even after a major recent life event like a loss.

In such circumstances, EMDR is a, or perhaps even the, ideal tool for the clinician to help men in distress. In the remainder of this chapter, we will explore how this can be done, with cases from the more straightforward, to the more complex.

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Using EMDR with Diffuse Symptomology in Civilian Men

Often, men themselves are in effect confused about the origin and significance of their symptoms. In such situations, EMDR can be useful in helping identify, and ultimately resolve the issues in question. Steve was a case in point.[1]

When he presented for treatment in his 40s, Steve had had a sense of malaise for as long as he could remember—certainly since adolescence. He had no real idea, he said, 'of what feeling good is like'. His current life

[1]NB All case material presented here is composite and highly anonymised.

seemed reasonable—he had work he quite enjoyed and was good at, as well as a partner, children. He 'got on' with life day-to-day. But he nevertheless felt bad, most of the time. Steve had no specific words for how he was feeling, other than 'bad'. Sometimes this affected his work; it certainly affected his life at home, since he felt that he was far from the partner or father he wanted to be. For one thing, he was living his life through the fog of chronic and severe anxiety and chronic, low-grade dysthymia and somatic symptoms in the form of chronic muscular tension.

Steve was surprised to discover that he met the criteria for 'severe' on psychometric measure of anxiety. He said that he had more or less 'always felt this way'. Like many men, Steve had been living his life, and 'carrying on as normal' while carrying a large burden of suffering with, as we were about to discover, little idea why.

On exploring, during our initial assessment sessions, his life of recent decades, there was little of psychological note to explain his feelings. He worked hard—but not so hard as to be self-destructive. There had been minor professional and personal setbacks, too, but little that seemed to either have activated his malaise, or explain its force.

We turned our attention, consequently, to Steve's earlier life. He said, he thought, that there was 'not much to find there, either'. Steve outlined that both his parents had been present for most of his childhood, that finances had been broadly sufficient, and that he had had a reasonable experience of school. It was on leaving school that he began to find his professional niche. We agreed that all sounded OK. Steve's symptoms told another story. As the sessions progressed, we tracked his somatic symptoms, including difficult back pain that at times made concentration at work even more difficult. As with many men, it was far from clear initially, how Steve had come to feel so bad, including about himself, and his life. There was nothing to pin the issue on. He had even wondered if a physical issue was the problem—but blood tests showed nothing.

We only had one lead. Steve had a memory of being harshly criticised by a teacher whom he valued, which he experienced as mildly traumatic. He rated the SUDS as a 3. Not high, but of interest nevertheless. We used the Standard Protocol and processed that memory.

Steve: This was the last thing I expected from him. I respected him so much.

Therapist: Just notice that [eye movements: EM].

Steve: I felt so disappointed, so betrayed. Before that, he had meant so much to me.

Therapist: Just notice that [EM].

Steve: It left me so alone. I felt so isolated. There was no-one to turn to. I've never thought that before, but that was part of it, it was just me, and that was it.

Therapist: Just notice that. Go with it if it's OK to do so [EM].

Steve: I felt like that before. It wasn't the first time. Only the first time with the teacher. It was home where I'd felt it.

Steve had associated to memories from around that time on his life and earlier, and went on to elaborate. We completed the processing, and closed down the session. We were aware, though, that we had tapped into a new and different seam of memory for Steve.

Over the next few weeks, Steve's mind naturally started to bring forward related material for EMDR. These were memories which—while not of major, 'big 'T' traumas', were nevertheless important.

It emerged that, despite Steve's initial sense that his childhood had been happy enough, there had in fact been a hollowness to it. Steve was getting in touch with these memories. We processed one, the SUDS of which started as a 4.

Steve: Dad was sitting there in the kitchen. Away from my Mum and everyone else. The atmosphere wasn't good.

Therapist: Just notice that. [EM].

Steve: It was often like that. Not so much tension, but distance. For some reason, Dad just pulled away from us. I see now he was really unhappy.

Therapist: OK. What was he unhappy about do you think? [EM].

Steve: There were arguments between the two of them. Not big ones, but it led to a distance. They wanted to keep up appearances - you couldn't be seen to be unhappy. So it was all behind closed doors.

Therapist: Just notice that. [EM].

Steve: While there was this freeze between them, I was left by myself. No-one was looking out for me, then.

Steve had come to the realisation that, beneath the surface of his childhood memories, there was an emotional aspect that he had missed. He had been a lonely and unhappy little boy, caught between unhappy parents at a time when it was less socially acceptable for couples to separate. He was coming to see his childhood in a very different light.

By now in our work together, Steve was coming to feel a little better. His chronic dysthymia had lifted somewhat, he said he could 'see things more clearly'. But he remained troubled by his very high level of anxiety.

We looked at the options. Was it the case, we wondered, that he had a naturally very sensitive, anxious temperament? This didn't ring true.

Then in one session. Steve reported that he'd recalled some 'low level' bullying to which he'd been subject. 'The kind of thing that happens all the time', he said dismissively. I wondered out loud about this, and we agreed to process the bullying memory. Steve put the SUDS at an 8.

Steve: I was friends with these guys from the other school. We sort of got on. But on this day, they just turned on me. I remember my heart beating so fast, I just wanted to get away.

Therapist: Just notice that.[EM].

Steve: I'm running away from them through these woods. I know they're after me. I just don't know why. I can feel my heart thumping in my chest now.

Therapist: If you're OK to do so, notice that.

Steve: That's it. We've stopped in this clearing. I'm terrified. There's no way out. They force me into my hands and knees. I've no choice. One of them says, 'No-one knows you're here. Your Mum and Dad aren't interested'. I'm terrified.

Therapist: Just notice that.

Steve: That was it. They knew I was vulnerable. That no-one was interested. Even at home. I was left to fend for myself. They knew that and used it against me. That's when the fear (anxiety) started. When it took hold of me.

We had accessed the core of Steve's malaise. While there were other memories that we would come to, this was the key component. We had moved from a position where Steve's long experience of psychological suffering had seemed inexplicable, leaving him disconnected from himself and others. Like many Western men of his generation, prior to treatment, Steve had not fully grasped how difficult his early experiences were, having tended to minimise them, so that even significant psychological events were downgraded as being, in effect, meaningless. EMDR had given him a more nuanced understanding, though, and a richer, more meaningful narrative about what had gone on in his life. Above all, perhaps, EMDR had allowed Steve identification of, and access to powerful feelings that had—owing to the circumstances of his upbringing, and the narrative that belonged with them—been shut down. But with this memory identified and reprocessed, Steve's anxiety reduced very significantly. This made his daily existence much easier, and much more enjoyable. The psychological fog between Steve and his reality, the emotional residue of an unhappy earlier life, had been cleared. Such a

pattern is common when using EMDR with troubled men: issues that may be on the edge of, or just outside, consciousness, can be identified, uncovered, and usefully processed.

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EMDR with Military Veterans

A growing international literature addresses psychological working with current and former Forces personnel (e.g. Hacker Hughes 2017). Part of this body of work examines the use of EMDR with those veterans who carry operational stress injuries of one kind or another (Russell and Figley 2013). This is wise, since it is well-recognised that veterans can face specific psychological challenges on various levels which—if they are not identified and addressed—can (1) reduce the effectiveness of treatment, and (2) may even prevent treatment being accessed in the first place. Both of which are now avoidable outcomes.

In the UK, around 90% of military personnel are male (Houses of Parliament 2016). The psychological issues that affect veterans, moreover, are well-documented. The most common issues affecting veterans are anxiety and depression (at around twice the rate of the general population). Historically, substance misuse issues have been and are also frequent (Kamienski 2016), and co-morbid with other problems; in its pure, formally diagnosed form, PTSD is rather less commonly seen in veterans (Houses of Parliament 2016). Other issues, inextricably linked to those already mentioned above, are also quite commonly found in veterans. To take one example, ex-armed forces personnel are disproportionately likely to come into contact with the criminal justice system, experiences which can have potentially devastating consequences for the individuals and families concerned (Hacker Hughes 2017).

In short, the psychological profile of military veterans who are troubled strongly echoes that of civilian males, who may, at times of emotional strain, be more prone to misuse substances, and evince externalising disorders (Kingerlee 2012). A case can also be made that—in fact whatever their biological sex—military personnel and veterans display, in psychological terms, a kind of hyper-masculinity. This tendency has been noted over the last century not only by scholars (e.g. Theweleit 1977), but also by novelists. In his comic expressionist masterpiece *Berlin Alexanderplatz* (1929), the German novelist and psychiatrist Dr. Alfred Doeblin (1878–1957) consciously depicted the World War One veteran Franz Biberkopf as a lovable man,

but one with tendencies to alcoholism and violence, troubled by intrusive images from his experiences of combat, yet unable to articulate his distress (Kingerlee 2001).

For veterans now, hyper-masculinity can be understood to mean various things. First, military training can tend to amplify certain human responses (notably aggression as a response to threat), and reduce other responses (any sense of physical and psychological vulnerability) (Woodley 2017). Second, notions of hegemonic masculinity (Connell 2005) that often pervade civilian male populations, and in which ideas such as strength and stoicism are foregrounded, may themselves seem to be amplified in those who have had military training. In practice, this has often meant that traditionally, veterans almost automatically ascribe to the idea that they are (or should be) psychologically as well as physically 'strong'; and a commensurate reluctance, often to the point of aversion, of acknowledging any sense of 'weakness', vulnerability, or 'abject masculinity' (e.g. Shields 2016). Indeed, some argue that often, veterans perceive it to be easier to go into battle than to be open about their psychological issues with others (Westwood 2017). Fortunately, this clinical picture can change as a veteran engages with treatment.

Leading on from these aspects of hyper-masculinity—and again reminiscent of the psychology of civilian males—is the understandable initial reluctance of veterans to seek help, and indeed to avoid it. Like their civilian counterparts, it is well-known that military veterans can be extremely reticent about asking for help, even from usually trusted sources like a GP. This procrastination where help-seeking is concerned may, though, eclipse that of civilian men. It is not unusual in clinical practice, for instance, to hear anecdotally that a veteran has been aware of an emotional issue that needed attention—but put off asking for help for a decade or longer.

Rather than seeking help, many veterans understandably find themselves turning to other means as a way of self-managing difficult feelings. One of the most common methods of maladaptive self-soothing is over-use of alcohol, which can bring further secondary health issues—and risks to self and others—in its train. It should be noted at this point that in many military cultures internationally, alcohol has an important, and multifaceted, role to play—and can easily become a problem when times are hard.

Overall, it can be argued that in comparison to civilian males, veterans, prior to engagement in treatment, are frequently still more psychologically defended. Subject to a combination of the hardening psychological and physical conditioning and the effects of military social norms on the one hand, and (often) the experience of very challenging and traumatic events on the other—and sometimes compounded by moral injury—it is perhaps

to be expected that affected individuals may be reluctant to acknowledge an emotional issue fully. In this way, as discussed above, troubled veterans may find themselves in a position—again quite understandably—of denying their issues in the service of 'saving face'—a challenge for those wishing to offer psychological services to them. They may suffer, in short, from what could be termed Veterans' Disconnection Syndrome (VDS; Kingerlee et al., this volume), where defences against the inner and outer worlds of an individual are—temporarily—in place. But beneath this carapace, a human being somewhere resides: someone with lived experience, some of it painful; someone with morality and a moral compass; and above all, perhaps, someone with human feelings. To some degree, it is the extent to which the person under the carapace can be reached that determines the likely success of the work with a veteran. While a good degree of cultural awareness of military life is essential in the process of initially engaging a veteran in psychological help (Russell and Figley 2013), partly via establishing the therapist's credibility in the eyes of the veteran, it is a central contention of this chapter that EMDR can directly assist in the actual therapeutic work.

Behind the Defences: Ben

Ben, a tired-looking man in his 30s, had come for treatment with great reluctance. His wife, concerned for him and despairing by turns, had more or less forced the issue, by taking Ben to the GP and helping to explain what was happening, and what had happened.

Ben had joined the British Army as soon as he left school, aged 16. He enjoyed Basic Training, and the military ethos, and looked forward to operational tours. The initial tours to Iraq in which he took part were difficult but also rewarding work, Ben having had the sense of a mission that was thoroughly worthwhile. Among his positive memories of those years he reported engaging with a local population who were sometimes grateful, and the building and rebuilding of schools.

When he reached psychological care, though, Ben was deeply affected by his operational stress injuries. Assessment showed that he was suffering from severe post-traumatic stress (as evidenced by regular flashbacks, some dissociation, and nightly nightmares), and secondary symptoms of moderate-to-severe anxiety and depression. To try to cope—and thereby keep his civilian job—Ben had been using alcohol to help him sleep. This had been useful to begin with, but had got out of hand such that Ben would, after a second bottle of wine, come close to oversleeping. This drinking also

jeopardised his work with machinery. In the initial, stabilising phase of the work, we developed Ben's grounding skills, so that he felt less dependent on alcohol to self-soothe. We also contracted that he would not drink in the weeks when we were doing EMDR.

Psychological exploration showed that one particular set of military memories were resurfacing for Ben in a problematic way. These memories focused on a firefight and its aftermath. Like many veterans, Ben was extremely reluctant to discuss it to begin with, but over a session we established that the situation—a house being raided—had been a threatening one to the point that Ben thought that he and all four of his five comrades that night would be killed. There were, Ben felt, three difficult sub-aspects to the memory. Having carefully prepared with Ben over a handful of sessions for actual processing, we began with EMDR.

Using the standard protocol, the initial part of the memory, in which Ben and his colleagues arrived quietly at the scene in the middle of the night to extract an enemy combatant from the location, was swiftly processed, with SUDS falling to 1 more or less unhindered over a session. We were both pleased at this and, after a further session debriefing the following week, agreed to process the next identified part of the memory. At the start of this following session, Ben seemed slightly uneasy. The sense of relative relaxation after our first success had given way to a sense of anxiety, of something troubling him. Nevertheless, Ben wanted to proceed. We are, in the memory, inside the location.

Ben: I can't see where the Hell I'm going. There's all manner of noise.
Therapist: Just notice that. [EM].
Ben: I've kicked my way out of one door, heading down the stairs full tilt. Someone – can't see who it is – has got in my way. I've just gone over them – we've got to get out fast.
Therapist: Notice that. [EM].
Ben: The five of us are downstairs now. But they've locked the door. If we don't get out now we'll be killed. All of us. We can hear them coming down the corridor.
Therapist: Just notice that. [EM].
Ben: We've got to get out. I'm going to shoot the lock so we can get out. The noise of the gun. The lock is gone. There's a scream. We head outside as fast as we can. […] I can hear the chopper.

At this point, just when one would perhaps expect to see somatic expressions of relief, something different happened. Ben became silent, and palpably withdrew into himself, saying that he thought we had 'done enough for

the day', a wish that—empathically attuned to him as well as curious about what had happened—I naturally respected. After ensuring the session was safely closed and that Ben was sufficiently stable, we agreed to meet the following week.

At the next session, Ben looked particularly tired. He had had a difficult week, feeling very low, and tempted by—though not succumbing to—the use of alcohol to help manage his feelings. Unlike his previous demeanour, Ben's gaze was very avoidant throughout, as though he had found himself in a new, and worse, psychological place. He looked ashamed. Exploration showed that, during the week, Ben had not been thinking so much about the memories of Iraq, but about his father. Indeed, he had had various nightmares during the week, in which his father had featured. I recalled that previously, Ben had only said that his relationship to his father had not been 'particularly close'—as many men say, and feel. In EMDR, it can often be very profitable, once a person is confident having EMDR, to process a nightmare. This is what we did next, starting with a nightmare, the central feature of which was Ben's father's face on particular time. He rated the SUDS as 9.

Ben: All I can see is his red face, frowning hard. His eyes drilling into me.
Therapist: Is he saying anything? [EM].
Ben: Shouting at me, he was always shouting at me. I'm not good enough. I'm never good enough. I am a nothing.
Therapist: Just notice that. [EM]
Ben: It's moved to what really happened that day. I tried to fix his bike in the garage. But I didn't know what I was doing and broke it. [Tears streaming down Ben's face now]. I was always trying to please him. It was never good enough for him. His face is full of anger. He hates me. There's nothing I can do.

By this point, it was clear—from the strong affect and abreaction—that Ben was finding this memory very disturbing, to the extent that he was struggling to maintain his orientation to the work. I therefore knew that we had to change tack slightly. The Loving Eyes procedure (e.g. Knipe 2015), can be used in such situations to help a person maintain dual awareness, and process effectively. Once Ben had calmed, and was clearly stably oriented to the room again, we continued.

Therapist: Sitting here, the adult you are now, can just see that boy?[EM].
Ben: I can see him.

Therapist: Just see whatever you see with that boy. [EM].

Ben: I see a boy who feels like his Dad doesn't love him. A boy who loves his Dad, but never feels good enough himself [tearful].

Therapist: When you look at that boy there, can you see that little boy's feelings?[EM].

Ben: I can see how hurt he is. He's been carrying these feelings for so long. I feel for him so much. There is nothing that he can do.

Therapist: Looking at the boy there, how do you feel about him?

Ben: I feel that he is a good lad. He is a good guy. He has tried so hard, and his Dad has thrown everything back at him. But I know that he was doing his best. Beyond his best. That's what he always did. Dad could never see that.

Therapist: Just notice that [EM].

Using the Loving Eyes Procedure, we had reconnected with, and processed a nexus of temporally distant childhood memories of which Ben had previously been unaware. After the above session, Ben reported a huge sense of relief, saying he felt 'a weight had been lifted'.

Having taken—as so often happens in EMDR—an unexpected associative detour into an aspect of the past, we were able to return to the military-related memory where we had left off. At the point where Ben had, in effect, been frozen by the emerging memory of his critical father, we could now proceed more freely. What had happened subsequently could now become clear.

Ben: The door came off its hinges. I realised that the scream was Fergal behind me. He had been hit in the leg by something. Or someone. All Hell was breaking loose, it could have been anyone.

Therapist: Just notice that [EM].

Ben: He couldn't keep us with us properly as we ran to the chopper. He was half-limping. One of them got him. He was on the floor. We dragged him on with us. He was never going to make it [tearful].

Therapist: Just notice that [EM].

Ben: I tried CPR, I was pumping on his chest to keep him going. Anything to keep him going. There was nothing I could do. There was nothing anyone could do.

Therapist: Just notice that [EM].

Ben: We had to let him go. [Strong abreaction]. I was holding his hand as he was fading. There was nothing we could do but let him go.

As will be clear, this was a very powerful session. When it was over, Ben said that he felt much lighter than he had previously. It seemed that way; he was standing taller and more confident, his gaze much more direct.

A week later, we were able to make sense of what had happened. Ben had felt unbearable—and unspeakable—guilt over Fergal's death. In the chaos going on around it, Ben had—with unprocessed memories of his father pressing on his consciousness unidentified—he had blamed himself, and with the force of his father's anger and criticism. Once these memories had, using EMDR, been identified and processed, Ben, having successfully reconnected with parts of his own life and, ultimately, himself, could begin to move on in his recovery.

*

Ben's story with EMDR has elements shared by many ex-Forces personnel. Military training and conditioning, combined with strong male norms and operational stress injuries can leave veterans appearing very defended against the feelings associated with their difficult experiences. But with the help of EMDR, these defences can be penetrated to reveal the man—and before the man the boy—beneath the armour. Often, the psychological wounds of boyhood and adolescence turn out to be as important, or more important, than the psychological wounds from the battlefield.

For many traumatised veterans, too, the psychological homecoming enabled by EMDR in this way opens the door to an adaptive psychological homecoming to adult civilian life after service. Often, the boy who came before the soldier and the veteran needs to be heard before this adjustment can happen. EMDR is a way to listen to the boys who were left behind.

Conclusion

It is increasingly recognised that, owing to various factors—neurological, developmental, cultural, and social—some men can find help-seeking for their emotional issues very challenging. But even when they do seek help, it is often observed in clinical practice that men may struggle first to identify, and then to articulate, the issues in question. These avoidance-related tendencies can be amplified in veterans, given their experience of military conditioning and, often, operational stress. Research and practice in EMDR, however, suggests that EMDR can be exceptionally helpful and effective in working with civilian and veteran males, by helping them to get to the bottom of their problems, often in ways that they did not expect, and could not have foreseen.

EMDR can be used, here, with a narrow focus and a short time frame (suiting many problem-focused and emotionally avoidant men who come to therapy); or with a broader focus, and a deeper understanding of the conflicts

between the life narratives held by the individual man. When focused on the internal conflicts and incongruities between ego states, EMDR can help men towards resolution by directly addressing the anxieties, anger, idealisations, and addictive patterns that can leave a man psychologically debilitated, and often (in their own initially critical perception) 'weak'. In such ways, at best, EMDR can enable men to access and synthesise unknown aspects of themselves and give them—perhaps for the first time—a sense of genuine personal strength: strength of character (Knipe 2017); and so play a significant part in the arc of their ongoing recovery.

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Of Compassion and Men: Using Compassion Focused Therapy in Working with Men

Joanna Smith, Sunil Lad and Syd Hiskey

Introducing Compassion Focused Therapy

Founded by Gilbert (2000) around 20 years ago, Compassion Focused Therapy (CFT) emerged out of the recognition that many individuals, particularly those with high shame and self-criticism, responded poorly to therapy despite engaging with traditional cognitive and behavioural therapy tasks (Rector et al. 2000; Bulmarsh et al. 2009). Gilbert observed how these individuals had difficulties generating kind, warm, and self-supporting emotional tones to their inner dialogues. CFT was developed to facilitate the creation of these affiliative feelings. The CFT approach is underpinned by evolutionary psychology, attachment theory (Gilbert 2010a) and neuroscientific evidence that affiliative motives and emotions can have a major impact on self and affect regulation (Cozolino 2002). Feelings of warmth and encouragement are linked to a specific affect regulation system that evolved with attachment—to which we will turn later in the chapter. The capacity to soothe is often underdeveloped in people with high shame and

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self-criticism because they have experienced little soothing as a child in early care giving relationships (Masten 2001). CFT, using compassionate mind training, teaches individuals to develop compassionate motivation, attention, thinking, imagery, and behaviour. As CFT grew out of CBT, many CFT interventions draw on CBT interventions but these are used, as Gilbert puts it, "through the eyes of the compassionate self" (Gilbert 2010a).

While definitions of compassion vary, the one adopted by CFT, the compassion based intervention on which this chapter will focus, is "sensitivity to the suffering of the self and others with a deep commitment to try to alleviate it" (Gilbert and Choden 2013). Gilbert distinguishes between the two mind-sets of compassion. The first is the ability to engage and turn towards pain and distress rather than avoid or deny it. The second requires the development of insight and wisdom to try to prevent and alleviate suffering (Gilbert 2014).

As explored earlier in this volume, men can face specific challenges to their psychological health; and since research indicates that men are significantly more likely to cover up negative feelings (Gottman et al. 1996) than approach them, and may be less skilled at identifying and reflecting on their emotions than women (Levant et al. 2009), one might expect that many men might particularly struggle with this first mind-set of compassion.

Common Male Coping Styles

In the context of Western culture that has been dominated, over recent decades, by hegemonic masculinity in which notions of strength and stoicism are privileged over emotionality (Connell 2005), evidence suggests that men and women respond differently to stress. The "fight or flight" response may be characteristic of men, while women lean toward "tend and befriend" and reflect on their distress (Smeets et al. 2009). These male, externalising patterns in response to distress include anti-social behaviour (Logan et al. 2008), substance abuse (Shead and Hodgins 2007) and suicide. One hypothesised reason for this gender difference is that many men can feel restricted to act in traditionally masculine ways that serve to detach (Levitt 1991) or distract (Cochran and Rabinowitz 2000) them from their emotions. In turn, men can avoid threats to their perceived social status and become vulnerable to shame (Gilligan 1996). While some externalising behaviours may be an effective short-term strategy—perhaps having a face-saving function—they can produce poor long-term health outcomes for men when they go unidentified (Seager and Wilkins 2014).

Finally, it might also be noted that Western men may on average be less involved in caring for others then women: the majority of mental health professionals in the UK, for example, are women, with around 80% of British clinical psychologists being female (Morison et al. 2014). It is perhaps no surprise, therefore, that in clinical practice men often seem relatively poorly equipped to care psychologically for themselves, especially when they first seek treatment.

The Significance of Shame

Understanding and working with shame plays a major role in CFT. From a CFT perspective, shame is understood in the context that humans have evolved to want to create positive feelings about the self in the mind of the other (Gilbert 2007) in order to feel socially safe. CFT distinguishes between external shame (fears in the mind of the other) and internal shame (fears of one's own inadequacies). Social threat is therefore a major threat to humans, linked to basic, evolved fears of rejection, and becoming the undesired self (Gilbert 2010b). The threat of shame can lead to unhelpful coping strategies and competition with others for resources such as territory, food, social position, and social rank to avoid subordination. The latter is what Gilbert termed the social rank mentality (Gilbert 2010b). As we will see, this may be especially relevant to men.

Cultural, Social, and Developmental Pressures on Men

Unemployment and redundancy in the current financial climate can amplify existing, socialised pressures on men to be strong and invulnerable, because these characteristics are often affiliated with being the (male) "provider" (Williams et al. 2014). While, traditionally, men are taught from an early age, either directly or indirectly through cultural practices, to achieve, accomplish and win, few men are taught how to accept one's strengths and weaknesses in a non-shaming way (Cochran and Rabinowitz 2000).

These factors can arguably leave men more intolerant to their own vulnerability and shame—and without the self-soothing abilities that would lend emotional balance. Consequently, distressed men may engage in maladaptive forms of self-soothing, as a way of trying to survive difficulties within the constraints of masculinity. In turn, acknowledging and expressing feelings

of powerlessness, shame, fear, and vulnerability can be inhibited by the dread of external shame—of being "unmanly" (Seager and Wilkins 2014). As Kingerlee (2011) points out, status-seeking behaviours—or, in CFT terms, a "competitive mentality", can interfere with male abilities to connect with emotions and adopt a "care seeking mentality", because this can be interpreted as a shameful social defeat in the male mind. CFT can help here, with a key focus on de-shaming these struggles, using psychoeducation to highlight how the evolved human brain is caught between old brain motives and desires on the one hand; and new brain capacities of planning, imagining, and reasoning on the other, which together create unhelpful feedback loops in the mind. The key point to be reached in CFT is that much of what goes on in our minds as a result of evolution and early environment is not of our design, choice, or fault, while at the same time instilling the message that it is our responsibility to make changes in our lives to improve our own well-being.

In addition to the impact of cultural factors on men's coping styles, developmental factors are key. Males typically have different experiences of being parented and socialised compared to females, with less focus on nurturing for boys (e.g. Seppala 2013; Diamond 2004). Taking this further, Pollack (1995) proposes a model of male development that draws on the effect of child-rearing practices. The model proposes that prevailing conceptions of masculinity which encourage autonomy and separation in boys leads to a premature dislocation from the emotionally secure attachment of the mother's care and love. Pollack (1995) states this leads boys to defensively distance, protect, and armour themselves against painful affect. Furthermore, this dislocation can render boys with little guidance on how to manage feelings of hurt, sadness, or grief (Pollack 1998b) and, in CFT terms, potentially further compromise the development of affiliative soothing in order to regulate threat-based feelings and result in a male-specific vulnerability to mood disturbance. According to Pollack's model, unresolved feelings are carried into manhood in the form of avoidance of emotional states.

The Three Affect Regulation Systems/Three Circles Model of Emotion

Drawing on research on the neuroscience of emotions (Depue and Morrone-Strupinsky 2005) and studies of threat-based emotions (LeDoux 1998), CFT distinguishes between three types of emotion regulation systems, which operate interdependently, controlling our different motivations

and actions (Gilbert 2010a; Ribeiro da Silva et al. 2015). In CFT, this is referred to as the three circles model of emotion.

Threat and Self-Protection Focused System

All living things have evolved to detect and protect against threat (LeDoux 1998). The threat system is designed to detect and pick up on threats quickly, process these, select an emotional threat-based response (e.g. anxiety, fear, anger, and disgust), and an appropriate threat-based behavioural response (e.g. freeze, flight, fight, submit). It follows a "better safe than sorry" principle and is designed to allow for false alarms for survival purposes, based on rapid actions rather than complex thinking (Gilbert 2005, 2010a). CFT considers how the human mind, with its capacity to create negative feedback loops, via worry and rumination, can act along with emotional memories to stimulate the threat system (Wells 2000). Triggers for the threat system can be internal (e.g. thoughts and feelings) or external factors. The sensitivity of the threat system is therefore troublesome for humans and can lead to threat-based responses that have unintended and undesired consequences (Gilbert 2010b).

Drive-Seeking and Acquisition Focused System

This system focuses on the seeking and acquiring of rewards and resources and gives rise to the positive emotions of drive, excitement, and vitality (Gilbert 2014). It is understood to be strongly linked to dopamine activity, status seeking, and avoiding rejection (Depue and Morrone-Strupinsky 2005). The drive system regulates the threat system but, if used alone, threat-based feelings will eventually be re-experienced when frequent achievements and rewards cannot be met. When balanced with other systems, the drive system helpfully guides humans towards important life goals (Gilbert 2010a). As Depue and Morrone-Strupinsky (2005) suggest, though, since status seeking, competitiveness and working to avoid rejection are linked to this drive system, it is possible, however, that men are at higher risk of over stimulating their drive system in the service of trying to avoid the threat of shame and so maintain their social status.

When the sympathetic nervous system is activated under threat, higher order cognitive capacities, including mentalisation are inhibited (Klimecki et al. 2014; Liotti and Gilbert 2011; Thayer and Lane 2000). Loss of such skills in response to threat-based feelings has been considered specifically in the male psychology literature in the form of Kingerlee's (2011) hypothesised reflection abandonment mechanism (RAM). For many men, it has been

proposed that meta-cognitive beliefs, largely based on internalised traditional Western masculinities, including such notions that negative feelings are unacceptable and must be hidden from others, can launch the RAM. This prevents further reflection on distress and results in men engaging more readily in fight/flight, threat-based behaviours. In contrast, activation of the parasympathetic nervous system through compassion focused skills helps provide feelings of safeness, enabling mentalisation via activation of the prefrontal cortex (Klimecki et al. 2014; Liotti and Gilbert 2011; Thayer and Lane 2000). This is one way that compassion may help men reflect on their distress more and select more compassionate ways of responding to themselves and others. In short, a CFT approach to working with men may, to some degree at least, be a potential antidote to the status-seeking default mode of many Western men.

Soothing and Affiliative Focused System

This system is associated with positive affect which is very different to the drive resource seeking system, which is experienced as peacefulness, contentedness, and well-being (Gilbert 2010a). This, like the drive system, has a role in threat regulation. Individuals who have not had a secure attachment to develop capacities for affiliation, or for whom caring others were also frightening, abusive, or neglecting, can have a compromised capacity for experiencing and expressing affiliative emotions and a hyper active threat system. This can severely limit their abilities to regulate the drive and threat systems (Gilbert 2014). Given the aforementioned research on sex differences in early parenting and developmental factors, it might be suggested that the male soothing system is at increased risk of being underdeveloped and under-stimulated.

Core Principles of Compassion Focused Therapy

CFT emphasises how people tend to find themselves trapped between the threat and drive systems, which can often bring about a sense of failure and high levels of self-criticism and shame (Gilbert 2014). Given males tend to experience harsh self-criticism in response to distress (Pollack 1998a), which manifests shame, men can easily end up in an increasingly threat-focused mindset.

As human brains did not evolve for happiness but for survival and reproduction it is, however, vital to learn to accept, tolerate, and work with

difficult emotions (Gilbert 2010b). CFT targets the activation of the soothing system using compassionate mind training, which teaches mindfulness and compassion focused skills required to develop the key qualities of compassion. This is so the soothing system can be more readily accessed and used to help regulate threat-based emotions of anger, fear, disgust, and sadness. The aim is to bring these three systems in balance and create a different—warm, wise, and courageous—way of relating to oneself and others by activating the "caring mentality" via compassion (Gilbert 2010a). Indeed, compassion as a social mentality can flow in three directions and compassion focused exercises can be orientated in these directions: (1) compassion for others; (2) compassion for self; and (3) the ability to receive compassion from others (Gilbert 2014).

Myths About Compassion

The word compassion can initially be misunderstood as "fluffy" or "airy fairy" (Maxted 2017). Men, in particular, can be frightened of compassion because of meta-cognitive beliefs that it is feminine, which can (in men's perception) translate to weakness (Gilbert 2010a, 2015); a threat to status, indulgent or not "masculine". Compassion is, however, more than just kindness. Expressions of deep compassion are not always nurturing, for example, heroic acts in the face of danger to help others. This requires strength, courage and commitment in the face of suffering and fear (Seppala 2013), all compassionate qualities that can be easily missed.

Key Phases of Compassion Focused Therapy

There are five, nonlinear, key phases to Compassion Focused Therapy summarised by Gilbert (2014). A key aspect of this is the compassionate mind training.

Phase one involves giving psychoeducation about the evolved brain, the three affect regulation systems, and the "not our fault" message, while building responsibility to change.

Phase two focuses on formulating how early life experiences led to the individual's current threat, drive, and soothing-based capacities and strategies, as well as understanding the function of safety strategies which result in unintended and undesired consequences. Both phases lead to the seeds of compassion being sewn by de-shaming symptoms and difficulties.

Phase three focuses on compassionate mind training where compassionate capacities are cultivated, largely through various imagery, breathing, and postural exercises. The attributes and skills for developing these are summarised below.

Phase four focuses on further developing capacity for compassion with behavioural practices in order to learn how to take a compassionate perspective.

In *Phase five*, these skills and are used to engage and work with specific problems in the remainder of the therapy (Gilbert 2014).

Compassionate Mind Training—Compassion Attributes and Skills

Compassionate mind training focuses on the development of six key qualities or attributes of compassion through the application of compassionate skills. These attributes include (1) a caring willingness to turn towards suffering rather than away; (2) developing a sensitivity to feelings and the needs of self and others; (3) developing sympathy for and in tune with feelings; (4) developing abilities to tolerate rather than avoid difficult feelings, situations and memories; (5) developing empathic insights and understanding for why we feel what we do; and (6) developing a non-judgemental approach to ourselves and others (Gilbert 2014).

These attributes are established by developing various skills, not necessarily in order. Firstly, in directing attention compassionately to what is helpful; secondly, by learning how to think and reason compassionately; thirdly, by behaving in ways that are helpful (that may be anxiety provoking and take courage); fourthly, enabling appropriate feelings; fifthly, using imagery to stimulate affiliation; and finally, using sensory work such as breathing exercises, warm voice tones and postures to generate physical states which activate the parasympathetic nervous system and feelings of safeness. CFT distinguishes safety seeking behaviours from safeness. Whereas safety seeking is associated with preventing or coping with threats, as is the case with typical male externalising behaviours, safeness is a state of mind that enables individuals to feel content with themselves (Gilbert 1993).

Effectiveness of CFT

The evidence base for CFT is growing, with a recent systematic review by Leaviss and Uttley (2014) on fourteen evaluation studies concluding that compassion is a promising target upon which to focus psychotherapeutic

intervention, particularly for individuals who are high in self-criticism. While larger scale controlled trials with adequate follow up are still required, current research has shown that CFT can lead to significant reductions in depression, anxiety, and shame in high-security psychiatric settings (Laithwaite et al. 2009), for personality disorders (Gilbert and Procter 2006; Lucre and Corten 2013) and eating disorders (Gale et al. 2014). A number of benefits for physical health have also been demonstrated, for example, the practice of compassionate mind training has been shown to improve the body's immune response by reducing stress (Pace et al. 2009). The development of self-compassion has also be linked to lower levels of rumination (Neff 2003), worry (Raes 2010), and higher levels of cognitive flexibility (Martin et al. 2011), self-reflection (Samaie and Farahani 2011) and increased mentalising (Mascaro et al. 2013). All of which may be pertinent to men.

The following sections of this chapter will consider clinical applications and case illustrations of using CFT with men in two different clinical settings, a masculine prison environment, and working with older men. Responding to adaptations and challenges with CFT will also be discussed.

Compassion and Men in Prison

Applying the CFT approach is useful to understanding offending behaviour and can have important implications for rehabilitation and reoffending rates. The evolutionary model can be applied to understand why individuals may react in certain circumstances with violence, hostility, callousness, and dominance. Within the male prison population several studies have shown higher incidences of certain disorders such as Antisocial Personality Disorder and Borderline Personality Disorder (Fazel and Danesh 2002). These diagnoses are also associated with childhood experiences of trauma (Battle et al. 2004; Bierer et al. 2003). Martens (2005) suggests that the link between childhood sexual/physical abuse and severe deviant behaviour is mediated by a long-lasting experience of lack of safety, warmth, love, and social support and confrontations with harshness of life, emotional suffering, and loneliness. Individuals that are subjected to experiences such as bullying, abuse, and neglect in childhood can become highly sensitive to threats of rejection or criticism from the outside world, can quickly become self-attacking, experiencing their internal world as hostile (Gilbert 2009). Similarly, individuals that have experienced abuse will have highly sensitive threat systems that lead to defensive behaviours in order to protect themselves. Such behaviours can lead to impulsivity and aggression, will work on the principle that it

is "better to be safe than sorry" and are based on the motivation to keep the individual safe from injury and further abuse and harm (Gilbert 2001; Panksepp 2010).

The threat system will often give rise to a negativity bias. Aversive events will influence the ability to make decisions and focus on negative events rather than positive ones (Baumeister et al. 2001). This is important in a prison population where individuals often fear being perceived as vulnerable and weak. The prison environment is often hierarchical, and can—despite the best efforts of prison staff—promote victimisation as a means of survival. Goleman (2006) suggests that in order to survive in such environments an individual's amygdala will be activated which leads to hyper-vigilance, distrust of others, and readiness to fight.

In a male prison environment men live with other men who have committed violent and sexual crimes and therefore there is often a belief that they need to remain vigilant at more or less all times and keep threat systems activated for self-protection. As a result, individuals may often fear the consequences of being inferior or subordinate to others. They may fear that they will be hurt/harmed, or subject to criticism or attack due to the crime they have committed, rather than be helped or accepted. Marshall et al. (2000) found that prisoner social hierarchy was one of the factors that are likely to trigger depression, anxiety, and attempted suicide in male prisoners. In response to this, individuals can become "driven" to compete, to avoid being seen as inferior by others, or viewing themselves in this way (Gilbert 2003). This may appear in the form of having or showing no remorse for their behaviour, being in denial or minimising what they have done. This constant striving in a hostile environment leads to a difficulty in feeling content, socially accepted and safe (Gilbert 1989, 1995, 2005). Within the prison environment the drive system may be used to regulate this threat by activities such as going to the gym, or seeking status and power. Individuals will also have learnt that being aggressive leads to others not getting close to them so that they then feel strong, but also they remain unharmed, maintaining and reinforcing their threat system. Studies have also found that behaviours that threaten masculinity can prompt men in prison to obtain status, improve reputation and defend their masculinity among their male peers (Sim 1994; Sabo et al. 2001; Crewe 2006). As a consequence of trauma-related experiences, too, men often find it difficult to receive emotional feedback, which will also fuel attitudes related to survival such as selfishness, being indifferent and hostility. This can, in turn, maintain an inability to trust others and build pro-social networks. These well-developed competencies can—regrettably—be associated with a lack of self-realisation,

self-insight and, a lack of happiness (Martens 2004). It can therefore be very difficult to experience self-compassion in this environment.

Shame

A key focus in CFT is on the emotion of shame. Shame as an emotion will motivate efforts to deny, hide, or escape the situation that induces shame. As a result, shame will disrupt the ability to connect empathically with others, whereas experiencing guilt can allow for recognition of consequences of behaviour. Studies have found that experiencing shame is positively correlated with anger, hostility, and the propensity to blame others (Bear et al. 2009; Paulhus et al. 2004; Tangney and Dearing 2002).

Studies conducted by Hosser et al. (2008) and Robinson et al. (2007) found that an individual's ability to experience guilt about specific behaviours serves as a protective factor and involvement in the criminal justice system, and can help to predict reoffending. However shame is positively associated with a number of psychological problems, and a range of risk factors for criminal recidivism. In a review by Tangney et al. (2011), shame was found to be associated with a denial of responsibility, substance abuse, psychological symptoms, predictors of recidivism, and recidivism itself. They argue that the use of interventions such as CFT could help reduce reoffending rates.

Given the complexities of factors within the prison population, the following case example will illustrate how CFT can be applied.

Case Example

"James" is a man in his 30s, and in prison for a violent offence. At the time of the offence he was under the influence of alcohol and cocaine. The victim was a friend who James thought had stolen money and cocaine from him. James has spent much of his adult life in prison serving short sentences for acquisitive crimes in order to fund his use of cannabis and cocaine. He reported that these substances were used in order to feel relaxed, and would give him a "buzz" and a way to escape.

As a child he experienced physical abuse and witnessed domestic violence, where his father would regularly get drunk and attack his mother. He did not do well at school and later got expelled for fighting with other children. As a teenager he started to socialise with peers that were engaging in criminal behaviour. He reported that he felt part of a group and had a sense of belonging when with them. He also learnt to fight and started to learn that when he was aggressive he wouldn't be taken advantage of and at this age his father stopped attacking him. As an adult he felt shame for not being able to protect his mother, or fighting back when his father was attacking him. In prison James came to therapy as he was experiencing high levels of anger and he wanted

to ensure that he didn't get extra time in prison as his partner was expecting a baby. He also didn't want to repeat the patterns of violence towards his own child.

Phase one of therapy involved providing psychoeducation about the evolved brain, the fight/flight system and the three affect regulation systems. As a result we spoke about the "not your fault" message, while emphasising the responsibility to change. There was a careful balance to be struck, in recognising that due to the experiences James had and, given the ways that he had learnt to survive, it was understandable he reacted in this manner. While stressing the importance that he can have control of his behaviour, and that he will need to practice techniques to manage his emotions, rather than responding to emotions where he can harm others.

During this period of psychoeducation the example of thinking about his reaction if a lion walked into the room was given, rather than stating what most people would state and experiencing fear James and many men in prison speak about trying to punch the lion and showing no weakness. It was important to recognise with James that prison is an environment where people are physically unable to engage in their "flight" responses and showing fear may be associated with weakness. This phase of treatment also involved psychoeducation helping James to recognise that it was not his fault that he was unable to defend his mother as a child. Also, his use of substances was a way to block out the emotions of shame, anger and fear that he repeatedly experienced in relation to these memories which were so painful for him.

Phase two of therapy involved formulating how James' early life experiences had sensitised his threat system. Specifically violence at home led to a highly sensitive threat system that may subsequently have been reinforced through the safety strategies of violence and aggression. The threat system would often become triggered when fears related to being weak or vulnerable would appear. Being in a male prison environment maintained this view. We formulated how James received safety and a sense of belonging when he engaged in criminal behaviours with others; but also how substance use led him to block out these difficult experiences which were left unprocessed. We also recognised how his behaviour had led to the unintended consequences of coming into prison, which maintained a view of being worthless and preventing him from feeling grounded and stable.

Phase three of therapy was the most difficult due to fears and blocks of compassion activating his threat system. James had previously experienced negative experiences related to breathing techniques when engaging in prison interventions for anger management. In the past he would focus on his breathing with the expectation that everything would be better, but when experiencing a difficult emotion he was ruminating on his thoughts, which would then exacerbate his anger rather than reduce it. We spoke about breathing and attention and why his threat system may have been activated due to ruminating; this understanding enabled him to benefit from this simple practice. He was then introduced to the competencies and attributes of compassionate mind training through imagery work. James really struggled with the word compassion associating it with being "fluffy" and in a prison environment would make him vulnerable. Within therapy the competencies of strength, wisdom, and courage were stressed rather than viewing compassion as a weakness.

James developed an ideal compassionate self and was able to receive a different way of perceiving events through his ideal compassionate self. Through imagery practice, he developed these competencies and then was able to embody those attributes. James started to notice when he got angry and what had triggered that off. He was able to generate alternative thoughts, by thinking that the men he lived with in prison were likely to be experiencing fear and using aggression as a way to mask this. Through practice he was able to empathise with others and found that his levels of anger and anxiety had reduced, due to reduced levels of hyper-vigilance and distrust. This also led to other people approaching him rather than fearing him—so bringing him closer to others.

The final stage of therapy involved processing memories of physical violence and why James was unable to defend himself, and why he was not to blame. Talking about the subject historically activated his threat system and with time he was able to disclose that within prison he often felt anxious, and scared. However, he was not willing to show this as he did not want appear vulnerable in a macho environment. We ended therapy where he wrote a compassionate letter to himself as a way to remind himself of the difficulties he can encounter and encouraging him to express his feelings, rather than keeping them bottled up.

After finishing this work James completed offending behaviour work where he was able to understand and reflect on his role in his offences. Previously high levels of shame had led him to minimise his actions and not take any responsibility for harming others. His progress via CFT, therefore, marked a significant psychological step forward for James.

Compassion and Older Men

Given the near doubling of life expectancy in the past century, research has begun to focus on factors associated with well-being in later life (Allen et al. 2012).

Although stressful life events such as loss of partners, health problems, and death are inevitable with ageing, people show great variability in coping with such difficulties and it is known that many in later life have high levels of subjective well-being (Blazer 2008). As we will see, exploring the emotional, behavioural and cognitive mechanisms that differentiate those who age well and those who do not may shed further light on this process. In particular, self-compassion may offer us a helpful way to consider successful ageing, especially in men, given its focus on how to treat one-self well when life becomes difficult.

Meta-analytic work by Yarnell et al. (2015) has examined gender differences in self-compassion, with largely younger adult samples (i.e. <50 years of age) and concluded that men have slightly higher levels of self-compassion than women. They caution that researchers and practitioners should remain

conscious of such differences but not overemphasise them, given the relatively small effect size ($d = 0.18$) that they observed.

In contrast, while self-compassion has been found to increase with age (Homan 2016), relatively little is known regarding what contributes to compassion in senescence. Indeed, in a large (>1000 participants) dedicated sample of older adults (mean age = 77.3, sd = 12.2). Moore et al. (2015) found that those who report higher levels of self-compassion are also more likely to be *female*, not married (or currently in a marriage-like relationship), have higher levels of resilience and have experienced more significant life events. Associations between increased self-reported compassion and being female, having greater resilience and a greater number of significant life events were then supported further in a subsequent analysis. In later life, then, it may be women rather than men who show the greatest levels of self-warmth in the face of adversity.

Moore et al. (2015) study is noteworthy as one's relationship to suffering may be important to consider in a therapeutic context. Current compassion, in as much as frequent significant life events and higher resilience through experience relate to greater self-compassion in later life, may be worthy of clinical intervention especially for those who rate themselves as low on this construct. Moore et al. (2015) work also supports the idea that when an older person has experienced significant negative life events in the last year (such as divorce, death of a loved one or another significant loss) they are also still as likely to report wishing to support others. This is highly relevant for compassion-based clinical interventions, such as that described in the case example below. Moore et al. (2015) conclude that older people may be in a strong position to contribute to the greater good given their natural resources, their life experience and the typically greater availability of their time. The work of individual therapy, for older male clients, may, then, be to harness these capacities and apply them in support of the self.

To explore the degree to which self-compassion might be helpful to older people struggling to cope with the ageing process, Allen and Leary (2014) assessed participants' thoughts when writing about positive, negative, and neutral age-related life events. They found that greater levels of self-compassion predicted positive responses to ageing, with compassionate thoughts mediating the relationship between trait self-compassion and the emotional tone of responses and between trait self-compassion and the *belief* that attitude can help us adjust and cope with age-related events. In other words supportive, encouraging, and accepting thoughts seemed important ways to both feel and believe one can manage. Older adults who were lower on self-compassion, yet who experienced similar age related events to those

high on self-compression, tended to consider events more negatively. Therefore a focus on self-compassion may improve adjustment to later life events.

That self-compassion can affect our reactions to unpleasant situations may be important as it has long been known that some older people can become self-critical and angry, in the context of comparing themselves to their younger selves (Mirowsky and Ross 1992). As such self-compassion can help us deal with negative life events, within and beyond our control (Leary et al. 2007).

Then again, Allen et al. (2012) considered the relationship between self-compassion, life circumstances and well-being in older people and found that high self-compassion was associated with self-perceived successful ageing, greater well-being and life satisfaction, and lower levels of emotional problems. Those with higher levels of self-compassion also continued to report greater well-being and life satisfaction in the face of higher levels of physical pain, sensory difficulties (such as poorer hearing), increased physical problems, and poorer health. Self-compassion was therefore seen to moderate the relationship between physical health and subjective well-being.

The work of therapy may, then, be to help clients develop what Allen and Leary (2010) have termed a self-compassionate *mindset*, in which people high in self-compassion try to engage in behaviours that help well-being *in the face* of adversity. Interestingly, in support of this, Allen et al. (2012) found that older people with high levels of compassion were much more willing to ask people to repeat themselves when they could not hear what has been said and were also more prepared to use a mobility aid in the light of walking difficulties. Hence both an acceptance of ones limitations and a preparedness to engage in the suffering associated with the loss of perceived skills/abilities may be valuable as part of one's adaptation to the ageing process and perhaps represents the opposite process to that described above by Mirowsky and Ross (1992).

Importantly, too, Allen and Leary (2014) found that self-compassion was unrelated to the advice on ageing older people would give to younger generations. In other words, while people found it easier to encourage others to be self-compassionate in terms of ageing, this was *regardless* of their own experience of self-compassion. As we will see, compassion for others can be a helpful clinical position from which to approach client needs in the context of ageing.

Congruent with the theme of a compassionate mindset, Siedlecki et al. (2008) have argued that subjective well-being in older people is more

dependent on the *interpretation* of ones circumstances than the circumstances themselves. As an adjunct to this, recent case study research (Harris and Hiskey 2015) has pointed to the importance of emotional and social connection (warmth), while developing alternative and supportive views as part of a talking therapy.

However, as a caveat, it cannot be assumed that knowledge of the potential benefits of self-compassion will translate seamlessly into good therapeutic outcomes. For example, Lacey et al. (2017) found marked difficulties when trying to recruit carers of people with dementia into a self-compassion focused expressive writing task, encountering barriers to participation such as a poor understanding of the term compassion and a likely over-focus on the needs of the person with dementia. Depression in carers of people with dementia may also relate in part to feeling trapped in a role, but also being vulnerable to criticism and feelings of inadequacy in that role (Martin et al. 2006). In sum, self-compassion may be needed to face such fears, prior to engaging in emotionally expressive clinical work.

Dementia Care

Currently, there are around 700,000 people in the UK caring for a family member with dementia (Alzheimer's Research UK 2015). Although caring can be a rewarding experience, high levels of carer stress, anxiety and depression are often reported. Research suggests that self-compassion can play an important role in mitigating this as carers, with higher levels of self-compassion report lower levels of carer burden (Lloyd 2014). A systematic review of behavioural and psychological symptoms in dementia and related challenges for family carers (Feast et al. 2016) has noted carer perceptions of symptoms as challenging relate to a sense of a decline in the relationship, transgressions against socially acceptable behaviour and tacit beliefs that people with dementia will lose their "personhood" over time. It is therefore not necessarily the stage of illness that is associated with the most burden, and therefore the unmet psychological needs of family carers should be acknowledged and treated as each situation requires.

Various strategies exist for developing self-compassion (Gilbert 2009) with recent research pointing to the feasibility of using CFT with people with dementia and their carers (Craig et al., in preparation). The case below draws on the experience of such work.

Case Example

Harold is an 84-year-old White British man, caring for Violet his 82-year-old wife. Violet was diagnosed with Alzheimer's Disease three years ago. Her main behavioural and psychological symptoms as a result of the illness are wandering, temporal and geographical disorientation, word finding difficulties and rapid forgetting. Harold has reluctantly told some of the couple's close friends of Violet's diagnosis, given the progressive nature of the condition. The couple's friends are sympathetic, which Harold finds socially difficult and experiences as pity.

Moreover, Harold finds their situation and the social consequences of Violet's behaviour deeply embarrassing and is ashamed of the way he sometimes loses his temper with her. He has never been physically aggressive towards Violet but has shouted on occasion, leading him to feel guilty about his actions, once he has calmed down.

Violet has limited insight into her illness and cannot understand why Harold seems so upset. She quickly forgets if he becomes frustrated or annoyed. She is now heavily dependent on Harold for many instrumental activities of daily living including household shopping, meal preparation, medication management, travel to and from appointments and some elements of personal care.

The formulation diagram below (Fig. 1) is from Gilbert and Procter (2006) and has been supplemented by an explicit focus on the impact of Harold's *carer role*, intersecting between his long-standing safety behaviours and the unintended consequences of these. Harold's role as a carer can therefore be seen as amplifying his responses to feeling threatened, weak and inferior, themselves developed in the context of and informed by much earlier memories of how boys (and by extension men) are expected to present, according to the traditional Western masculinities within which Harold grew up.

Therapy consisted of 12 weekly sessions. Phase 1 of the work (sessions 1–3) involved an assessment, psychoeducation and an introduction to the evolutionary psychology model of CFT. Throughout we remained mindful of the need to make any necessary adaptations (e.g. to the pacing of therapy, by providing written supportive literature and using more concrete language/terms) that can sometimes be needed when working with clients in later life (James 2010). During assessment, Harold's history allowed us to develop a shared formulation (Phase 2) of his/the couple's current difficulties, from his perspective. This afforded an alternative view to the narrative that Harold had developed around his inadequacy as a husband (and by extension man). By encouraging him to speak to other male carers as part of the groups run by the local branch of the Alzheimer's Society (which Harold had previously refused to attend) he began to recognise a sense of common humanity and shared experience of change/loss, as well as how other men were able to manage this. Harold's experience, in other words, was helpfully normalised.

Phase 3 (sessions 3–8) featured attention training to enable Harold to more quickly notice frustration, by exploring common triggers of this within Violet's behaviour. Mapping these flashpoints allowed us to bring in behavioural work so that Harold could practise self-soothing (using dedicated compassion-focused breathing and imagery practices) to head off his anger more quickly. Cognitive restructuring with a focus on emotional warmth for the couple's difficulties (see Harris and Hiskey 2015) also helped establish that there may

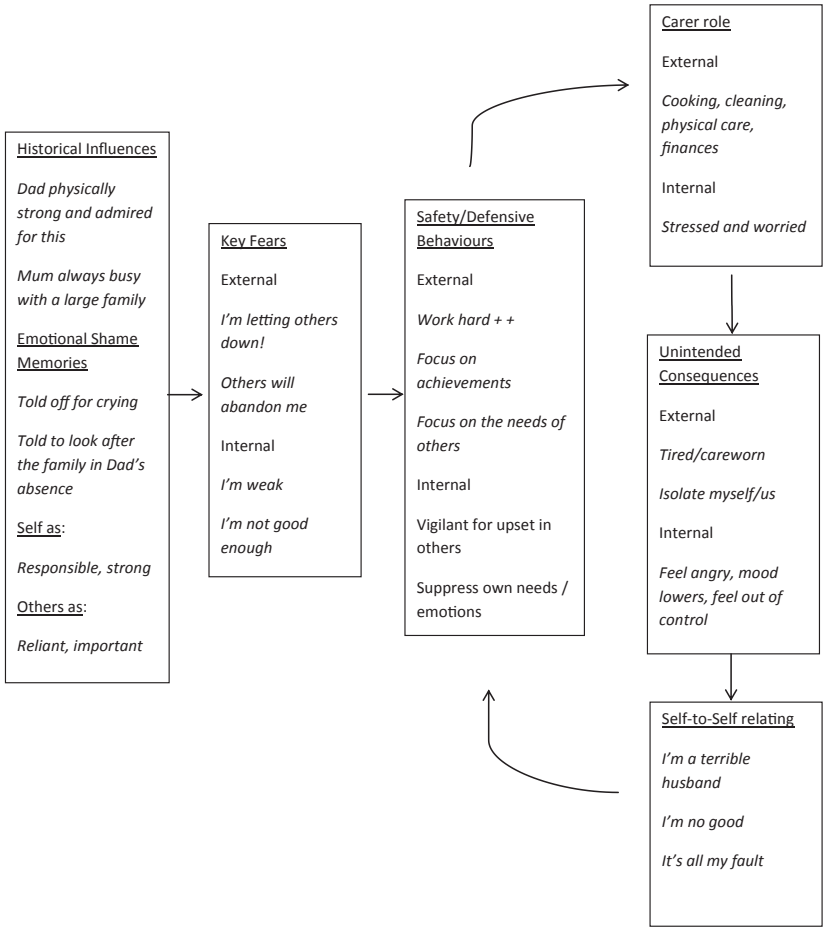

Fig. 1 Harold's compassion focused therapy formulation

be credible, kind and fair alternatives to the way Harold had learnt to think about problems (i.e. that his failure to deal with them represents a personal inadequacy).

By Phase 4 (sessions 9–12) of treatment Harold had tried compassion-focused expressive letter writing, in terms of constructing a supportive letter to a dear friend whom he imagined had encountered some of the problems Harold had recently been facing as a carer. This proved to be a breakthrough as enacting kindness to others he cared for proved to be much easier for Harold, who then began to more fully appreciate just how unfair he was being to himself. Beyond an intellectual empathy, Harold now experienced the affective component of his experience allowing him to access the sadness of his situation and, while *staying with* rather than avoiding his distress, consider his own as well as Violet's developing needs.

Relapse prevention work (session 12) completed the treatment, by focusing on a review of the phases above, developing a practical and realistic plan for what to do in the event of a setback and ensuring that Harold had activities planned both with Violet and also on his own (with sufficient respite care in place).

In terms of outcome, self-reported levels of both anxiety and depression reduced, Harold experienced far fewer episodes of anger and he noted a marked improvement in the tone of his relationship with Violet.

Discussion

Clinical practice suggests that Harold's case may be typical of the experience of many older male carers who struggle with the shift in their role (i.e. in becoming a carer) as they also find themselves changing as a result of the ageing process. These issues may be linked and are amenable to a CFT approach. As Phillips and Ferguson (2013) have argued self-compassion can relate to subjective well-being and *meaning finding* in life in older adulthood. Similarly, Homan (2016) has argued that self-compassion in later life may be associated with more realistic self-appraisals, leading to a motivation to improve one's current situation *as one is able*.

Crucially, working on self-compassion allowed Harold a way to manage previously overwhelming affect from a position of common humanity, personal warmth and kindness. It may have also afforded him the space to problem-solve from a practical perspective (i.e. consider avenues for support/locally available resources) such that he might manage his environment more effectively. Such work may be particularly well-suited to the issues presenting within an older adult psychology/specialist dementia service, and may—given their exposure to and conditioning in traditional Western masculinities during their development—be highly pertinent to older men as they face and adapt to the challenges of later life.

Conclusion

We have outlined the CFT approach, and why it can be particularly helpful when applied to men, in relation to their social and developmental worlds, internal shame, and subsequent behaviour. Given the relative emotional deprivation faced by many men during childhood, adolescence and adulthood, leaving them all too frequently emotionally unskilled, feeling unsafe on various levels and hypervigilant to social threats, CFT offers a potentially powerful solution, by deliberately targeting and further developing

the mind's soothing system, in a way that is new to many men. Finally, we explored two examples of CFT in action, from the position of prisoner and carer. Each highlights the dilemmas that numerous men face, and how it is possible to approach treatment in a way that engages, de-shames and ultimately reframes male experiences as a path to a different relationship with the self. For many men, this can prove to be a powerful and wholly unexpected turning point, and open the door to a newer, richer, and ultimately more rewarding emotional life for them, and those with whom they share their lives.

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Opening a Dialogue: Using Cognitive Analytic Therapy with Depressed Men

Roger Kingerlee, Jane Cawdron and Conrad Barnard

Introduction

Depression is a major contributor to the overall burden of disease, both in the UK and globally (World Health Organization 2016). Surprisingly, however, while research into various aspects of depression continues, until relatively recently, little has been known about *male* experiences and treatment of psychological distress (Wexler 2009). Consequently, depression has in all probability often been under-diagnosed in men (e.g. Cochran and Rabinowitz 2000). Such under-diagnosis may have grave consequences for men. For one thing, depression and heart disease can be linked (Carney and Freedland 2016). For another, there is a significant association between depression and suicide—and in the UK and beyond, the rate of male-to-female suicides is 3:1 in most age groups (ONS 2017). In short, there are excellent reasons to explore new psychological interventions for men's depression.

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This chapter examines how the theory and practice of cognitive analytic therapy (CAT) can be applied to working with depressed adult males.

Conceptualising Men's Ill-Being: Depression

Conceptualising male distress and depression is problematic because, as an emerging literature attests (Kingerlee 2012), men often do not exhibit 'classical' symptoms of depression, making identification and treatment complex. In men, an insidious depressive syndrome may be hard to identify—but nevertheless damage health. This has, historically, been termed 'masked depression' (Pichot and Hassan 1973), which may incorporate such behaviours as alcohol abuse, delinquency, reckless behaviour, anger and somatic concerns. It may be that, as Clare (2000, p. 3) says,

> men renowned for their ability and inclination to be stoned, drunk, or sexually daring, appear terrified by the prospect of revealing that they can be – and often are – depressed, dependent, in need of help.

Instead of expressing the emotional impact of losses, men may outwardly diminish difficulties to retain a sense of control. Studies show that men are more likely to rely on externalisation-based defences and coping styles detaching them from their emotions (Levit 1991). This accords with traditional (Western) male cultural training that stresses stoicism, control, denial of weakness and 'logical' thinking (Brannon 1976). But while such strategies may initially be effective, they may become counterproductive, so that men's distress often goes unidentified (Farrell and Gray 2018); and the losses of life that accumulate for many men may result in apparently inexplicable depression, and bouts of anxiety around mid-life. And for older men who rely solely on a significant other to buffer them against life's tragedies, loss of such a person multiplies men's psychological and physical health risks (Fitzpatrick 1998). Given all of which, a better understanding of men's depression may therefore be required in the clinical setting.

Brief Overview of CAT Theory and Practice

CAT is a brief, focused, time-limited therapy that stresses the continual impact of social interactions during human development and life (e.g. Ryle et al. 2014; Marriott and Kellett 2009). CAT theory draws on,

Table 1 The stages of a procedure in CAT

- **External factors**
  Events, cues, context
- **Psychological processes**
  (a) appraising the situation and consider action; (b) relating these to aims, beliefs and values; and (c) selection of response based on prediction of outcome
- **Action**
  Completion of action
- **Evaluation or revision**
  (a) evaluating consequences of the action; and (b) confirming/revising the aim and/or means used to achieve aim

and develops, notions derived from such fields as personal construct theory (Kelly 1955); evolutionary psychology (Price and Stevens 2000); developmental neurobiology (Schore 1994); and attachment theory (Bowlby 1988). All the above, like CAT itself, stress the lifelong importance of the nature and quality of human interactions. Consequently, CAT may be viewed as a 'dialogic' therapy, in which the principal model of the self is based on interactions or dialogues of various kinds, with others.

Within CAT, all interpersonal behavioural sequences—or 'procedures'—'involve predicting or seeking to achieve certain outcomes' (Ryle and Kerr 2002, p. 9). In interpersonal procedures, individuals play a role based on their expectation, wish for or actual attempt to elicit a particular result: the acknowledgement and reciprocation of a given role. Each procedure consists of four connected stages (Table 1).

Developing the theory further, the notion of 'reciprocal roles' is a central concept in CAT and describes, as Denman (2004, p. 56) argues,

> the socially-imparted knowledge of paired social roles which together encode social knowledge about the relationships between people, between self and others, and between the different parts of the self. […] Reciprocal roles describe the parts agents play in enacting certain kinds of relationships and are learned by observation and enactment throughout life.

This, as we shall see, has potential resonance for many men, and the boys they once were. And as Denman (2004) points out—and as often witnessed in clinical practice—the adoption of one part of a reciprocal role in respect of another person may, via a particular sequence of procedures, pressure the other to enact the corresponding role.

In CAT practice, the repertoire of a client's reciprocal roles, and the negative consequences that may result from them, may be systematically mapped as reciprocal role procedures (RRPs) on a diagram, the sequential diagrammatic reformulation (SDR)—which is used to guide, and ground, moment-to-moment interactions in therapy, and outside it. They are also likely to be described, by the end of the first four sessions of therapy, in a jointly constructed narrative, the reformulation letter (e.g. Ryle and Kerr 2002).

The use of such tools points up another key feature of CAT: the stress, derived from such theorists as Vygotsky (1978) and Bahktin (1986), on the use of 'signs'. In brief, signs (whether verbal or non-verbal communication) are one medium through which an individual's internal and external psychological structures of communication, control and self-regulation are developed and altered (Denman 2004; Ryle and Kerr 2002). Or, as Leiman (1995, p. 118) puts it, 'CAT is based on the joint creation of symbolic tools that begin to mediate the patient's maladaptive action patterns'.

During the time-limited therapy, increased awareness of problematic procedures is likely to precede change in maladaptive behavioural and cognitive sequences that are reciprocal-role-derived—and which are largely or wholly self-destructive. By the end of therapy, clients are provided with a powerful psychological framework for the analysis of their difficulties—and will already often have been helped to begin to remove some of the 'roadblocks' to change (Denman 2004, p. 309).

Finally, there is a good reason to think that the male participants will benefit from the use of CAT. As well as empirical work suggesting that CAT is indeed an effective psychotherapy for various psychological issues, including depression (Marriott and Kellett 2009; Calvert and Kellett 2014), there is, above all, a high level of anecdotal evidence nationally and internationally—strongly reflected in the writers' clinical practice, supervision and research, that CAT can be an effective intervention for men with depression. That is, drawing men's attention to their hitherto unrecognised problematic psychological and behavioural procedures involving their thoughts, feelings and behaviours, in the light of a detailed and empathic understanding of their own psychological history.

We feel that the theory and practice of CAT is especially well-suited to working with men, not least since, as Ryle and Kerr (2002, p. 38) argue, that the process of collaborative reformulation of the salient psychological problems aims to reflect and understand what each [client] brings to therapy, including their cultural assumptions and formation.

This is particularly apt in the current context, since a large and ever-growing body of work, that has emerged over the last century and the last twenty years in particular, has begun to shed light on the cultural context of Western masculinity. While scholars readily acknowledge that there are many partially-distinct, but also overlapping types of masculinity (Beynon 2002; Connell 2005; Elliott 2016), and that these types in all probability have part-evolutionary, part-cultural roots (Price and Stevens 2000), certain commonalities between these 'masculinities' have been identified. Collectively, scholars have suggested that Western men may tend to experience less empathic, emotion-focused care when young—vitiating their ability to effectively emotionally self-regulate (Clare 2000); be treated generally more harshly, and generally less empathically, than women—at cost to their health (hence—possibly—Western men's lower life expectancy than women) (Farrell 1994); and, in keeping with widespread notions of toughness and its importance to masculinity, treat themselves, and other men harshly. One key component here is the minimisation of—or, in some cases, almost complete disavowal of—emotional needs (e.g. Frosh et al. 2002). Here, psychodynamic perspectives can be helpful.

Psychodynamic Perspectives

Psychodynamic perspectives provide insights that can be used to inform a CAT approach to men's depression. A key feature of CAT is that the human mind is formed *socially*. In other words, it is via physical and psychological contact with others, the meaning of which is often mediated via signs (e.g. in the form of language), and internalised by the child in a process that recalls Vygotsky's (1978) notion of the zone of proximal development (ZPD) that the child and his or her reciprocal roles develop. During this process, early caregivers can provide a 'scaffold' for the child's learning and development and, as Ryle and Kerr (2002, p. 42) argue,

> The child's sense of self and emergent repertoire of reciprocal roles will largely reflect the style in which the scaffolding for early learning is supplied.

It is against this developmental background that later psychological development occurs, including the elaboration, from the CAT perspective, of reciprocal role procedures.

A principal exponent of psychodynamic approaches with men is the American clinical psychologist Pollack (1998, 2005), who in effect translates

the cultural notions around masculinity discussed above into psychological terms. Pollack (1998) suggests that men may be prone to:

- separate intellect from feeling;
- express anger, but repress other emotions;
- shut off the more vulnerable, emotional parts of themselves;
- experience feelings of shame—but feel forced to deny the actual experience;
- act less empathically towards others;
- criticise the self harshly (or in Freudian terms, have an over-active super-ego), both consciously and unconsciously;
- tend towards perfectionist behaviour, with self and other; and
- find it difficult—when faced by such actual losses as bereavements—to fully acknowledge loss, and so risk remaining trapped in depression (Pollack 1998).

So, Pollack (1998) argues, Western men would be prone to developing what he terms a false sense of self-sufficiency, often searching for an emotional connection with others, but finding it extremely difficult to achieve this. From this point of view, men are all too prone to pull away from any intimate, and possibly helpful, psychological intervention that is offered.

Put another way, owing to the various pressures on them, men in distress can often find it very difficult to be honest about how they feel—either to themselves or others (cf. Trivers 2011). This leaves key human communication channels blocked, and distress no avenue of escape. Men can find themselves, then, in a state of forced inauthenticity. Sometimes, after years or even decades spent at emotional sea like this, men become in effect marooned, far from sure who they really are.

In sum, psychodynamic perspectives on men's experiences of depression are relatively well-developed including, as they do, salient developmental and cultural material. This, as we shall see, can directly inform the use of CAT with depressed men.

Common Reciprocal Role Procedures and Reciprocal Roles in Men with Depression

Given the integrative nature of CAT, and its manner of incorporating notions from developmental psychology as well as cultural studies, this form of therapy lends itself well to psychological interventions with depressed males.

Above all, the process of identifying depressed men's reciprocal role procedures (RRPs) in CAT arguably offers a unique opportunity for intervention with men. According to Ryle and Kerr (2002, p. 220), RRPs can be defined as

> a stable pattern of interaction originating in relationships with caretakers in early life, [which determines] current patterns of relationships and self-management. Playing a role always implies another [person], or internalised 'voice' of another, whose reciprocation is sought or experienced.

Given, however, the above material—and in particular Ryle and Kerr's (2002, p. 157) contention above that some procedural patterns remain tied to gender stereotypes that are maintained by cultural, economic and perhaps even evolutionary pressures, it is arguable that men show specific types of procedure.

First, it might be predicted that, given their (hypothesised) lack of early empathic care, as well as the premature truncation of this by caregivers (Pollack 1998, 2005), men would tend to show restricted relationships with others as part of their procedural sequences. In CAT terms, this might mean that men generally, and depressed men in particular, tend to show reduced, restricted and possibly less fulfilling interactions with others. This accords with our clinical experience.

Second—and given especially the psychodynamic material above regarding the lack of empathic early care for men—it could be predicted from the point of view of CAT that depressed men would tend to *treat themselves more harshly*, or at least in different ways, compared to depressed woman. In view of the fact that men are, on average, less likely to seek help for an existing spell of depression than women, and day-to-day clinical practice, this is very probably the case. Under stress, many men find it challenging to 'look after themselves'.

In terms of specific reciprocal roles, in our experience, men experiencing depression are often subject to the following (Fig. 1).

Overall here, the CAT framework offers a concise means for pinpointing—and then changing—the intrapersonal and interpersonal difficulties confronted by depressed men, and so allow the gradual identification, development and mobilisation of what Ryle (1975, p. 13) terms the psychologically healthy, 'central self'.

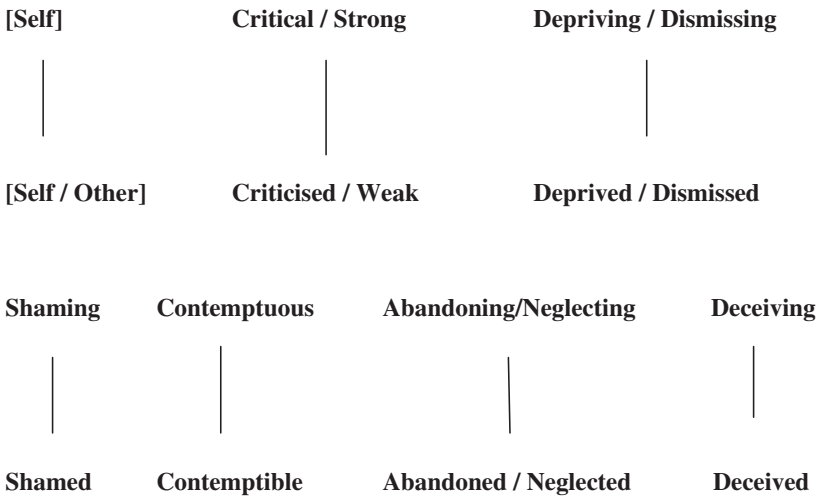

Fig. 1 Reciprocal roles frequently evinced by men

Beginnings: Establishing and Developing the Therapeutic Relationship Up to Reformulation

The material above can be used to inform the establishment and development of the therapeutic relationship with men.

Pollack (1998) argues that men, having been subjected to relatively unempathic early care may—if they get so far as to begin therapy—do so either very reluctantly, begin very hesitantly and are prone to try to pull away from the process. This is observed in CAT with men, where their initial presentation in the service or clinic can be very tentative.

At these times, potentially unhelpful reciprocal roles may be operating. If unidentified and unaddressed, these can lead to the premature truncation of the work—and a state of psychological stasis for the man in question. Reciprocal roles here may include Deceiving/Deceived (where the man is less than honest with himself or others about his feelings), and Abandoning/Abandoned (where the man leaves the opportunity to engage with the clinician).

As another example, some men re-enact a strong and/or controlling role from the outset, as a defence mechanism. One of us experienced an older male making critical comments about the office in which we were meeting, as a way of initially trying to exert control over the (anxiety-provoking) clinical encounter.

In short, rather than colluding in the notion that the clinical issues—perhaps the man's feelings above all—do not need to be addressed, they can be gently and compassionately explored. Here, it can in our experience help to keep in mind such roles as Listening/Listened to; and Engaging/Engaged.

At this early stage of the work, the stress on transparency within CAT—notably around the time of the development of the SDR and the Reformulation letter—usually but not always presented to the person in Session 4—offers certain opportunities. At the very least, these processes offer clear opportunities for specific 'taboo' issues—for example the (potentially shaming) notion or feeling of being a man 'in therapy' to be discussed. Such conversations can also have the effect of both naming, and often, in effect, *reducing* the sense of shame felt by the man—and so promote readiness for psychological change. Furthermore, explicit discussions focusing on the matters of male gender and psychological therapy at an early stage in the work can also make it straightforward to return to such themes as gender-based feelings of shame, if necessary, during the later stages of the work. In particular, there can be discussion of *what masculinity means* to the man in the way that he has led, and leads, his life—including how this might be affecting his well-being and specifically, how this might impact on his depressive symptoms.

As well as linking the man's story of their earlier life with their current (problematic) ways of relating to self and others, a CAT reformulation also considers how those same problematic procedures may be enacted *in relation to the therapist.* One of the main specific therapeutic factors in CAT is the recognition, naming and (respectful) non-reciprocation of those procedures. For many men who present for CAT—particularly who have had experience of emotional neglect and/or abuse to some degree, the reformulation process can be revelatory. This may be the first time in their life that another person has taken the time to get to know their inner life intimately; the first time that a systematic attempt has been made to make sense of it; and the first time that the key issues—and potential solutions—have been spelled out. Openly stating what has happened can also be a huge emotional and even somatic relief for men. Recent evidence suggests that men highly prize such characteristics as being 'honest', 'reliable' and 'dependable' (Men and Boys Coalition 2018). CAT offers an excellent environment for men to rediscover these traits. We now turn to look at how this can work in practice, in a therapy with which one of us was involved.

Case Example: Philip[1]

Philip, a 50-year-old professional gentleman who had been diagnosed with depression, arrived for the therapy assessment on time. At the time of seeking treatment, he was on long-term sick leave from his employment. This had affected his mood but also his level of self-esteem, sense of purpose, role and status as a man.

In hearing Philip's story, it was apparent that there were a number of relational difficulties evident, affecting self and other. We also identified triggering patterns that had lowered his mood. Interestingly they had mirrored problematic patterns from his early years, leaving Philip feeling bullied, criticised, hurt and let down. This led to Philip feeling depressed and lacking in motivation or energy. He shared sadly how he felt he had 'no passion anymore'. It was hard for him to connect with any rage or anger that could have related to how he had been treated by others who had authority over him.

We explored embarking on a longer 24-session Cognitive Analytic Therapy (CAT) and information was given about the intervention, explaining that CAT was a time-limited, relational therapy which focuses upon the problematic procedures that fuel the symptoms affecting the mental distress.

The therapy plan was explained in a way to ensure informed consent and we discussed incorporating mindfulness meditation around session eleven. There is strong research to indicate the value of mindfulness helping not only with observing and developing the ability to radically accept mind states and emotions but to also expand the capacity to recognise the problematic patterns and work towards creating some change (Wilde McCormick 2004; Williams et al. 2007; Hick and Bien 2010).

Sessions 1–4

During the early sessions, we constructed a genogram together and a timeline to gather an understanding of the significant events in understanding Philip's history and story.

After Session 1, Philip took the CAT Psychotherapy File away to complete at home, in his own time and at his own pace. It is designed to help

[1]For the purposes of this chapter, name and details have been anonymised.

identify the traps, dilemmas and snags that form the problematic procedures. In these first few sessions, we also quickly identified the significant reciprocal role and reciprocal role procedures that had been internalised from his early life experiences and relationships with caregivers.

The problematic reciprocal roles for Philip were: 'Conditionally Controlling to Withdrawn and Alone or Passively Rebellious', 'Contemptuous, Violent Bully to Contemptible Victim', 'Neglecting Dismissive to Neglected and Dismissed'. Also it was important to note that Philip held a 'wished for belief' that his 'Utopia' existed where he would experience others as: 'All knowing & providing Ideal Care to Ideally Cared For and Special'. From reflections about the role he had taken on at work and those in his care, he would try to provide this for others. However it would often be at the cost of meeting some of his own needs, usually leaving him feeling let down or used.

The first stage of CAT is, as noted, to collaboratively make sense of the client's problematic procedures and establish the aims or focus for the therapy by reformulation. This is done both in a letter and mapping it visually in a SDR. At the fourth session, the Reformulation letter was read out. Philip has kindly chosen to allow parts of his letter to be shared in the extracts below. Comments relating to CAT theory are in parentheses.

Reformulation Letter

Dear Philip,
[…] When we first met you were able to tell me about all of the previous therapy interventions you have had in these recent months following being off sick from your job […]. In talking about what you felt the problem was you said how you felt "like a little boy, expecting to be punished and still waiting for mummy to love me".

(Here, I was naming how we had noticed very early in the relationship the problematic reciprocal roles that the therapist was being invited into—either "Kindly rescuing or Critically telling off".)

We have begun to talk about your early years and what life was like growing up in your family in […]. We spoke of how you grew up feeling you were a mistake and laughing told me that it was a family joke that you and your brother […] should have been born girls, as Mum wanted the "perfect family". Your laughter seemed to cover the immense pain of not being able to change or be different from how you are born. I do wonder what has happened to the anger and disappointment you feel from not feeling accepted for who and how you are?

(Naming a pattern that we can begin to observe in starting to recognise from Philip's target problem procedures. This was one of his attempts to distance himself from his emotional pain and the anger that he feared. The fear for him was that if he showed anger, he would be like his father, out of control, a violent bully, so his response to this dilemma was to bottle up and suppress his distress and rage.)

You talked of your Mum as someone who was very critical, controlling and blaming. It always felt as if you could never do anything right. Often your feelings and needs were not valued or listened to. It is not surprising that you learned your feelings and needs are not as important as others', and that you were unworthy. That must have left you feeling very despairing and alone.

(This summarised what had been spoken about and naming his core pain and deep sadness of not feeling good enough and acceptable.)

It made you feel you could never "man up" and you felt that at such a young age you were written off. The lack of support and nurture certainly taught you to and left you with the dilemma of either be the "strong man who does not need others" or the overwhelmed "little boy lost". Sadly no-one was able to teach you how to stay with difficult emotions, have a sense of your own power and allow yourself to have support.

(The shame Philip had felt had prevented him from previously addressing his unresolved emotions as it was so painful to acknowledge and accept. The feelings linked to his shame that he found so unbearable were terror, hurt and humiliation. Therefore to connect to his emotions meant, he could no longer distance himself from his distress and inner suffering [Wilde McCormick 2011; Gilbert 2010]. It was important to validate his courage and the strength it took to begin to face these feelings within the therapy.)

Trusting people has always been difficult and felt risky. Either you put on the front of the big smiling […] strong man or you retreat to isolation, withdrawing from people becoming the little boy lost. As we have begun to explore your feelings a little more closely you have begun to notice how angry, despairing and empty you feel. It leaves you feeling embarrassed for the extent that you often feel the victim, unable to stand up for yourself and as if you are trampled on like dirt on people's shoes.

(At this point we name the one of the dilemmas that we could work on recognising during the therapy.)

Noticing how you feel and having a voice for those emotions is in some ways a new step for you. Finding your voice and letting people know how you truly feel seems to be a big challenge in helping you move forward with your life.

(Identifying the second target problem we would focus on during the therapy.)

I look forward to working with you in our remaining sessions over the next few months. Together we will work trying to gain a better understanding of how these patterns become enacted in your life and how you find ways to become more true to yourself, and meet the "Real Philip".

With very best wishes,
(Therapist)

In the next session, Philip shared a response that he had written. Extracts and commentary follow.

Dear (Therapist),
Thank you. Thank you for listening and putting into words some of the feelings and thoughts that have been broiling away in my mind for years. I have never found it easy to personally express my feelings verbally and so hearing your do that for me was a revelation. Half way through the letter that you read to me, I found that I was nodding along in agreement. It was extraordinary experience […].

(This demonstrates the start of Philip developing a sense of his "voice" feeling heard and the dialogic relationship between client and therapist forming. In CAT—which draws heavily on Vygotsky and Bakhtin— dialogue is crucial in forming the collaboration and trust within the relationship [Ryle and Kerr 2002; Leiman 1992]).

[…..] Some of the insights that you have made concerning my upbringing were unknown, or more accurately, unrealized by me previously and quite literally opened my eyes to what has been happening inside my head, insidiously undermining me all my life […]

(Philip communicates that I had heard his story and in the reconstructive narrative and collaboratively we had made the links between his past experiences and the current procedures gaining a clearer understanding of how this impacted on him.)

We went on to map the reciprocal role procedures on a sheet of paper and begin to name some of the overwhelming emotions that Philip had shared, such as: anxiety, fear, emptiness, despair, hurt, shame and self-hatred. The importance of getting into dialogue with the gritty, disavowed reciprocal roles of his core pain began to bring a richness of understanding into our therapeutic relationship (Hepple 2011).

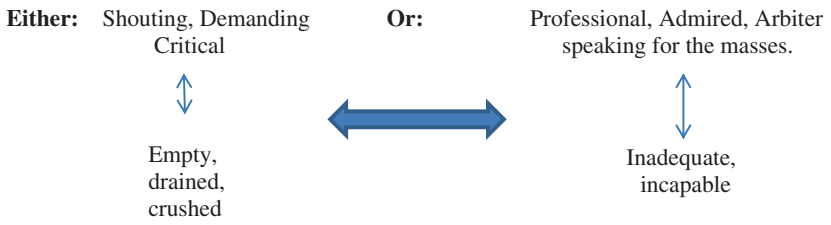

Fig. 2 Extract from Philip's sequential diagrammatic reformulation

Also alongside the SDR (extract in Fig. 2), we had mapped the dilemma that Philip frequently found himself in.

Middle: Exploring and Deepening the Therapeutic Relationship with Men

At best, the therapeutic relationship in CAT for depressed men can offer a precise and transparent means of operationalising key notions. Above all, working with the reformulation letter, SDR and the therapeutic relationship, a detailed picture can be developed of the male client's own sense of relating to the therapist (male or female)—as well as of the therapist's sense of relating to the client. On this basis, the male client's earlier experiences, including those interpersonal experiences which seemed to impact on his sense of having male identity, can be gradually explored, and put in the context of the therapeutic relationship as a way of initiating and enabling change, mid-therapy.

To take another example from our clinical practice, a male client recalled distinctly from his early relationship with his father that to talk 'sensitively', about 'feelings', was to 'talk stupid'. Careful exploration of these memories midway through a CAT therapy, and comparison with the male client's current experiences with the male therapist, went at least some way to begin to undermine and change certain of the client's key reciprocal role procedures (RRPs). The therapeutic relationship within CAT for depressed men can offer a key forum for addressing and normalising the male client's feelings of gender-based shame, notably by helping to pinpoint his place in, and feelings about, the therapeutic relationship.

Frequently, too, in the middle phase of a CAT therapy with men, the clinician and client may find themselves passing through alternating emotional states, a jocular or jovial (and slightly defended) state on the one hand; and a deepening emotional connection on the other. As the man feels more

confident in the clinical setting, and trust grows, very valuable therapeutic work can be done. As layers of defence fall, new, unprocessed material can emerge, and be safely contained, in the therapeutic relationship.

Case Example: Philip—The Middle of the Work

Sessions 5–18

During this phase of the therapy, we continued to work on recognising the identified target problem procedures and gaining more details of Philip's story. He bought a notebook and started to keep a journal reflecting upon his thoughts and feelings during the week, writing down what he was noticing. Frequently throughout the course of his therapy, he would bring his journal and use it as an aide memoir. He actually found it very difficult to connect to his feelings as he either became overwhelmed and distressed or worked hard in trying to distance himself by intellectual efforts such as focusing on wider issues of society or the world. It remained a careful balance to bring back the focus of our sessions and yet respect his limitations. I found myself gently pushing him to the edge of his zone of proximal development, helping Philip to step just a little outside of his avoidant level of comfort and explore his emotions (Ryle and Kerr 2002; Vygotsky 1978).

There were times that it felt as if I moved too quickly to enable him to recognise, only to notice this and then take a few steps back to stay with the feelings related to past trauma. Supervision was essential in helping me to identify this and work effectively with staying within Philip's window of tolerance. This took time and it was very important to pay attention and highlight how he was able to regulate his emotions following connecting to some very difficult feelings. It was helpful that we had contracted a longer period of CAT therapy. As the relationship developed at this phase, Philip talked in more depth of a number of painful and traumatic situations. It became clearer how these more recent events had connected him to the unresolved distress of his core pain.

Following this point, we had incorporated the use of mindfulness into our sessions to develop the skill of this practice to help to become more self-aware and notice what he was feeling (Segal et al. 2002; Williams et al. 2007; Hick and Bien 2010). The aim was that this could provide a platform for Philip to begin to non-judgementally validate his emotional experiences and work towards developing some self-compassion. Philip made a commitment to regularly practicing. By using mindfulness Philip was able to develop a way of helping to name, accept and regulate his difficult emotions. It also proved valuable

in assisting him to access a deeper level of connection to his feelings than we had previously managed. Philip created a "safe place" for himself where he would meditate mindfully, internally constructing an image of Mount Kailash in Tibet. With this in mind, he described being able to stay with and accept the emotions, along with the bodily sensations that he experienced, thus leading him to develop a greater capacity of acceptance and understanding for himself.

Philip regularly shared his dreams within the CAT session, as this deeper connection with his difficult emotions seemed to play out when he slept. Many of his dreams had violent, disturbing content, and we were able to consider how this gave 'voice' to his anger, rage and fear of events that he found so difficult to express, previously, by day.

It was during this working phase of the CAT therapy that we were also able to utilise the benefit of writing "no send" letters which enabled Philip to access, express and process many unresolved feelings, learning to have a voice. Reading these aloud enabled Philip to hear his own words and feel more empowered, while also releasing his feelings of grief, anger and loss related to the traumas he had encountered.

The therapeutic alliance was providing him with a different response to managing his emotions and began to equip him with scaffolding he needed. Philip was starting to find alternative ways of responding to his target problem procedures and feelings as they were evoked.

Philip identified these "Exits" as: Recognising the feeling/Finding a voice and open up to others/Being kinder to myself/Use mindfulness/Connect with others (through hobby)/Recognise I have choices/Allow self to do things that are enjoyable and develop new hobbies.

First Step Towards Change

The emphasis in CAT on the 'creation of a non-collusive, collaborative relationship' (Ryle and Kerr 2002, p. 33) also offers a clearly-defined testing ground for change in the midst of therapy. This inevitably means different things to different men; but where—perhaps for the first time—particular feelings start to be noticed, say, they can be carefully and gently explored in the previously unfamiliar setting of individual therapy, enabling men's awareness of and confidence in their emotional lives to begin to develop.

This can mean, too, men 'trying out' new reciprocal roles which previously would have seemed strange to them, or would have been shunned. In our experience, through the vehicle of CAT, men are often able to begin to become more caring and empathic towards themselves, often for the first time.

It is helpful, if this issue emerges, for it to be explicitly identified, discussed and normalised within the therapy.

In this way, the middle phase of a CAT therapy with men can be a critical one, where the historical defences can be reduced; and authentic contact is established both between the clinician and the man concerned and between the man and his own interior, emotional life. Where such trust and honesty emerges, significant therapeutic progress can occur.

End: Working Towards Endings in CAT with Depressed Men

CAT requires the therapist—and the client—to keep the end in mind from the beginning (Ryle and Kerr 2002). A CAT reformulation letter will often name enactments of problem procedures which are likely to occur around termination. For some men, in an echo of the early phase of CAT noted above, this includes the possibility that they would abandon therapy before it abandoned them—either dropping out or withdrawing emotionally prior to the ending. In order to avoid this, the therapist can note the passing of sessions in each session counting down the remaining number—and openly discussing the implications.

The other main technique to facilitate a good ending is the writing and exchange of therapy 'Goodbye letters'. These perform a number of functions—they require both parties to really focus on the end. They are meant to allow each party separately to make a realistic evaluation of what has been achieved. The therapist explicitly invites the patient to name the (inevitable) disappointments of therapy as well as what has been valuable, to avoid as far as possible unhelpful idealisation, placation or avoidance. The therapist's Goodbye letter also may serve as a transitional object—a sign that can carry something of the relationship in the absence of the therapist, as well as of the exits from problem procedures that are to be practised in future. They are read aloud, given the power of hearing the spoken word. For the client, this entails acknowledging their experience of the alliance now the therapy is at the end, to express both progress made and give voice for any disappointments and sadness, thus validating the end—and often in a different way to previous endings experienced (Ryle and Kerr 2002; Corbridge et al 2018).

Sometimes, clinical experience shows that men—perhaps unexpectedly—cherish both their Reformulation and Goodbye letters, keeping them for years, referring back to them at times of emotional need.

Case Example: Philip—Moving Towards the End of Therapy

Sessions 19–24

We had previously spoken and named our ending, counting the sessions down each week on our sheet of session dates. The ending of our work naturally brought up some difficult emotions for Philip as it triggered strong feelings from the past and he was reminded of his core pain and previous endings encountered. This connected him with feelings about significant losses in his life, especially as he had made a decision to end his career and not return to a job he had loved. This was a painful choice. But he was able to recognise that he "deserved better" and it was not a healthy environment. Philip understandably had fears about ending the therapy as he felt he lacked confidence. Helpfully, he was able to voice these fears and we validated his feelings. We talked about the usefulness of having follow-up sessions to be able to come back and reflect together how he was learning to 'stand on his own feet'.

We negotiated to share goodbye letters in the penultimate session which enabled greater time to process the letters together and reflect on the ending. Philip read his letter to me aloud first. Exchanging letters in this way often enables clients to feel less anxious as they are able to voice their own letter first and are not comparing what they have written to what is delivered by the therapist and anxious that they may not have 'got it right'.

Extracts from Philip's Goodbye Letter follow.

Dear (Therapist),
I really don't know what to write in this. I really think I don't want to write this. […] You know I hate goodbyes […]. Firstly, thank you for listening to me. I certainly have never spoken to anyone at such length about what goes on inside my head.

Thank you for making me feel comfortable enough to open up and […] for helping me to see and understand that feelings are part of the human condition and as such should be embraced and not locked in cupboards marked "not to be opened under any circumstances". I know that you understand that I still find dealing with emotions difficult but I now understand that they need dealing with. That remains an adventure for the future! Not one I'm particularly looking forward to but one I know that I have to undergo […].

(Philip was able to express his thoughts and feelings about this therapy in a balanced way, including, later on in the letter, naming the difficulties of

ending that he feared, as well as the work that he knew he still needed to address).

Extracts from the therapist's Goodbye letter follow.

Dear Philip,

[…] It is sad that for so much of your life you have struggled to be yourself or allow yourself to feel, respond or express your emotions. Instead you lived your life by how you think you "should be" rather than accepting and valuing who and how you are. Trying to control yourself to push feelings away has not helped you tolerate, value or understand your feelings. This pressure has created the distress you feel as it has been virtually impossible to be yourself or feel valued for being or feeling the way you do. […]

Letting me see the part of you that can have difficult feelings, such as when you have been frustrated, disappointed, felt shame or annoyed has been a big step. It is one you still struggle with but nevertheless has meant you have taken huge risks to manage things differently. Allowing the "real Philip" to be seen and heard in turn has enabled you to value yourself and recognise what you have needed. […]

You are now able to give much more thought to yourself and what <u>you</u> may need, not just giving it to others. It has been a pleasure to see how you are [moving] towards developing the self-care and compassion you need. There is a small light of hope and excitement starting to glimmer through as you think of the future with more positive feelings.

The reflections and the ensuing discussion allowed Philip to think about what he had accomplished during the therapy, and what he still needed to focus on after completing the intervention. Philip was able to share his appropriate emotional response to the sadness of ending and saying goodbye, as he had valued the therapeutic relationship.

Philip attended the usual follow-up appointments that are indicated for CAT and demonstrated that although things were not dramatically different for him, he had been able to maintain the changes. Further contact from Philip at a later date where he had written a letter out of the blue also highlighted how he had positively managed to hold on to these changes, and was still using his exits two years after his treatment.

*

Working with many men in CAT in this manner, it can feel, towards the ending, that therapist and client are moving inexorably back to the emotional shallows, having explored the depths. Follow-up meetings with such men, however, indicate in fact that—as within the work with Philip—the

benefits of deeper, authentic emotional contact are not fleeting, but are seen as personally valuable, and sometimes transformative. For many men, having CAT may be a unique experience in their lives, especially if they have developed within, and have learned to re-enact, reciprocal roles associated with traditional, restrictive Western masculinities. Often, these men develop new roles during CAT that can take them forward in new and adaptive ways. Frequently, too, men in CAT proudly discover or rediscover their capacity to be honest, loyal and dependable—prized characteristics for many males—with others, and above all with themselves.

In this sense, for many men, CAT can chart and begin to untangle the early damage done by abuse, neglect and trauma to their ability to reciprocally relate. Given the central importance of relationships to human health, this alone can be a major step forward for an individual man.

Conclusion

With its careful, detailed emphasis on a person's developmental beginnings, focus throughout on interpersonal relating, and the use of the therapeutic relationship as a crucible for change, CAT has much to offer men who experience depression as a model of psychotherapy. Extensive clinical experience using CAT in the UK and elsewhere over the last three decades or so indicates that many men—some of whom bring high levels of attachment and/or developmental trauma, and associated interpersonal difficulties to the clinical setting—do very well indeed when they take the opportunity of engaging in this modality, and opening a dialogue about how they really feel.

In our experience, unquestionably helped by the humane transparency that is a hallmark of CAT, many men who encounter depression come to see themselves, and their relationships, more openly, honestly and with less stigma, and understand more clearly how their issues originated, and how they have been re-enacted in their day-to-day relationships. Perhaps, above all, men come to mobilise this new emotional and psychological awareness to reconfigure their self-to-self relationships, or self-care, in ways that, sometimes, they would not have thought possible.

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Working with Homeless Men in London: A Mental Health Service Perspective

James Duffy and Andrew Hutchison

Introduction

2016 marked the 50th anniversary of Jeremy Sandford and Ken Loach's powerful drama, 'Cathy Come Home'. This seminal film (released in 1966) was shocking on many fronts; not least because it depicts a family's descent into poverty and homelessness. In doing so, the film challenged many of the commonly accepted beliefs and assumptions about those affected by homelessness and its underlying causes. The characters depicted, a woman and her family, were a far cry from the stereotypical 'tramp', 'hobo', or 'vagrant' of popular culture and parlance, and were not who the viewer might have expected to end up outcast by society.

50 years on, in the era of 'I, Daniel Blake', homelessness in the UK shamefully remains a huge social issue and is linked to the broader housing crisis and welfare reforms depicted in the film. In fact, the government has recently been directly implicated in rising rates of homelessness and accused of taking a 'light touch approach' to resolve the situation (National Audit Office 2017).

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Homelessness has now taken on different guises, with new terminology, which includes less visible groups, i.e. 'the hidden homeless' and 'sofa surfers'. This makes it harder to estimate numbers, and in fact, there are no national figures for the total number of homeless people within the UK; though evidence reveals that numbers continue to rise and are estimated at over 250,000 (Shelter 2016).

It is now particularly important to be specific about what populations and homeless groups we are referring to, as there may be very significant differences between the problems faced, the reasons for becoming homeless, and the possible solutions to help people. This chapter will focus on the most extreme form and most at risk group, those who are rough sleepers.

Recent rough sleeping estimates for England published by the Department for Communities and Local Government (DCLG 2016) suggest that the number of people sleeping rough has more than doubled since 2010. Within London, data recorded on the Combined Homelessness and Information Network (CHAIN[1]) for 2016–2017 reveal a 25% rise in rough sleeping since 2013–2014.

Different populations are increasingly ending up being forced onto the street. These include the young, people from other countries, and women. Although the overall gender split has reduced, male rough sleeping still vastly outweighs women. Of the total number of rough sleepers recorded in London during 2016–2017, 85% were men. These figures were also reflected in a recent audit by START, a specialist mental health service for street homeless people in South London, who found a near identical breakdown of gender for the rough sleepers under their care, with 82% men.

While the figure of 85% is widely reported by organisations working with street homeless people across the UK (e.g. St Mungo's 2016a), there is little published literature to explicitly explore the underlying reasons linked to this observed gender imbalance.

A storm of social factors has multiplied the numbers of rough sleepers over recent years: shortages of housing and the rising costs of renting; cuts to services including funding for Supporting People; welfare reforms, e.g. the so-called 'bedroom tax' and caps on Housing Benefit; as well as other international factors, such as the expansion of the European Union, global instability, and prolonged wars that have forced mass migration.

[1]CHAIN—a multiagency database for recording information about rough sleepers and the wider street population within London.

However, it is not only sociopolitical factors that have directly contributed to the increase in rough sleeping. Available data highlight the significant proportion of people within the homeless population who are classed as having additional support needs. For example, CHAIN's annual report for the year 2016–2017, published by The Greater London Authority (2017), revealed that 47% of rough sleepers in London were found to have additional mental health needs. Forty-four per cent were found to have alcohol-related support needs, and 35% drug-related supported needs. Despite this, access to specialist services is typically very limited within the rough sleeping community, and people's support needs often remain unmet (St Mungo's 2016b). Consequently, there is clearly a need for better service provision to support the needs of the UK's growing rough sleeping population.

Based on the observations highlighted above, this chapter aims to explore both the issue of male homelessness and the challenges associated with meeting the support needs of people within the homeless community. This will be achieved by presenting and reflecting on the work of START. Specifically, a detailed account of male homelessness will be presented and discussed with reference to relevant literature throughout. Attempts will be made to consider how existing evidence/literature might explain the higher rates of homelessness in men compared to women, and the clinical implications of this will be explored. By introducing the work of START and presenting a clinical case example, this chapter will also highlight the importance of specialist service provision within the homelessness sector.

Introducing Tony

Throughout the course of this chapter, readers will be told the story of Tony, a 48 year old man with a history of entrenched rough sleeping and significant mental health difficulties. Although all of the issues highlighted, are based on a true account of male homelessness, all names, locations and other potentially identifying information have been changed to protect the anonymity of the person involved. It is written using a combination of Tony's own personal account of his experiences and the account of those involved in his care. As the chapter progresses, you will learn about a number of Tony's early life experiences, the subsequent difficulties he experienced and his contact with services, including the support he received from the START team.

Understanding the Range of Issues That Can Contribute to Homelessness—The Role of Trauma

In recent years, it has become increasingly well accepted that entrenched homelessness is not just related to a housing shortage or the result of unfortunate unforeseen circumstances, but rather the consequence of long-standing social exclusion, personal violations, and disrupted attachments (Cockersell 2015). Therefore, the problems of rough sleepers will not be solved by simply offering someone accommodation (Maguire et al. 2009). As Seager (2015) stresses, 'a house devoid of 'empathy, warmth and genuineness' is of no more use to a homeless person than it is to a developing child' (P20).

Unfortunately, a large section of homeless people have not had that necessary consistent empathy, warmth, and genuineness at any stage of their life. Rates of childhood abuse or neglect in homeless people have been found to be over 80% (Torchalla et al. 2012). This raises the question, what do these groups of homeless people associate with being housed? It is perhaps not the same warm feelings of safety, security, and connection, or the pleasant sense of nostalgia that many of us experience when within our own 'four walls'.

Not only have most rough sleepers had disrupted, neglected, and unpleasant early lives, but the majority have experienced further trauma that can be associated with additional barriers to them accessing and maintaining a home. Traumatic life events have been experienced in over 90% of homeless people (Buhrich et al. 2000), and homelessness in itself will often expose people to further trauma, victimisation, and learned helplessness (Torchalla et al. 2014). In addition, the high prevalence of violence experienced on the streets may prolong entrenched rough sleeping further (Kim et al. 2010).

Despite trauma and historic abuse being commonplace in the lives of homeless men, research in this field has primarily focused on women. It has been suggested that the exclusion of men from studies could be related to additional barriers to engaging homeless men in research, including males tending to lead more isolated lives, enduring more severe mental health problems, and presenting with particular presentations of post-traumatic stress related to military involvement (Kim et al. 2010).

When considering gender as a factor, a cyclical hypothesis makes sense. This is because men vastly outnumber women as rough sleepers, so the likelihood of exposure to further trauma is higher. This cyclical process of repeated traumas is exaggerated by the fact that men in the UK are generally more at risk of being a victim of violence, with approximately 61% of

victims being male and 39% female (Office for National Statistics 2017). However, women who are rough sleeping are clearly at increased risk of violence and may not perceive sleeping out on the streets as a viable long-term option (Hill 1991).

One consideration in regard to gender is the types of trauma that men and women are exposed to. Males are more likely to experience physical violence and psychological traumas, while women are more likely to be subjected to sexual violence and domestic abuse (Jainchill et al. 2000; Tolin and Foa 2006; Sonne et al. 2003). Such differences can have implications into routes into homelessness and how people are supported by organisations.

Women may be housed sooner due to additional specialist services (such as women's refuges or services that address the specific needs of women). Additionally, some women will be (rightfully) considered priority status related to pregnancy or dependent children (see Shelter 2017).

Another reason that some women do not become entrenched rough sleepers and remain members of the 'hidden homeless' population is that they are exploited into sex or sex-working, which temporarily removes them from the street (Reeve et al. 2009; Homeless Link 2014). It is reported that significantly more homeless women (25% compared with 2%) turn to prostitution than men (St Mungo's 2014). Such women have been found to be at increased risk of turning to such desperate measures if they have been subject to previous sexual abuse (Simons and Whitback 1991).

Also of note is how different forms of abuse and trauma impact on people and the ways of coping that they develop to manage such intrusive and distressing experiences. Gender differences have been found, including more internalised and avoidant behaviours in women, and more externalised and 'fight or flight' responses in men, for example increased aggression or substance misuse (Torchalla et al. 2014).

There is, of course, debate as to whether males' tendencies towards aggression and problematic alcohol/substance use are biologically driven, or the result of social learning and adopting more socially accepted gender roles (e.g. Archer 2004; Wilsnack et al. 2000). However, such behaviours place men at increased risk of breakdowns in placements and facing further problems in being re-housed.

> Many of the above issues are evident in Tony's story. He was born and brought up in a small town, where he lived with his parents and older sister. Although his recollection of his upbringing and early life experiences was somewhat unclear, he recalled not feeling close to any of his family and described often feeling unsafe as a child. He linked this to a constant threat of physical

violence from his father, who was a heavy drinker and someone who was often physically abusive towards his mother.

When Tony was 16, he moved away to work as an apprentice for a year. He described this as a positive experience, as it allowed him to escape some of the difficulties he had been experiencing at home. However, he also recalled starting to drink quite heavily at this time of his life. He suggested that alcohol gave him confidence, which was something he felt he lacked, as a result of his difficult upbringing. Tony also felt that his drinking provided a means of escaping some of the difficult memories of his past.

After a year, he moved away again to start studying for a National Diploma. However, he soon dropped out of this course, as he was spending increasing amounts of time drinking and smoking cannabis. He later started to use harder drugs such as crack and heroin. Although he never felt that he became physically dependent on substances, he recognised that he often used them as a way of managing stressful situations.

Complex Trauma and the Role of Personality with Homelessness

Parallels have been drawn between the frequently traumatising, disrupted, and abusive histories of homeless people and those who are diagnosed with 'personality disorder'.[2] The prevalence of this diagnosis in the homeless population is unclear, and there have been wide-ranging estimates of rates between 2.2 and 71% (Fazel et al. 2008), with 'anti-social' type (particularly associated with men) at between 10 and 40% (Ball et al. 2005).

Difficulties that define the construct 'personality disorder' such as problems with regulating emotion, impulse control, relating to others, and maintenance of relationships have been described as features of the heterogeneous homeless population and factors that place individuals at risk of breakdowns of accommodation and causing issues securing support (Ball et al. 2005).

The nebulous nature of these presentations can mean that it is challenging for services to decide who is in need of clinical interventions and may also serve as an excuse to avoid complex and ambiguous cases, particularly considering stretched resources and histories of non-engagement (Crane and Warnes 2001; Timms and Taylor 2015).

[2]This reflects the language typically used in the research literature but we recognise that some people have a preference for the term 'complex trauma'.

Men presenting with more significant mental health difficulties (including 'personality disorder' diagnosis) have been found to be particularly difficult to engage, partly because of higher rates of anti-social traits and forensic behaviours, and more common problematic alcohol or substance use (O'Brien et al. 2009).

> Throughout his early twenties, Tony recalled leading quite a transient life, whereby he would regularly move around the UK, living in different cities. At the time, he was typically living in squats or staying with people he had got to know. While Tony had some brief relationships, he had difficulties getting close to people. He found it hard to trust them, expected them to let him down, and would often move on, protecting himself from further predicted pain.
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> Later in life (after a prolonged period of rough sleeping), Tony was eventually accommodated in various hostels. But he didn't like the crowded environments, started to have problems with other residents, and felt singled out by staff. He was referred to mental health services but did not think that they were of relevance to him; instead preferring to visit local hospitals when he really needed help. Placements broke down following fights, service-charge debts related to substance use, and spells in prison. Tony returned to sleeping rough and it was often assumed he was 'making a lifestyle choice,' rather than responding to a sense of threat by making the logical decision to remove himself from that situation.

Psychosis, Gender, and Issues with Housing

Rates of psychosis[3] are particularly high in the homeless population (Fazel et al. 2008, 2014). This is not necessarily surprising, as such difficulties are often associated with problems securing and maintaining accommodation (Lettner et al. 2016).

This, in part, explains why the START team have always primarily worked with rough sleepers presenting with psychosis, however ambiguous these presentations sometimes are (Timms and Taylor 2015). Unfortunately, over the years the team has had to adapt and prioritise this group (over people with less severe mental health problems or those that are in temporary accommodation) due to wider funding constraints and pressures on public

[3]The term 'psychosis' is a reference to the range of complex difficulties often experienced by the people who access our service. We take the position that such presentations are often rooted in adverse experience (i.e. trauma and abuse), which is highlighted by the clinical case example presented and wider literature.

and homeless services (see Timms and Taylor 2015 for further details on the history of the team). We are currently working with commissioners to consider other models of working that can improve access to rough sleepers with all significant mental health needs.

It is important to consider how difficulties linked to psychosis have the potential to make people actively turn away from support and societal structures or norms. Experiencing paranoid or grandiose beliefs, or associated experiences (e.g. commanding voices), can also put people at higher risk of abandoning accommodation if re-housed, or make it harder for people to sustain tenancies without the right support.

High prevalence rates for psychosis within the homeless population could also go some way to explaining the gender differences in the street homeless population. One initial explanation is that men may be at more risk of developing psychosis. Traditionally, it was understood that incidence and prevalence rates of psychosis were comparable across genders; however, more recent research suggests that incidence rates are significantly higher in men (Ochoa et al. 2012). Through large-scale reviews, estimates of ratios have been made at 1.4:1 (McGrath et al. 2004) and 1.57:1 (Saha et al. 2014). Therefore, if psychosis increases a person's vulnerability to homelessness, this may help explain the higher numbers of homeless men.

As well as incidence rates, another consideration is the age of onset of psychosis between genders. In relation to this, it is widely recognised that men have an earlier onset than women (Donoghue et al. 2014). This is of relevance because there is some evidence of homeless groups being younger when first hospitalised (Opler et al. 2001) and that more entrenched homelessness is associated with a younger age when first becoming homeless (Patterson et al. 2012).

While there is a significant body of evidence to suggest that males develop psychosis at an earlier age, the discrepancy in age of onset may not be as marked as previously believed. A meta-analysis by Eranti and colleagues (2013) looking into the diagnosis 'schizophrenia' found that the combined difference in age of onset was only 1.49 years. As well as methodological issues and diagnostic discrepancy, Eranti et al. (2013) suggest that there might be notable differences between genders in the speed of access to services from when they first experience psychosis. Therefore, this more recent review highlights that age of onset may be less relevant than first thought, but that males may be slower to engage with services.

Earlier age of onset and delays in seeking support in males could place them at greater risk of homelessness during the early stages of psychosis and

also later in life. In part, this could be related to disruptions in acquiring functional skills and social development, found to be deficits in men with psychosis, while women have been found to be much better at developing social support networks (Gayer-Anderson and Morgan 2013; Thorup et al. 2014; Vila-Rodriguez et al. 2011). Lee et al. (2016) found that cohabiters and renters (rather than those who were unsheltered or in institutions) were significantly more likely to be women and have experienced a shorter duration of homelessness. They inferred that social support appears to protect against street homelessness and that low levels of social support may increase the risk for becoming homeless immediately after losing rented accommodation.

A related factor associated with poorer functioning, social adjustment, and social support in men are so-called negative symptoms of psychosis. 'Negative symptoms' have been found to be more severe and common in males and are a predictor of poor outcome (Malla and Payne 2005; Morgan et al. 2008; Thorup et al. 2014; Willhite et al. 2008). These blunting and lethargic aspects of presentations are commonly seen in the homeless people that we work with and can be disabling, both to functioning and recovery. They can make planning and organisation more challenging and leave people more apathetic with tasks important to sustaining tenancies, such as organising finances and maintaining adequate care of accommodation.

After a further transient period of rough sleeping, Tony was eventually accommodated in a smaller hostel, and subsequently moved into a council flat. Initially this seemed to be a positive change for him. However, it was not long after moving into his own flat, that Tony started to become increasingly unsettled and became aware of things that he'd not noticed before. He described these experiences as if seeing into "another life" or an "alternative reality". He also recalled that the images contained references to real life past events. Tony described becoming increasingly distressed and threatened by these experiences. As a result, he abandoned the flat and went back to a nomadic rough sleeping lifestyle, as this felt safer for him.

He started to avoid contact with other people, who he was becoming increasingly suspicious of. He described feeling a general sense of fear and unease, but he also suggested that there were times when he felt a "buzz" and a sense of excitement. This seemed to be linked to the belief that he knew things that others did not and that he had some kind of "sixth sense". However, he has subsequently acknowledged that he became increasingly caught up in this alternative reality, to the extent to which he started to seriously neglect his own self-care.

Crisis Interventions of Specialist Teams

The importance and success of specialist community multidisciplinary mental health street outreach teams has been noted, particularly in re-housing entrenched rough sleepers with severe and enduring mental health problems (St Mungo's 2016a). As well as MDT engagement, social and psychological interventions, inpatient treatment can also be an important or sometimes essential intervention. This is particularly the case for those presenting with psychosis and may also be an important step towards more permanent accommodation. For example, Lettner et al. (2016) found that 74% of hospitalised clients with psychosis were subsequently housed, compared to 13% who were not admitted. As well as improvements in accommodation status, Timms and Perry (2016) found that previously homeless patients had positive outcomes in engagement with their clinical team and registration with a GP following compulsory admission from the street.

Street Mental Health Act Assessments pose many practical as well as ethical issues (Timms and Perry 2016). Admitting people to hospital wards against their will is clearly an extremely difficult decision for any mental health professional and has definitely felt very uncomfortable for us personally and professionally. These have often been decisions made out of extreme situations, where people have been at real risk of death and where people are not in a capable position to look after themselves safely, e.g. sleeping on the streets in winter months when temperatures will drop to below freezing.

There are also situations of more chronic homelessness, where we as psychologists have supported admissions to hospital. This has been on the grounds of enabling re-housing and giving people a better chance of recovery and a new life. While there are discourses of 'lifestyle choices' describing persistent homelessness in the UK, the conscious choice to isolate oneself and live among the risks and squalor of the streets is an anomaly (Seager 2015).

> Tony eventually came to the attention of services when staff at a homeless day centre became seriously concerned about his physical and mental health. Staff noticed that he was dangerously underweight and extremely guarded and suspicious of those around him.
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> By having close working relationships with the local homeless day centres and street outreach teams, who provide invaluable support to members of the homeless community, START were able to respond to the concerns raised. This initially involved a mental health outreach worker from the team, visiting the day centre that Tony had sporadically started using. There was a need to

approach this assessment with caution, due to fears that he may abandon using the day centre and be lost to all services. Therefore, initial contact with Tony, involved attempts to engage him in informal conversation, often with support from staff at the day centre.

It quickly became clear that he was unwilling to accept any form of support and seemed unable to recognise any of the risks that others were highlighting. This prompted a formal mental health assessment to be arranged, which resulted in Tony being admitted to a psychiatric ward for further assessment and treatment. Tony recalled this as being a surreal experience, which at the time, he understood as him being singled out because of what he knew.

While on the ward, Tony was given a diagnosis of 'paranoid schizophrenia' and was treated with antipsychotic medication. Tony remains unsure about this interpretation of his difficulties and felt that the medication he was initially prescribed made little difference. However, he acknowledged that he felt physically stronger after six weeks in hospital. He was discharged into supported accommodation, where he continued to remain under the care of the START team. More recently Tony has spoken about the value of continuity and consistency in his care. He recognised that at that time he found it extremely difficult to trust people, through regular contact with the same worker in hospital and after discharge, Tony was able to overcome this to an extent.

Gender Differences in Relapse of Psychosis and Substance Use

Despite intervening with hospital treatment, it is common for people to again lose accommodation and return to rough sleeping. Zammichieli (1997) followed up 110 previously homeless people post-discharge for six months and found that 29% of the sample became homeless at some point during the follow-up period, whereas 5.5% were chronically homeless. Overall, it was found that more males became homeless than females and that homelessness was related to not engaging with treatment.

Other research has similarly found that men are more prone to relapse in psychosis (Haro et al. 2008 and Ochoa et al. 2012). This has been explained by findings that men are less likely to seek support, to not take medication as prescribed, and to not engage with therapies offered (Galdas et al. 2005; Thorup et al. 2014). Refusing medication has been found to be associated with homelessness in men but not women (Opler et al. 2001).

Substance use is also associated with relapse in psychosis (Blanchard et al. 2000; Gregg et al. 2007), and 'substance use disorders' have been described

as 'consistently the most prevalent mental health diagnosis amongst homeless populations in Western countries' (Burns and Whittaker 2015). Substance misuse is much more common in men (Brown et al. 2011; Hambrecht and Häfner 2000; Ochoa et al. 2012), and homeless men have higher rates of alcohol and 'substance use disorders', including more risky use (Linn et al. 2005).

Opler et al. (2001) found that substance misuse amongst homeless women was even lower than among men that had never been homeless. Not only is substance misuse much more prevalent in men presenting with psychosis but they are also less likely to engage with treatment and display less motivation and readiness to make changes (Brown et al. 2011).

As well as substance use triggering relapse, we frequently see people who become street homeless related to substance misuse and addiction as problems in their own right. People will often fall behind in service charge payments or get into significant debts to dealers. Tenancies are lost due to people not staying at accommodation (e.g. frequent use elsewhere or prison sentences) or due to breaches of tenancies (e.g. challenging or problematic behaviours related to their own substance use or that of their guests). Sometimes people are in vulnerable positions and can be exploited by others (e.g. properties being taken over and turned into 'crack houses').

After living in supported accommodation for approximately six months, Tony was moved to a flat in a different London borough; where he was encouraged to manage more independently with floating support. However, Tony described finding this transition very difficult as he was suddenly expected to take responsibility for a wide range of tasks, many of which he had no real experience of. Due to the change in his address, his mental health care was also transferred to a local CMHT, as he was no longer living in one of the boroughs that START was commissioned to work with. This meant that he was assigned a new worker, who was only able to visit him once every two to three weeks. Shortly after the move, Tony recalled gradually stopping taking his medication, as he didn't feel it was helping. He also started to smoke cannabis again to cope with the stresses of his new situation. He spoke about becoming increasingly aware of the same unusual experiences, he had described previously.

In the end, Tony's change in circumstances and the changes in his mental state prompted him to decide to leave the flat and he returned to sleeping rough and squatting. He had limited memories of this time in his life, and was surprised to hear that several months passed before his most recent contact with services. More recently, Tony has come to understand that this was because he was caught up in the beliefs and experiences previously described.

Specialist Homeless Mental Health Outreach Teams

Specialist assertive outreach teams have been found to improve engagement with complex client groups (O'Brien et al. 2009). With the homeless population, assertive community interventions have been found to shift crisis-oriented care to ongoing outpatient care, with better outcomes in housing, mental health, and life satisfaction (Lehman et al. 1997).

But community mental health services are under huge pressures (Gilburt 2015), and assertive outreach teams are now a rarity (Firn et al. 2013). Despite the positive outcomes of the specialist homeless outreach teams developed through the Rough Sleepers and Homeless Mentally Ill initiatives of the early 1990's, such services have been heavily cut or disappeared altogether (Anderson 2007; St Mungo's 2016a; Timms and Taylor 2015).

Not only are specialist outreach teams (such as START) able to provide the assertive outreach and street assessment skills to engage entrenched rough sleepers; they also have specialist knowledge of housing and hold long-standing links with other key homeless service providers.

START have worked for many years with the independent and invaluable local day centres (Ace of Clubs; Manna; Spires, and Webber St), as well as with the tireless street outreach teams (of St Mungo's). This partnership working enables us to help many more people than would ordinarily be possible. This is partly because a significant number of homeless people are wary of statutory services and those perceived to be in authority (Marshall and Bhugra 1996; Timms 1996), perhaps unsurprisingly given people's histories of abuse and mistreatment by people in positions of power.

Smaller, independent services and initiatives have greater flexibility, can adapt to the local needs of a population, and sometimes offer more appealing practical interventions (Bunce 2000). A good example is the fantastic work achieved by Caris Boxing Club, which engages homeless people through the camaraderie of the 'sweet science' of boxing. Young men, especially, are more likely to want to connect with others from their community in a positive and less pathologising or stigmatising environment. This is particularly pertinent considering recent findings that possessing a sense of social identity is associated with improved self-esteem and reduced paranoia and low mood (McIntyre et al. 2017).

True therapeutic interventions for the homeless have been described as mirroring good parenting, providing an attachment and emotional involvement over time (Seager 2015). In order to provide the necessary regular

and close contact to complex and often chaotic homeless groups, there has been the development of a new model of therapeutic community, termed 'Psychologically Informed Environments', or PIE (Johnson and Haigh 2011). Williamson and Taylor (2015) describe how 'living alongside' residents enabled greater depth of understanding and gradual engagement of a man who would not ordinarily link with a therapist. Where such resources are not in place, START have provided the indirect psychological component of a 'PIE' to support teams in making sense of people's presentations and think about ways to help sustain tenancies or plan transitions.

After Tony abandoned his flat, the local CMHT notified START who in turn notified the day centres and outreach teams. He was eventually spotted rough sleeping by street outreach services, who notified START immediately. This prompted a further assessment visit (at his sleep site) by his previous worker. On assessment, Tony was found to be extremely malnourished and it was clear that he'd severely neglected his self-care. Once again, he was guarded and unable to recognise any of the concerns that others were highlighting. Another Mental Health Act Assessment was deemed necessary because Tony was unwilling to accept any help and was clearly in a very poor state of physical health. Although Tony was admitted to hospital under section, he recalled this experience as being "confusing" rather than overly distressing. He has also subsequently suggested that having a familiar worker with him throughout made the process much less distressing for him.

After a period on the ward, where he received treatment in the form of medication and regular visits from his named worker, Tony's physical health improved significantly and he became much less preoccupied by his thoughts. START were able to reflect on their previous work with Tony and consider what changes may need to be made to reduce the risk of relapse and/or abandonment. Ultimately, this led to Tony being offered a longer supported accommodation placement in a local borough, which meant that START were able to continue to support him (alongside staff at the accommodation) throughout this time.

As well as meeting with Tony, his worker also regularly met with Tony's assigned key worker at the accommodation, to help support her in working with him. This led to significant improvements in Tony's ability to manage a wide range of new skills (e.g. money management, computer skills). Over time Tony was also supported in identifying specific interests/activities that he could be supported in pursuing (e.g. photography). Alongside this support, Tony also engaged in weekly psychology sessions, which were aimed at helping him develop a more complete understanding/formulation of some of his experiences/difficulties, as it was felt that this was an important part of minimising future risks.

Role of Psychology Within START and Tony's Care

Psychology has featured as part of START for over 10 years. The approach, of course, needs to be more flexible to that of traditional psychology services, with the model mirroring that of the team assertive outreach approach (Timms and Taylor 2015). As well as offering longer-term therapy, psychology plays a role in early assessment and formulation of new rough sleepers, as well as shorter pieces of work if it is agreed that people require briefer interventions from the team. Meetings are offered in locations that people are most likely to engage and can be more informal in style and model, often with longer periods of engagement. Sometimes one-to-one therapy is not possible or appropriate, so joint or indirect working is considered, with provision of supervision, consultation, or training offered to the team and partner agencies.

> Through the psychology work, Tony began to develop an understanding of the relationship that often exists between a person's early life experiences and the ways they learn to cope or manage with difficulties. This allowed him to consider the possibility that he may have become more attuned to threat than others, as a result of the challenging early life experiences he described (i.e. living under the perceived threat of abuse). Specifically, this seemed to account for Tony's experience of having some sort of "sixth sense" or heightened awareness. While he continued to believe that a heightened awareness could be a positive thing, he also realised that it could be problematic. In relation to this, Tony recognised that there were times when he felt so "tuned into" or preoccupied by the potential for there to be something going on, that he ended up losing touch with reality. He also recognised that these instances of losing touch with reality seemed to coincide with him neglecting his physical health. Therefore, Tony felt that being too tuned-in could potentially be very risky. He also came to understand that a heightened sense of awareness had the potential to increase the chances of him misinterpreting events or attaching too much significance to them.
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> Tony came to recognise that his avoidance of people and sense of threat from others could be understood as a normal response to his early abusive environment (i.e. for good reason, he learned to be more vigilant and cautious around others). This prompted Tony to suggest that, from his late teens, he had always viewed life from a slightly different perspective. This is what he came to describe as a state of hyper awareness or a sixth sense, whereby he would often notice things that others may not have been aware of. Ultimately, this helped Tony to realise that living a more nomadic lifestyle, his use of

substances, and his aggressive tendencies may have become important ways of managing that heightened awareness or sense of threat, because it provided him with a means of escape and sense of control.

Through psychology work, Tony was also encouraged to reflect on some of the changes that had resulted from his contact with services. This led to him recognising that his decision to continue to take medication is the result of, what he described as, a trade-off. Specifically, he recognised that medication had definitely helped him to feel more relaxed and able to focus on the present. However, he also felt that it could sometimes feel a little strong and contribute to him experiencing a loss of clarity of thought. Based on this, he suggested that the correct dose is very important. Too little and he is prone to getting caught up in an alternative reality and become more fixated that there is something else going on. Too much and he experienced a loss of clarity of thought, which he found frustrating and would therefore be less likely to take as prescribed. This helped to create more of an open dialogue around Tony's medical treatment, which led to him feeling more actively involved/in control of his medical care.

Tony also came to recognise the importance of taking things at a steady and manageable pace. He revealed that, in the past, it had sometimes felt like he had been too led by services to achieve certain goals or attend to certain tasks. He also felt that this may have contributed to him disengaging from past support (i.e. stopping medication and abandoning his accommodation). Therefore, maintaining an appropriate pace, whereby he felt in control of things, didn't feel too pressured, and still had opportunities to experience a sense of freedom/independence, became important guiding principles of his on-going care.

Migration, Gender, and Homelessness

Although not relevant to the case of Tony, when understanding current rough sleeping trends in the UK, it is important not to overlook the impact of immigration. Within London, it is estimated that nearly 60% of rough sleepers are non-UK citizens (Department for Communities and Local Government 2016).

Shifting changes of nationality within the rough sleeping population appear associated with the expansion of the European Union from 2004. While rough sleeping has significantly increased generally in this time period, the numbers of Eastern European people sleeping on the streets have increased at an even more alarming rate, 77% compared to 23% over the same time period of 2011–2015 (St Mungo's or CHAIN).

Movement to the UK, following accession, is understood to have been driven by work opportunities, with fewer restrictions than in other EU countries (Lemos and Portes 2008). As well as those travelling voluntarily as part of economic migration, there are also concerning numbers of people who become homeless following being trafficked for forced labour (Homeless Link 2016). When men are unable to obtain work and find themselves on the margins of society, there can be additional burden from 'gender role discrepancy', where the social and internalised gender stereotypes of being a 'provider' is a mismatch with their position of poverty (Schindler and Coley 2007). This may be further exaggerated by certain cultural expectations; we have worked with some men who avoid returning to their native country or seeking support from family for feelings of guilt and shame of 'failure'.

It may be assumed that migration by men is much higher than women; however, this is not necessarily the case and distribution of migration by gender is a more complex topic (Jolly and Reeves 2005). This can be seen by looking at the breakdown of people arriving from the A8 countries. Perhaps surprisingly, in the year of Accession (2004) there was actually a lower proportion of male immigration. Males constituted an estimated 44% of inflows of A8 citizens (Gillingham 2010).

However, from the statistics available it is evident that there has been more immigration of Eastern European men than women. Of the A8 countries, there have been a higher proportion of males arriving since 2005 (International Passenger Survey 2005–2015). And with the A2 countries (Bulgaria and Romania), the gender split is more pronounced, with an estimated 69% of these arrivals being men in 2015 and 77% the year after accession. In comparison with total immigration (estimated to be 50.5%, IPS 2015), this gender divide is notably higher.

It is of importance that there is gender imbalance within these two migratory groups, as rapid increase of rough sleeping has also been seen. It is now estimated that Romanians make up approximately 20% of all rough sleepers in London (CHAIN). Though there is no known research into why high numbers are becoming homeless from this group, challenges arise managing such a rapid increase in homeless people from outside of the UK. There are firstly less statutory responsibilities to house people, meaning access to accommodation is much harder. The financial inequalities between the countries also mean that earning money can be a greater priority than having a roof over one's head, as there are reports of people turning down accommodation in order to avoid paying rent (St Mungo's 2016b). There are also noted cultural differences in the way that people seek help, for instance

a greater reliance on emergency services rather than accessing primary or secondary care (e.g. Health Protection Agency and Partners 2010).

Migrants can end up trapped in positions of limbo where they are not able to legally work or remain in the country but are afraid or unable to return to their home country, where they may be at serious risk or will be placed in an even worse state of destitution in their country of origin (Mostowska 2014).

Stringent measures have been introduced to reduce numbers seeking asylum and deal with those over-staying unlawfully (Steel et al. 2006). The 2017 BBC Panorama programme 'Undercover: Britain's Immigration Secrets' highlighted some of the horrific treatment that exists within UK detention centres. Related research suggests that both prolonged detention and temporary protection contribute substantially to the risk of ongoing depression, PTSD and mental health-related disability in refugees (Steel et al. 2006). If there are no other housing and support systems available for foreign people under our care, we would try to 'repatriate' them via schemes such as 'Routes Home' (St Mungo's), which help people to travel back to their country of origin in less traumatic ways.

Final Reflections

Throughout this chapter, we have touched on some of the key factors at the root of entrenched rough sleeping and also the reasons for the disparity of gender in this marginalised group. Topics have included: the role of trauma and different ways of managing the associated long-term distress; the impact of psychosis on engagement with support and ability to maintain tenancies; how crises of mental health can cause wider social breakdowns; and some of the issues of migration that leave men particularly vulnerable to homelessness.

As male clinical psychologists, we are a minority working within the profession, but perhaps less so within the wider workforce of those supporting the homeless. It is not particularly the case that we were attracted to working with or alongside other men. However, being able to offer a service to those who are at the fringes of society and those less likely to have the opportunity of psychological therapy was definitely a factor in our choice of clinical role.

Specialist services for rough sleepers are essential to the safeguarding of a sadly ever increasing group. However, it is the role of clinicians from all services to ensure that the people who depend on our care are not placed

in even more vulnerable positions of becoming homeless. This includes us making responsible clinical decisions around discharge and after-care, ensuring that social and support needs are met, as well advocating at appropriate levels the needs of those that are in such crisis.

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Mentalizing and Men's Mental Health: Helping Men to Keep Mind in Mind in Clinical Settings

Helena Crockford and Marco Pellegrini

Introduction

The ways that masculinities influence the presentation of psychological distress have been well-summarised in previous chapters. In this chapter, we explore what contribution research into mentalization, and its use in treatment, offer in addressing the particular challenges apparent for men's mental well-being.

Summary of Mentalization

Mentalization is a neurodevelopmentally acquired ability to think about intentional mental states—thoughts, feelings, desires, beliefs, hopes—in oneself and other people and is key to the interpretation of behaviour. It plays a central role in the regulation of affect, managing interpersonal relationships, and the development of a coherent sense of self (Fonagy et al. 2002). It develops initially within the context of early attachment relationships. A young child learns to mentalize robustly because he/she was mentalized in turn by an attuned, responsive caregiver. More parental mentalizing,

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or mind-mindedness, has been linked with secure attachment in childhood. Secure attachment is associated with a range of indices of adjustment, such as resilience under stress, ability to recruit support, and a creative response to adversity (Luyten et al. 2012). Insecure attachment, on the other hand, has been associated with behavioural difficulties, poorer peer relationships, and later adult mental health difficulties (e.g. Allen et al. 2008).

An increasing evidence base suggests that mentalizing comprises a range of processes and is therefore formulated as a multi-dimensional concept. These seem to be underpinned by distinct neurobiological pathways, described as the 'mentalizing network' (e.g. Frith and Frith 2003) or 'social brain'.

Mentalization is being widely researched and evaluated, across the fields of child development, neuroscience, evolutionary psychology, and in the treatment of a range of mental health problems. It has been proposed as a core effective ingredient in any psychological therapy and possibly 'the most fundamental common factor among psychotherapeutic treatments' (Allen et al. 2008).

In this chapter, we summarise the evidence base as it pertains to gender differences and men's mental health in particular. A range of overlapping ideas have been conceptually linked to mentalization in the literature, including theory of mind, empathy, and social cognition, and these will also be referenced where relevant. We then describe the treatment applications in areas where the prevalence rate is higher for men and offer suggestions for use of the mentalizing stance (Bateman and Fonagy 2016) to address the difficulties for men in seeking timely access to treatment.

Gender Differences in Attachment Patterns and Development of Mentalizing Skills

The literature on gender differences in the development of childhood attachment, mentalizing, and related concepts is summarised below. Gender differences in prevalence of childhood problems have been widely identified. Boys present on average with more 'externalising' problems, such as aggression and conduct disorder, while girls present with more 'internalising' difficulties, such as mood and anxiety problems.

As young as 12 months old, baby girls and boys show differences in their sensitivity to internal and external cues (Watson et al. 2011); boys appear less sensitive than girls to internal stimulation. This is consistent with findings of an 'interiority bias' for women over men—an attentional orientation to internal states that may help females be more socially aware (e.g. Bloise and Johnson 2007).

Gender-related differences have been noted in the development of theory of mind (ToM). Walker (2005) described sex differences in ToM in children aged 3–5, with girls performing better than boys on false-belief tasks. Devine and Hughes (2013) studied 8–13 year olds. Gender contrasts were found on tests of ToM, with performance improving with age, but girls out-performing boys, even when verbal ability was controlled for. This latter point is important as girls' verbal ability tends on average to be ahead of boys at the same age. They cited Maccoby's (1990) work on friendship styles in middle childhood and adolescence. Gender differences were described, with boys more likely to socialise in larger, less intimate, groups, while girls showed closer relationships with a smaller number of friends. They suggested that girls may have more opportunities to practise and refine ToM and mentalizing skills, through turn-taking in conversation, expressions of agreement, and acknowledging other points of view. Boys' social experiences on the other hand may instead promote the development of spatial skills.

David and Lyons-Ruth (2005) summarised the literature on gender differences in attachment responses in early childhood. They noted that gender differences have not usually been identified in secure attachment. However, significantly, when there are threats, and insecure attachment is apparent, boys are more likely than girls to show behaviours consistent with a 'disorganised' pattern of attachment. For example, 4-year-old boys who were insecurely attached were more likely to show attention-seeking, disruptive, and aggressive behaviours with peers than insecurely attached girls, or securely attached boys (Turner 1991). They suggested substantial literature indicates that boys are more likely than girls to exhibit behaviour problems in response to stress. Insecurely attached girls by contrast show more compliance, dependence, and affiliative behaviours.

Their own study of mother-infant pairs tended to support this finding. There were gender differences in infants' responses to frightening maternal behaviour. Boys showed more 'disorganised' attachment behaviours, and the less adequate the mother's response, the more likely the boys were to show overt conflict behaviours. In contrast, girls tended to approach their mothers more.

A number of studies link such gender differences to an evolutionary hypothesis. Taylor et al. (2000) proposed that males and females behavioural responses to fear and threat differ. While men and women share the same 'fight-or-flight' response at the physiological level, they may differ in their behavioural expression of this. Specifically, males are thought to show more visible, action-oriented, fight-or-flight behaviours, depending on the nature of the stressor. Females on the other hand show more 'tend-and-befriend', social-affiliative behaviours in response to stress. 'Tending' behaviours refer

to the nurturing of offspring, while 'befriending' refers to the active building and maintenance of social relationships as a way to deal more effectively with the stressor.

In adolescence, gender differences in mentalization were explored by Rutherford et al. (2012). Fourteen to eighteen year olds completed two measures of implicit and explicit mentalizing. Implicit mentalizing is a more automatic process, requiring less cognitive effort, and less of a verbal component; explicit mentalizing is a more effortful activity, involving greater cognitive control, and a greater verbal component (Fonagy et al. 2012). Distinct neurobiological circuits underpin each of these functions, with more subcortical and cortical processes involved in the former and predominantly cortical networks underpinning the latter. Results suggested that girls scored more highly on both kinds of mentalizing than boys. The authors proposed an evolutionary perspective, consistent with the 'tend-and-befriend' hypothesis, where girls may have more 'intrinsic motivation to understand the mental states of others', and hence develop this ability earlier than boys.

An interesting finding for boys was a closer relationship between language and explicit mentalizing, suggesting that for boys, language ability may be a more important mediator for making sense of mental states. It is possible to conceive a link with the findings of David and Lyons-Ruth (2005), above. If fewer behavioural differences are noted between boys and girls within a secure attachment relationship, this may have provided the context for the development of language for mental states, which in turn provided the scaffolding needed for boys to mentalize robustly.

Weimer et al. (2017) described the development of a related concept, 'constructivist theory of mind'. This relates to understanding 'the nature of mental processes', for example that people can easily misinterpret mental states. No sex differences were apparent in a mixed-age sample of 8–15 year olds. However in a larger sample of 14–15 year olds, boys performed less well than girls, even when academic performance was taken into account. Importantly, lower scores on this task linked to poorer prosocial reasoning about conflict, and more serious behaviour problems in school. Again, this suggests a mediational mechanism, where differences in the ability to mentalize may contribute to the gender differences in behaviour.

In terms of brain development, Mills et al. (2014) examined brain scans in children and young people aged between 7 and 30, specifically in relation to brain regions associated with mentalizing and the 'social brain'. Some gender differences were identified in brain structure. Sex differences have previously been described in the changes of white and grey matter volume—in the frontal and parietal lobes, grey matter volume increased in both sexes

pre-adolescence and decreased again post-adolescence (Giedd 2004). A gender difference in the time this volume peaked, in particular in the temporo-parietal junction, was identified in the current study, occurring earlier in girls than boys. This brain region is described as 'activated specifically in situations when one is inferring the mental states of others' and is part of the 'mentalizing network' (Frith and Frith 2003: 5). Mills et al. hypothesised that these brain differences could be related to the gender differences in language and mentalizing abilities, however, did not directly examine connections with social cognitive functioning.

Gender Differences in Adult Mentalizing

With regard to adults, women performed better than men in the general population on a measure of empathy (Baron-Cohen and Wheelwright 2004). A further study by Baron-Cohen et al. (2015) confirmed findings that women perform better than men on a test of theory of mind, the Reading the Mind in the Eyes Test.

Proverbio (2017) used neuroimaging to study face processing, an aspect of social cognition. Results suggested a gender difference with females showing more responsiveness to face stimuli than males. They suggested this supported other findings that women show a greater empathic attitude and more interest in social information than men.

The effects of psychosocial stress on social cognition were examined by Smeets et al. (2009). Men and women appeared to differ in the impact stress had on their ability to interpret mental states. In men who had a higher cortisol response to stress, social cognition seemed to improve, relative to men with a lower cortisol response, or controls. Women on the other hand showed better performance with a low cortisol stress response, rather than a high, or non-stress condition. The authors concluded this lent support to the Taylor et al. (2000) hypothesis of gender-typical behavioural responses to stress.

The impact of stress on another aspect of social cognition, the ability to distinguish self- from other-related mental representations, was explored by Tomova et al. (2014). This 'self-other distinction' is important because it contributes to flexibly regulated interactions, helps to maintain the boundaries between one's own and another's emotions, and is crucial in perspective-taking. By contrast, a self-centred response reduces both the capacity for empathy and the use of prosocial behaviours. The study compared males' and females' responses, initially hypothesising that increased psychosocial

stress would generally reduce the ability to make self-other distinctions. Groups were matched for socio-cognitive abilities, and interestingly, no gender differences were found in physiological responses to stress, or subjective stress ratings. However, men and women did differ in their responses to tasks under stress vs control conditions. Women became better at making 'self-other distinctions' under stress, whereas men showed an increase in 'emotional egocentricity', taking longer to distinguish their own from another's perspective. This was seen as evidence for the protective 'fight-or-flight' stress response and as lending support to the 'tend and befriend' hypothesis. The authors concluded that 'men respond to stress by defaulting to less resource demanding and more automatic processing strategies. As representing the feelings and intentions of others is resource demanding, they display a fall back towards more self-related or <egocentric> processes, when having to judge emotions or the perspective of others' (p. 101).

In mentalizing terms, this can be conceived of as a quicker resort to 'non-mentalizing modes' of functioning for men under stress. These modes are described more fully below. The cognitive-behavioural framework for understanding male responses to distress, proposed by Kingerlee (2012), echoes these ideas, describing a 'reflection abandonment mechanism' which serves to 'propel the man *away* from further reflection on his psychological condition…and *towards* one or more recognised male externalizing behaviours' (p. 9). Mentalizing theory encapsulates a similar notion that under stress, reflection on mental states is easily lost to more primitive modes of functioning.

A core component of mentalizing theory is its function in regulating emotions. Fonagy and colleagues (e.g. Fonagy et al. 2002) have described the process whereby in the early caregiver relationship, the child acquires labels and a second-order representation of primary emotional states, because the caregiver provides a 'marked and contingent' response to the child enabling them to make sense of their experience. They described this process leading to 'mentalized affectivity'.

Lecours and Bouchard (1997) delineated a number of steps in this process. Firstly, affect tolerance is required. This brings in delay before an emotion is expressed in action, increases control over how it is enacted and increases distance and objectivity towards the emotion. Secondly, there is cognitive processing, which transforms the sense of the emotion from bodily signs and symptoms to a subjective experience existing in the 'mental' sphere. They proposed a hierarchy of increased elaboration of expression, and alongside this suggested that emotions can be expressed through a range of modalities, from somatic, through behaviour, to verbal expression.

They used this framework to explore the ways that men and women express emotions (Lecours et al. 2017). Summarising previous research, they concluded men are less likely to express a wide range of emotions in words. Their own study analysed interview transcripts of men and women attending a psychotherapy assessment. They explored two hypotheses—whether women used the 'verbal modality' and owned their affects more than men, and whether men used more externalising methods to express their emotions. The results tended to support these proposals. Men appeared to 'mentally externalize' more (where '…an affect is explicitly recognized but is not yet completely tolerated as one's own. It is either mentally externalized and perceived as if caused by some external event or agency, or disowned and generalized to a group of people'). Men also used the motor modality of expression more often than women ('Motor expression involves the description of behaviour…', Lecours et al. 2017, p. 231). They suggested this lent support to the view that women are more apt at mentalizing affects than men.

In summary, previous findings more often than not suggest that gender differences may exist in mentalizing and related concepts such as ToM and empathy, with men seeming to have more difficulties in this area than women. Some researchers have offered an evolutionary explanation for this, while others have theorised a biopsychosocial framework (Kingerlee 2012). There is the implication that mentalizing is an important mechanism underpinning, and helping explain, the differing behavioural expressions of distress between men and women. In the next section, we draw links between these areas of mental health, mentalizing formulations, and interventions.

Mentalizing Approaches to Male-Specific Mental Health Problems

The mentalizing literature has addressed violent behaviour and antisocial personality disorder (ASPD), as well as alexithymia, compulsive sexual behaviour (CSB), and functional somatic disorders (FSD). All are areas of psychological difficulty more prevalent amongst men.

As described elsewhere, male psychological distress is more likely to be indirectly expressed, to go unreported and result in less help-seeking behaviour than in females (Morison et al. 2014). Externalising behaviour is more common amongst men and has been understood as a manifestation of distress (Lohan 2007). Men have higher rates of suicide (Kingerlee et al. 2014) and are more likely to perpetrate purposeful injury and to be its victims than women (Logan et al. 2008). In England and Wales, men produced

around 80% of antisocial behaviour (UK Government 2012) and have higher rates of incarceration (Wilkins 2010). Additionally, as reported by Haggett (2014) men are more likely to exhibit psychological distress by presenting with somatic complaints. Men also represent the majority of those with major addiction problems (Health and Social Care Information Centre 2012), including sexual addiction (Kuzma and Black 2008).

Formulating Mental Health Issues with Mentalization-Based Applications

Mentalizing is an ability that can be temporarily sent 'offline' by normal life events, such as stress, fatigue, or threat. The more primitive areas of the brain (involved in survival responses fight/flight/freeze) then come into play, as well as the attachment system. When insecure attachment patterns are present, this disruption of mentalizing can occur more rapidly and frequently and can impact on how quickly and effectively mentalizing is restored.

When mentalization goes offline, *prementalizing modes* of functioning emerge. These are understood as developmentally preceding mentalization (Bateman and Fonagy 2016).

1. *Psychic equivalence* corresponds to a thinking style where the mental state is no longer a possible representation or a tentative way to look at the reality but becomes the reality itself (Allen et al. 2008), often attributing to others thoughts and feelings with certainty, rigidity, and inflexibility. For instance, a man admitted to secure services might become fixated on the Ministry of Justice (MOJ) not granting leave as a way to punish them, rather than considering the backlogs public services often have.
2. *Teleological mode* is characterised by a thinking style focused on tangible and visible changes, and 'quick fix' actions to resolve mental states, rather than considering what might be happening in the mind of the person. For instance, it is not infrequent for men in an inpatient unit to make pressing demands for changes in medication to support their negative emotional states even when the multi-disciplinary team encourages them to explore these issues psychologically.
3. Finally, *pretend mode* involves a decoupling and disconnection of thoughts and feelings from the present experience. Conversations with an individual in pretend mode can be felt as inconsequential, boring, repetitive, or missing something undefinable, like the presence of the proverbial

'elephant in the room'. This mode can also lead to externalising behaviours, sometimes dangerously, because thoughts and feelings are decoupled from consequences, as if it was not real or happening in a film. In a recent supervision with a psychologist working on a male ward, we reflected on how the patient and staff were perceiving her attempts to provide therapy for a man with delusions, in order for him to be able to socialise more, as 'unhelpful' since the patient did not cause 'any management problems'. Staff and patient both seemed in pretend mode, avoiding thinking about whether living in a hospital bedroom and avoiding triggers for his delusions, really constituted 'wellbeing' for this patient.

In formulating mentalizing problems, consideration of the dimensions is also important. As described earlier, mentalizing is conceived as multidimensional, with distinct, if overlapping, neurobiological pathways underpinning these.

1. Mentalizing can be *automatic/implicit* versus *explicit/controlled* as described earlier, with the former being more preconscious, and the latter more effortful, controlled and overt.
2. Mentalizing also requires the ability to shift between an *internal* focus (thoughts, feelings, desires, beliefs, etc.) and *external* features (tone of voice, posture and actions), both in oneself and other people. For instance, as a result of traumatic experiences, individuals may become hyperalert to 'external' clues to interpret human behaviour, but struggle to make sense of their 'internal' experience. They may infer their own mental states from their behaviour (e.g. 'I got drunk, so I must be stressed') or misattribute the behaviour of others (e.g. 'You slammed the door so you must be angry with me').
3. The third dimension is between a focus on the *self* versus the *other*. Individuals with insecure attachment might find it harder to shift from focusing almost exclusively on themselves or others therefore missing the opportunity to accurately understand how mental states mutually interact to determine behaviours. Individuals with ASPD, for instance, can be surprisingly skilled at reading other people's mental states (Dolan and Fullam 2004) but can fail at reading their own internal experience.
4. The fourth dimension is between *cognition* and *affect*. Cognitive mentalizing reflects the ability to reason, name, and think about mental states. Affective mentalizing refers to understanding the feeling associated with the mental states, which fosters empathy (Bateman and Fonagy 2016). Individuals with ASPD can be skewed towards the cognitive dimension

of mentalizing, failing to understand the affective implications of their actions on themselves and others, and therefore acting callously and appearing unempathic.

Mentalization-based therapy (MBT) aims to develop more robust mentalizing, by helping to bring mentalizing back on line when pre-mentalizing modes are present and promoting balance and flexibility across the dimensions. This allows a more accurate understanding of mental states in oneself and others, helps regulate emotions, and brings a more balanced view of self and interpersonal relationships.

Aggressive Behaviour, Violence, and Antisocial Personality Disorder (ASPD)

The victims of most severe violence are related to the perpetrator by attachment relationships (Smith et al. 2010). The activation of neural systems associated with attachment lowers the ability to mentalize, and in turn low levels of mentalizing increase the risk of violence (Adshead et al. 2013). There is considerable evidence that violent offenders present with higher levels of insecure attachment compared to the general population (Bakermans-Kranenburg and van IJzendoorn 2009).

Studies of children suggest that there may be a subgroup of boys who, from an early age, manifest callous and unempathic attitudes, and later in life display violent behaviour (Wootton et al. 1997). A neurobiological correlate of this lack of empathy is the hypo-activation of the amygdala. This may be genetic or be the result of traumatization which will tend to reduce its size. 'The amygdala is central in the recognition of fearful expressions. It is therefore linked to experiencing empathy as well as experiencing fear' (Marsh and Blair 2008). A lack of fear can prevent the infant from regularly seeking attachment figures to be mentalized to downregulate their distress. This in turn restricts the development of mentalizing skills (Bateman et al. 2013).

As a result of trauma, attachment can be disrupted by a combination of social circumstances and inadequate parenting; alternatively, a child might find themselves in the position of wishing to avoid thinking about their caregiver's mental states, which would expose them to the awareness of being thought of in a hostile way. This repeated avoidance of thinking of mental states can affect the ability to take perspectives (O'Connor 2006).

Not surprisingly, forensic populations present with higher levels of dismissing or avoidant attachment (Adshead 2004), with patterns of thinking

which deny vulnerability (Hesse 2008). This can lead to objectifying and dehumanising the other and an increased risk of perpetrating violence.

In adolescents, the failure of mentalizing can be observed not only in juvenile delinquency but in problematic behaviours such as bullying. Twemlow et al. (2005) illustrated this with the story of an 11-year-old boy who was disruptive at school as a result of emotional abuse and neglect from his mother and how the school system responded in a way that further inhibited mentalization, such as being excluded from lessons. The Peaceful Schools Experiment, modelled on mentalization theory, aimed to create a school environment which reduced the occurrence of violent behaviour. The focus was on increasing mentalization in the whole system and not just in the 'problematic boy'. The study was conducted for 3600 children across 9 elementary schools in the Midwest (USA) and found decreased peer-reported victimisation, aggression, and aggressive by-standing compared to control schools. These findings were maintained in the follow-up year (Fonagy et al. 2009). In a similar study conducted over three years, in a Jamaican school for children with previous failure in entrance examinations, the implementation of the Peaceful School Project led to the teachers feeling more comfortable in the school, a decrease of serious dangerous fights from 18 to 3 per year, reduced victimisation for boys from a reported prevalence of 70 to 30%, and decreased numbers of children carrying weapons at school from 40 to 20% (Twemlow et al. 2011).

As noted earlier, ASPD is more common in men than in women with an estimated ratio of 3:1 (Alegria et al. 2013); men also account for 80% of antisocial behaviour (UK Government 2012). ASPD is linked to increased likelihood of committing violence (Coid et al. 2006) and is a very good predictor of future violence, reconviction, re-incarceration, and recidivism rates (Wormith et al. 2007). There is growing research suggesting that men with ASPD show impairment in social cognition and the ability to link mental states to behaviour (Bateman et al. 2013). They also have difficulty recognising negative affects such as sadness, fear, anger, and disgust in facial recognition tasks (Hastings et al. 2008; Dolan and Fullam 2004). These findings are in line with deficits in the amygdala mentioned previously. Individuals with ASPD can generally perform tasks where ToM is involved but can fail in higher levels tasks involving more subtle understanding of others' intentions. Furthermore, men with ASPD have shown more impairments understanding basic emotions than men who also meet criteria for psychopathy (Dolan and Fullam 2004).

This might indicate a specific group of men who are susceptible to manifesting violence, namely those with high affectivity and impulsivity.

Typically, these men might be socially isolated, misusing substances, and showing antisocial behaviour from late childhood. When feeling overwhelmed, for instance by a perceived threat, they may fail to mentalize and violence can erupt (teleological mode, as described above).

Individuals with ASPD can become 'experts' at reading others' internal states, albeit with the motivation to manipulate them. This can be to the detriment of their own internal, and especially affective, experience. They can also lack the ability to read certain emotions accurately, as previously explained. Reading other people superficially can be problematic, leading to non-mentalizing modes. In psychic equivalence mode, there can be excessive reliance on rapidly identifying, through external and unchecked features, reasons behind a certain behaviour. For instance, a denial of a request is seen as an attempt to establish a pecking order, rather than to the difficulties inherent in the request (psychic equivalence). This is further complicated by the failure to consider the affective component of metalizing, as it makes the mind of the perpetrator blind to the full consequences for the victim of abusive or violent behaviour (e.g. 'I did not hit him that hard').

Bateman and Fonagy (2012) have illustrated how rather than being a stereotype, the image of the antisocial man with jewellery, expensive cars and surrounded by good looking women, might be an expression of their reliance on the importance of 'face' (teleological mode).

Adaptations of MBT for ASPD have taken into consideration the propensity to over-control emotions, often achieved by seeking highly hierarchically oriented relationships. Threats to the hierarchy arouse the attachment system and a sense of threat to self-esteem. This leads to psychic equivalence mode, demanding respect from and controlling others, and creating an atmosphere of fear and intimidation. Group therapy is an essential component of the treatment as the group stimulates the attachment system less intensely than individual therapy, and men with ASPD are more likely to acknowledge comments from peers with similar experiences than from a therapist (Bateman et al. 2013).

MBT-ASPD focuses on rebalancing those dimensions of mentalizing that can be more easily destabilised, for instance by focusing on understanding emotional cues and recognising emotions in other people, by exploring how the individual with ASPD can be sensitive to threats to hierarchy and authority and how that can elicit emotional responses that impair mentalizing, and finally by refining the understanding of interpersonal situations in their complexity. These aims are pursued with a combination of *mentalizing education* and *mentalizing process*. The former includes a series of introductory groups focusing on the nature of emotions, facial expressions, and other

nonverbal behaviours. Self-disclosure is encouraged in a gradual way, letting men use examples that do not trigger shame which could destabilise mentalizing. Following the psychoeducational sessions, possible difficulties engaging with the process treatment are discussed, such as feeling diminished by another group member or disliking the therapist. The second part of the treatment (process mentalizing) establishes the group leader as an 'authority', to meet the need for a clearly structured and hierarchical relationship. The leader establishes this by actively checking in with each participant at the start of the session, directing the group towards mentalizing, and interrupting non-mentalizing when it occurs. The therapist keeps the focus on affect, and the internal dimension, preventing participants from talking about others and their 'faults'. Rather than focusing on 'victim empathy', MBT-ASPD aims to improve the management of violent impulses by enhancing the curiosity and therefore the understanding of how other people came to behave the way they did (Bateman et al. 2013).

Mentalization-informed treatments have been shown to reduce violence in men with ASPD. In a high secure setting, men with a variety of severe psychopathology increased their capacity to manage negative affect, and showed improved reality-testing and perspective-taking. This followed a course of 48 mentalizing group sessions across 14 months. At 18-month follow-up enduring changes in personal relationships were noted, with sustained decreases in levels of interpersonal violence (Adshead et al. 2013). Another study delivered MBT to male patients diagnosed with ASPD, in an outpatient setting over 18 months. They showed a decrease in aggressive or violent behaviours. They also rated their aggression towards others and themselves as decreasing in severity in the first six and a half months of treatment. Dropout rates with this client group can however be a significant issue, and in this study almost half the participants did not complete the treatment (McGauley et al. 2011).

Other Applications of MBT with Male Clients

Alexithymia

The term alexithymia refers to a difficulty identifying and naming emotions, with particular reference to the distinction between bodily sensations, feelings, and how they are elaborated internally in the mind (Levant et al. 2014). Alexithymia is more common in men than women in non-clinical populations (Levant et al. 2006). Alexithymia overlaps with

the notion of impaired thinking and expression of affective states characteristic of affective mentalizing. The inability to symbolise inner experiences in language can contribute to a sense of chaos and confusion. This can be overwhelming and further impair mentalizing, setting the scene for non-mentalizing modes to emerge. Using MBT, a therapist might tentatively 'fill the room' with a language of possible feelings (Skårderud and Fonagy 2012). This explicit mentalizing on the part of the therapist is 'marked' as his own hypothesis, to avoid superimposing his mind on the client, which can result in pretend mode emerging. Psychoeducational group interventions, based on mentalization and mindfulness, showed promising outcomes relative to controls, in decreasing alexithymia characteristics (Byrne et al. 2014).

Sexual Addiction

Failures in mentalizing can also underpin sexual addiction, again more prevalent amongst men (Berry and Berry 2014). This can involve pretend mode, with retreat into a fantasy world. A man may perceive himself as powerful by identifying with pornographic actors performing sex on submissive women, or by observing a woman performing sex acts for him in front of a webcam. Underlying these 'escapes', a man might be trying to decouple himself from painful realities.

Specific protocols based on mentalization-based therapy have been recently applied to sexual addiction (Berry and Berry 2014), and these encourage men to mentalize how their behaviour may impact on, and be affected by, the thoughts and feelings of self and others.

Functional Somatic Disorders (FSD)

According to Luyten et al. (2013), FSD are more prevalent amongst men. Some authors specifically highlight how psychosomatic disorders can indicate a deficit of 'affective mentalizing' (Fonagy et al. 2002). There is consensus that increasing the ability to mentalize is a first and important step for individuals with FSD to access further psychological treatment (Gubb 2013). In a study conducted in the Netherlands, Houtveen et al. (2015) describe how an inpatient and outpatient treatment was developed for individuals with chronic FSD to help them benefit from therapies such as CBT and ACT. The programme aimed to increase 'body-related mentalization' to improve engagement with further treatments. A study involving 183

patients showed a reduction in somatic symptoms and increase in health-related quality of life. These improvements were maintained at 2-year follow-up. Beutel et al. (2008) suggest that 'multimodal' treatments, including engagement with the body, through art or body-oriented therapy, are ways to promote mentalization in individuals with FSD.

Adapting the 'Mentalizing Stance' with Men in Clinical Practice

Having described a number of applications of MBT for disorders more common in men, we conclude this chapter by discussing the 'mentalizing stance' as a valuable engagement and treatment strategy with male clients. Bateman and Fonagy (2016) describe this as the core therapeutic attitude for practitioners of MBT. It is characterised by a 'not-knowing' approach, remaining curious, and non-judgemental, and avoiding making assumptions about what is happening in the mind of the other, or oneself. Attention is focused on mental states. The aim is for a flexible balance along the dimensions of mentalizing. We have found this helpful in working with male clients. An example for males with alexithymic difficulties would be to work first on the ability to put mental states into words, before attempting higher level psychological tasks, such as making links between past and present in psychodynamic therapy, or attempting cognitive restructuring in CBT. In our experience, this has proved particularly helpful with clients difficult to engage with more traditional psychological approaches, because it develops a scaffolding for mental processes which are a pre-requisite to engaging successfully. In one case, a male army veteran engaging in trauma work would become overtaken by flashbacks and crouch down on the floor, reliving his combat experiences (psychic equivalence). His early history suggested a non-mentalizing family culture, with an absence of talking about emotions. He identified not knowing how to describe his feelings. Working on developing a language for his emotions generally helped provide a scaffolding for trauma work which could then proceed more effectively.

The mentalizing stance is a less hierarchical approach, with the therapist taking a 'not-knowing stance', 'being ordinarily human', and acknowledging their part in any ruptures or mistakes. This may be helpful in addressing the issues of power, status, or 'loss of face' which may present barriers to men seeking help (e.g. Kingerlee 2012). In the following clinical vignette, an example of how the mentalizing stance can restore meaningful therapeutic interaction for a man with ASPD is illustrated.

Clinical Vignette: Albert

Albert was treated in a secure psychiatric unit. He had engaged fairly well with the individual therapist (MP) over four months, in a mentalization-based intervention, aimed at issues in the here and now, especially interpersonal difficulties.

An obstacle arose when Albert increasingly made derogatory comments, albeit with some humour, about MP's use of English (English was his second language). MP noted angry feelings towards Albert, fantasised about not seeing him and felt anticipatory anxiety at being on the receiving end of his comments. Despite the temptation to enforce the service policy on racial abuse and discrimination (teleological mode), MP tried to maintain a mentalizing stance to address the impasse. He shared with Albert what he was experiencing. He explained openly how humiliating it felt to be corrected when speaking. He said the way he was feeling was impacting on his ability to think with openness and curiosity about Albert. Albert responded positively to this disclosure and told MP he felt 'really gutted'. MP felt understood and warmer towards Albert. The therapeutic relationship with Albert flourished after this and the therapy was mutually seen as successful when it ended. In a follow-up session, Albert explained that when MP disclosed how he felt, he perceived him as 'human', and this helped to feel a connection with him. This episode illustrates how, after an interpersonal rupture in the therapeutic alliance has occurred, the mentalizing stance can help both the therapist and the client regain mentalizing, and restore engagement. In relation to ASPD, it also illustrates how it helped Albert regain his affective mentalizing of the other, who again became a human being affected by Albert's behaviour, rather than a hostile presence needing to be controlled.

To conclude with a final point, we note the relative flexibility of mentalizing approaches. While there are structured forms of MBT, it has been used in other kinds of interaction with a therapeutic purpose, which could help address the accessibility gap for men engaging with help. Williams et al. (2014) described how psychiatric in-patient staff prefer to work on male rather than female wards. They suggested male patients are less active in seeking staff contact, which places less demand on hard-pressed staff, who 'collude' with the males' lack of psychological engagement. The Star Wards project produced guidance for in-patient staff in psychiatric and acute hospitals, based on mentalization principles. This offered ways to enhance the quality of brief day-to-day interactions with clients, or carers, in a range of health contexts (Bray et al. 2014). This has potential relevance to engaging with men more flexibly in a variety of non-traditional contexts. Diamond (1998) described a community psychology approach conducted outside of traditional healthcare settings. This incorporated an 'Inquiry Paradigm' characterised by a 'not-knowing' rather than 'expert' style of engagement with

clients' experience. Kingerlee et al. (2014) described applying this approach to provide mental health support to men in a non-health setting, with positive results.

Conclusion

In this chapter, we have attempted to show the relevance of a mentalizing perspective to the development of male psychology and the way boys and men may express psychological distress. We discussed the application of MBT to a number of clinical areas which particularly pertain to men's mental health, including the vexed issue of male help-seeking behaviour. We hope this may point towards innovative adaptations to approaching men's psychological needs.

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Working with Men in Crisis: A Psychological Framework for Crisis Intervention in Home Treatment Teams

Luke Sullivan and Christopher Whiteley

Crisis Resolution Home Treatment Teams or Home Treatment Teams (CRHTTs/HTTs) form a key part of the mental health acute care pathway in the UK. CRHTTs provide an alternative to hospital admission for people in acute mental health crises, with a focus on those who present with risks to themselves, to others or from others. They are crucial in managing the limited acute care resources available to people in a mental health crisis because it is not possible to afford or accommodate all the patients who require admission (Hollander and Slater 1994). CRHTTs allow people to receive an intensity of treatment needed during a crisis whilst in their own homes, often their preference but also allowing them to maintain valued connections.

Reducing mental health admission rates in the UK is and has been a service priority (Keown et al. 2011). Between 1988 and 2008, there was 62% reduction in inpatient services in the UK. Inpatient services have been an integral intervention for the management of risk, including the risk of suicide. Whilst there has been a significant reduction in the number of suicides occurring in inpatient settings in the UK, the prevention of suicide

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in CRHTTs remains a challenge. Since 2003, the number of suicides occurring in CRHTTs has more than doubled (Hunt et al. 2014, 2016).

Despite men having taken their own lives at much higher rates since records began, it was only in 2012 that the male gender was recognised nationally as a specific risk factor (DoH 2012). Men are known to access health and mental health services later in the course of illness progression, if at all. They are less likely to access preventative psychological services at primary care level and more likely to come into services when difficulties are at the point of crisis (Sullivan 2011). This may in part be due to men not seeing depression and anxiety as a serious problem (Edwards et al. 2007) or being more inclined to deal with the problems on their own (Meltzer et al. 2003).

CRHTTs may be well placed to offer gender sensitive psychological intervention to men who may not otherwise have accessed to services or seen them as relevant to their needs. Unfortunately, although recommended by the Royal College of Psychiatrists (Buley et al. 2017) and the British Psychological Society (BPS 2008), clinical psychologists/practitioner psychologists are not a requirement and many CRHTTs in the UK do not have access to psychologists.

Part of the reason for the absence of clinical psychologists could be attributed to the view that that psychological work during acute crisis periods could make things worse or 'open a can of worms'. Combined with the unhelpful belief that there is not enough time to work psychologically in these settings, interventions are often ad hoc or taken from other models applicable to non-acute settings. Consequently, there is currently a dearth of evidence to support the applicability and effectiveness of psychological interventions across the crisis care pathway (Jacobsen et al. 2016). The result is that there exists no evidence-based psychological model for working with people in acute care despite some attempts (Clarke and Wilson 2009). CRHTT psychologists are often adapting other models to fit the setting (Jacobsen et al. 2016). Those which are well tolerated by service users with high levels of distress or disturbance may be promising (Linehan 1993; Mason and Hargreaves 2001).

Whilst there are important constraints to consider when working with people in an acute crisis, there are great outcomes that can be achieved during this period. This is because symptoms including problematic thoughts, feelings and behaviours are often more accessible (Jacobsen et al. 2016), and in our experience, people are willing to engage and work psychologically. The National Institute of Clinical Effectiveness, services users, and best practice guidelines are all clear that Psychology has a role within acute care. What is less clear is the kind of psychological work that is appropriate and effective in this setting.

Any model of psychological intervention for acute and crisis presentations need to take into account a number of key constraints. These include the likely short but intensive time frame of CRHTT treatment episodes and the need for interventions that are focused and readily available. A focus primarily on promoting the management and reduction of risks and the need to be deliverable at scale given limited resources and high numbers of service users. Hypothesising possible factors maintaining the crisis and risks can allow the provision of discrete and focused elements of psychological interventions rather than whole psychological therapy protocols for broader problem or particular diagnoses (Spring and Neville 2010).

The increasing rates of suicide in home treatment would indicate the need to continue to develop better and more effective interventions in the area, particularly interventions that help people to manage and reduce suicidal ideation, planning and intent. With men accounting for three-quarters of all completed suicides, crisis services likely to play an important role supporting men in crisis and encouraging them to make use of other available services.

This chapter presents a trans-diagnostic psychological model for working with people in crises (Sullivan 2018), combined with important considerations when working with men in this setting. Models and interventions draw on a broad base of cognitive and behavioural theories and a particular attention to 'third wave' CBT and metacognitive models.

Men's Use of Services in the UK

Men generally make less use of health and mental health services, which contributes to poorer health outcomes (White 2001). Men are less likely to voluntarily use mental health care services, including psychological therapies (Glover et al. 2010; NHS Information Centre 2010; ONS 2010; Sullivan et al. 2015); more likely to present to services at a later stage of illness (White 2001); and more likely to be entering services under coercion. Men take more risks with their health; are more likely to present with behavioural problems and externalise their distress (and therefore be over-represented in drug and alcohol services, homelessness and prison populations), they risk exclusion from mental health services; often receive less empathic responses; are less likely to be diagnosed with common mental illness; less able to identify and communicate psychological difficulties; and more likely to somatise (Sullivan 2011). Men's approach to seeking help is a major contributor to poorer health and mental health outcomes and crises become more inevitable.

Psychological Crisis Presentations

Crises are defined as times of intense difficulty and danger in which difficult or important decisions must be made. This simple definition highlights two important factors: the activation of the threat/stress system and decision making. Slaiku (1990) describes personal crises as:

> temporary state(s) of upset and disorganisation, characterised chiefly by an individual's inability to cope with a particular situation using customary methods of problem solving, and the potential for a radically positive or negative outcome.

Crisis situations are characterised by overwhelming stress, emotional disturbances, vulnerability, breakdown in coping, somatic symptoms, disorganisation in functioning, reduced defensiveness, cognitive biases and disturbance in thinking (Murphy et al. 2015). They are also periods in which outcomes can be influenced even when damage is inescapable.

Crises carry threat and condition us into states that activate thought and action to reduce harm and identify acceptable resolutions to the perceived problem(s). When we find safety and resolution, we find relief as the uncomfortable signalling emotion(s) dissipates (see Fig. 1). The greater and more immediate the threat, the more time and attention are allocated.

Some people manage to resolve crises through application of their internal and intuitive coping strategies; some may look to others for support, whilst some may benefit from specialist crisis intervention. Some people may benefit from offloading and sharing their thoughts and feelings whilst others prefer action, guidance and direction from others. In terms of gender, we could consider that, on average, men may be more likely to try to 'go at it alone'

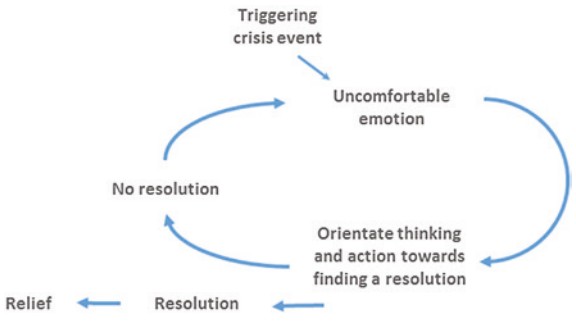

Fig. 1 Problem-solving challenging situations

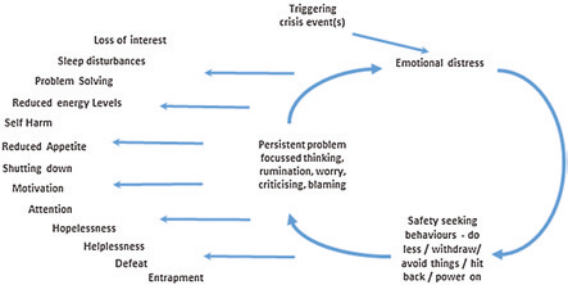

Fig. 2 Psychological mechanisms underlying crisis presentations

and women more likely to seek support from others (Galdas et al. 2005; O'Brien et al. 2005).

People who come to the attention of CRHTTs will have tried many times to find resolutions to their difficulties. In the absence of an acceptable resolution, people can become trapped within a threat-focused cycle leading to common crisis symptoms including hopelessness, helplessness, entrapment and defeat (see Fig. 2). It is at this stage that the intuitive problem-solving methods described above become part of the problem.

Hopelessness, helplessness, entrapment and defeat are the most significant risk factors for people who take their own lives (O'Connor and Nock 2014). These are all felt experiences, unintended consequences of crises and targets for intervention when working with people in acute care services, particularly for people presenting a risk of suicide. Gender may also impact on how this is experienced with ancient expectations for men to be fighters and winners (Seager et al. 2014).

The Causes of Crises?

Crises are often caused by financial difficulties, workplace stress, relationship issues, bullying, major life loss, changes in circumstances, bereavement, trauma, abuse, threat to self/others, isolation, self-neglect, sleep problems, poverty, loss of security, health and mental health difficulties. All of the above can happen to us all at some stage in our lives, with or without a diagnosable mental illness. The impact of any of these precipitating factors can be negatively impacted by contextual factors such as marginalization, alienation and poverty (Hatzenbueler et al. 2014) although importantly crises

also occur in the context of privilege and affluence. We can also consider an intersectionality of male gender and other characteristics such race and ethnicity which may exacerbate the severity of risk and crisis.

Precipitating events can be situational and caused by factors within our environment such as a physical assault or the loss of a job. They can also be linked to transitional developmental life stages and the challenges involved in moving from one stage to the next: for example, leaving home and heading to university (Erikson 1956; Maslow 1943).

The Role of Emotion

Emotions are our 'sixth sense'. They signal to us at any point in time where we stand in relation to ourselves, others and the world around us. They signal to us when problems arise that need our attention and when good things are happening. They are central to human functioning, social connectedness and survival.

Emotions are central to intervening with people in crisis and across the acute care pathway (Clarke 2015). Low emotional literacy has also been found in people diagnosed with Emotionally Unstable Personality Disorder (EUPD), where frequent crises and emotional dysregulation are common (Linehan 1993). The over-control of emotion can also lead to crises (Lynch 2018) and can be seen in people who report the absence of feeling numbness.

Low emotional awareness and literacy are hypothesised to be more common in men (Levant et al. 2009). For men and boys, the message throughout development and into later life is that emotions should be shut down and expressed in more limited ways. This results in fewer opportunities for learning and developing an adaptive relationship with emotional experience. In later life, this may place men at greater risk of adverse outcomes during times of crisis. It may also account for low social and emotional connectedness.

Emotional literacy has been considered a central component in developing psychological resilience and is often an underdeveloped skill in many disorders. The starting point for emotion-focused work with men will be different as for many the language around emotions is likely to be less developed. Being able to help men see the utility of emotions for themselves is important and should not be avoided.

Suicidality and Crises

Whilst mental illness increases suicidal risk, with some estimates citing evidence of a mental health problem for 90% of suicides (Cavanagh et al. 2003), it is not a causal factor. Seventy-two percentage of all suicides occur outside mental health settings, with many people not presenting as mentally unwell. Suicide itself must therefore be thought of as a distinct problem. Thinking in terms of crises may help us to understand suicidality and intervene more effectively.

Psychological theories of suicidal thoughts would suggest that suicide and suicidal ideation occurs in the context of a psychological difficulty in which a lack of belongingness and burdensomeness (Joiner 2005; Joiner et al. 2012), as well as defeat and entrapment from stressful, humiliating or defeating circumstances, occurs (O'Connor and Nock 2014).

Suicidality often occurs at the endpoint in the search for a solution. In the absence of an acceptable solution, people can find themselves trapped in a cycle of intolerable and unabating emotional distress (see Fig. 2). Suicidal thoughts themselves can bring a sense of control, reduce emotional distress and offer a possible solution in the absence of any other. The emotional relief can act as a negative reinforcer leading to more planning and intent to act. The relief can be interpreted as an indicator that suicide is a credible option. Indeed, people who act on their thoughts describe a sense of peace prior to the act (SpeshulSnek 2018).

Psychological Crisis Intervention in Crisis Resolution Home Treatment Teams

The Setting

CRHTTs (or HTTs) were introduced into NHS services in 1997, in an attempt to reduce the need for inpatient services by providing intensive support to people in acute crisis within their home environment. Although CRHTTs vary across the UK, the universal ambition is to provide support that is accessible to people with mental health problems in crisis, 24 hours a day, all year round. CRHTTs work with cases where there is a significant and immediate risk to self or others due to a psychological disorder. They provide home visits primarily by nurses and psychiatrists and where possible other professionals including social workers, occupational therapists,

psychological practitioners and clinical psychologists. Support can be provided through a combination of home-based or clinical-based contact on average once or twice a day. On average, people are estimated to stay with a service between four and six weeks.

This level of contact provides a considerable window in which a piece of psychological work can be carried out. Many of the tasks of a clinical psychologist working in this setting overlap with the shared tasks of the wider service, particularly psycho-social interventions. However, clinical psychologists in this setting provide additional benefits by offering more advanced and specialist intervention, particularly for complex cases. Additionally, they can provide support for the wider team in order to develop the psychological skills they already have, build resilience in challenging environments as well as learn and apply new skills and knowledge.

The following intervention provides a framework for working psychologically in CRHTT. It also includes a shared direction for psychological work in this area and attempts to provide a common and consistently shared language.

Making Safe

Under the care of CRHTTs, people present with actual and immediate risks to themselves, to others or from others. The first intervention and primary task of a CRHTT are to ensure that adequate risk management care plans are in place in order to minimise the potential for harm, starting with the most immediate risks and then providing support to prepare for more distal risk and potentially destabilising future events. This is a shared task for all HTT practitioners, including psychologists, and is a particular strength of CRHTT practice.

Risk assessment and intervention are crucial in helping to reduce the anxiety and fear that surrounds crises and should be shared with service users and formed collaboratively. CRHTTs provide additional practical and cognitive resources to help people find safety. The very presence of a service that offers hope that a resolution may be found can provide that safe framework which may have been missing.

Crises bring with them vulnerability. Being able to identify, acknowledge and accept vulnerability may be more challenging for men and can be masked by other emotions, including anger, which often serves to push people away. Whether men agree with dominant masculine values (such as independence) or not, there will be an impact on the person about how well they

live up to the dominant masculine archetype, particularly for those with less cognitive flexibility (Pleck 1995). Sensitivity to the relationship between masculinity and help-seeking is likely to be helpful in engaging men in crisis.

Psychological Crisis-Specific Assessment and Formulation

Psychological assessment and formulation in CRHTTs should be crisis specific. Providing a psychological framework for individuals' crisis presentations helps to validate a person's experience, which can act as an intervention in itself. Service users will have experienced an assessment of their crisis at the initial point of contact and probably at other stages in their journey. Duplication should be avoided as it can be a source of frustration or potentially retraumatising. A psychological crisis assessment and formulation can be partially established from recent assessments, team discussions and clinical notes. Being able to summarise what is already known avoids additional assessment whilst also communicating to the person that you understand what is going on for them. In our experience, service users fill in any gaps in knowledge or inaccuracies, which subsequently leads to collaborative reformulation. Considerations of the impact of gender should be integrated into the working formulation and will help to identify the right starting point for any further psychological work.

Validation of the Journey

When working with people in crisis, it is important for them to know that the causes of their crises have been understood by individual practitioners and the wider team. Validation, a term often used in Dialectical Behaviour Therapy (DBT), is communicating to service users that their responses make sense and are understandable given what is currently taking place in their lives (Linehan 1993). Note that this does not mean that we agree with them.

Validation includes listening and observing, accurate reflection, articulating the unverbalised, validating in terms of sufficient (but not necessarily valid) causes, validating as reasonable in the moment and radical genuineness (treating the person as valid) (Van Dijk 2012).

Helping to identify what is not being said may be particularly important when working with men. Careful consideration may also be needed as to the

level of emotional literacy and the use of language to describe a felt experience. The journey into services can be a challenging one, particularly for men where dominant masculine gender roles downplay help-seeking. Framing help-seeking as a strength and legitimising the act may be important, and implicit functional validation may be a powerful tool given men's hypothesised preference for action orientated intervention (Emslie et al. 2007).

Addressing Welfare and Essential Needs

For many people coming into contact with crisis services, their social security may have been compromised due to the problems meeting their basic needs, including difficulties with accommodation and lack of financial support. Helping people access welfare support with accommodation, financial and social needs helps to provide the essential foundations for functioning and security. This type of intervention is an example of implicit functional validation (Van Dijk 2012) and is a core task many CRHTTs work with. Specialist welfare support from within or outside of the team is often required before psychological crisis work will be effective.

Modelling Problem-Solving and Establishing Reasons for Living

During periods of crisis, people's ability to problem solve is often impaired by unhelpful cognitive biases and ruminative/worrying problem-focused thinking. Stepping into support someone in finding new and alternative resolutions contributes towards re-establishing hope, whilst helping to release people from feelings of entrapment. The specialist skills of CRHTTs can offer new and previously unthought-of possibilities. Modelling problem-solving and working collaboratively alongside people is important.

Some people may be resistant to alternative solutions or not ready to let go of their struggle. Work to facilitate this may be required and finding the motivation to begin recovery a starting point. This may be particularly true in relation to loss/bereavement, situations where it is difficult to see a future worth living and people who present with anger. Re-connecting people with things that are not lost to them helps to identify possible future goals. Identifying reasons for living often forms an important element of work within CRHTTs, particularly with people who are suicidal.

Psycho-Education on Psychological Responses to Crisis

Human beings are sense-making. For many people, perhaps particularly men, it can be difficult to make sense of how they arrived at their crisis point. For example, they may not have known or been able to see that they had a problem until the last minute. Helping people to understand how they arrived at the point of crisis helps to validate the experience as an understandable response given the situation.

By explaining how people react intuitively during crises, we are able to introduce key concepts for psychological work. By doing this in the third person, the discussion becomes less threatening and helps to normalise individual reactions. By describing psychological crisis responses and maintenance factors, people are able to confirm how it relates to their current experience, giving credibility to a psychological approach to psychological crisis intervention. It will also help people towards understanding how some of the distress can be created by our relationship to the problem rather than the problem itself (Harris 2009). This is likely to be a novel solution for most people, which can again offer hope and help people to feel less trapped within their own minds.

Addressing Emotional Disturbances

Emotional Under-Control

We have seen that crisis presentations are often driven by emotional distress, which persists in the absence of a resolution to crisis events and by the meaning attached to these events. Isabel Clarke in her work with people on inpatient wards states that work in acute services should start with a focus on emotion (Clarke and Nicholls 2018).

Emotions are messengers that indicate to us when we need to pay attention to a situation of importance. The stronger the emotion the more attention we give to it. Emotions can help us to determine whether we are under threat, whether we have lost something important, if we have done something to upset someone, if we are safe, comfortable or happy. The emotions we experience need deciphering, which we primarily do through cognition and thought. Once understood, we can put something in place to either resolve distressing emotions or seek out those which give a sense of comfort

and pleasure. Distressing emotions are prioritised as they have a greater potential for harm.

We all have the capacity to feel so emotions must be helpful and useful to us. Many people want to avoid unpleasant emotions, push them away or numb them (Harris 2009). The problem with this is that people miss the opportunity to understand and make sense of their emotions, their origins and meaning. Avoidance of emotion in the long term affects our ability to cope.

High emotional dysregulation affects our capacity to think. Unabating emotional dysregulation and the absence of a resolution to intolerable emotions can become difficult to bear. At this point, the emotional experience can become the problem and the threat. In such circumstances, it is important to help people see their emotional arousal as the source of their distress and to support them in learning strategies to manage emotional dysregulation. This includes breathing techniques, self-soothing and relaxation strategies, and mindfulness techniques that are adapted for practice with people in crisis.

Sometimes it may not be possible or safe to do these practices. However, helping people to recognise emotional dysregulation as a source of their distress may increase the likelihood of them learning more about these techniques at a later date.

Over-Control of Emotion

It is not just emotional instability that can become a problem, but also over-control of emotion (Lynch 2018). For some people entering into crisis, there may have been a numbing, dulling or shutting down of emotion in order to find relief. By over-controlling emotions in this way, people also numb themselves to more desirable emotions such as joy, pleasure and connectedness. It can also lead to a disconnect with the world and with our social and emotional connectedness (Lynch 2018).

For some people, emotions may not have played much of a part in their experience, and the disconnect and over-control may have happened much further back in their development. Whilst it would be challenging to address this experience in crisis services, being able to identify a problem as one of over-control can help to explain the nature of the difficulties that come with this way of coping, which include low social and emotional connectedness. Again, this may peek curiosity in the service user and offer a possible avenue for recovery.

In these circumstances, it is important to reconnect people with emotional experience and upregulate emotion. Interventions are likely to involve increasing social connectedness and emotional involvement in rewarding and pleasurable experiences. As people re-engage with emotion, it is helpful for them to have an understanding of managing distress as an alternative to shutting down and numbing. This is particularly important for people who also experience emotional dysregulation.

Re-establish Cognitive Effectiveness

As problems present themselves, our thinking will naturally be drawn towards them and we are designed to give our attention to threatening situations over and above nice, pleasant and pleasurable experiences (Mathews and MacLeod 1994; MacLeod et al. 1986; Mogg and Bradley 1998). This bias in attention and processing is believed to be adaptive and beneficial to our survival, as it primes us for rapid detection and response to threat (Bar-Haim et al. 2007). This attentional bias towards threat has been found in a range of disorders.

In situations, where our thinking becomes overly focused on problems, there is a risk of entering into patterns of problem-focused thinking such as rumination, worry, blame, self-criticism and judgement. These styles of thinking can become particularly pervasive and maladaptive during time of crisis, with cognitive biases clouding judgement and reducing problem-solving capabilities. Cognitive biases in attention, memory and interpretation play a key role in the aetiology and maintenance of emotional disorders. Nevertheless, the persistence of the mind in its conviction of its usefulness allows thoughts to continue to dominate cognitive space in hope that a resolution will be found. This is particularly true for people who hold positive beliefs about these styles of thinking (Wells 2000).

Continued use of problem-focused thinking is likely to lead to a range of problems, including unachieved goals (Burwell and Shirk 2007), impaired problem-solving (Hong 2007), impaired concentration (Nolen-Hoeksema et al. 2008) and maladaptive emotion regulation (Burwell and Shirk 2007). Therefore, symptoms will persist and the mood disturbance will perpetuate (Nolen-Hoeksema 2000).

Psychological crisis intervention in HTT involves a reboot of the cognitive system which at some point has unintentionally become part of the problem. Attentional control training, present moment focus and mindfulness practices can help to divert the attention away from threat, thus

preventing preoccupation and overwhelming constant problem-focused thinking (Mobini and Grant 2007).

Baseline Functioning, Behavioural Activation and Graded Recovery

During times of crises, our actions and behavioural responses will be orientated towards dealing with the crisis, and other things will become less important and relevant. Priority will be given to the crisis until an acceptable resolution is found, which makes sense as it decreases the likelihood of harm occurring.

Our primary behavioural response to threat is the flight-or-fight response. Helping people in crisis to understand this threat response system is important, as regulation of the threat system is integral to dealing with crisis situations. This is especially true in instances where running, fighting or freezing leads to a worsening of the situation. Understanding the fight-or-flight system can help people to understand how their actions are inadvertently leading to a worsening of the problem, particularly when withdrawal and avoidance become the main strategies. This lays the foundation for behavioural activation and graded exposure.

Crisis situations leave little time for engaging with anything other than the crisis itself. This can be problematic when focus on the problem situation is unabating and all-consuming. It becomes hard to find time for other things, and people lose motivation and interest in activities that previously gave them enjoyment, satisfaction and pleasure. Whilst activated to deal with threat energy levels can become depleted, appetite becomes reduced as digesting food is difficult, sleep patterns become disrupted and contact with others often too effortful.

Even the smallest task can appear insurmountable as people withdraw and disengage from tasks, they would normally do without thinking, which can be a source of frustration. Some people may try too hard to get back to functioning fully, which can lead to further collapse and despondency about not being able to do the things they expect of themselves.

The aim behaviourally is to build the right foundations from which to be able to function optimally. During periods of extended crisis, people's basic physiological functioning becomes impaired and their safety compromised. Without the right foundations, the more complex demands of daily life become difficult to sustain. Helping people to accept what they can and

Fig. 3 Adaptation of Maslow's Hierarchy of Needs (Maslow and Lewis 1987; Maslow 1954)

cannot do and helping to build the right foundations allows them to begin to refocus and reclaim their lives. Maslow's Hierarchy of Needs can be helpful here (Fig. 3).

Building Social and Emotional Connectedness

Social and emotional isolation are major predictors of mental health problems (Lynch 2018). They may also be the cause, a contributor or an outcome of crises. The more alone we find ourselves the more likely we are to find ourselves alone with our minds searching for a solution in the depths of 'problem focused thought'. Building social connections are supportive in many ways, as they can be a valuable source of comfort and distraction as well as a source of help to resolve or overcome challenges.

Sometimes when working with people in crisis, there is a sense of being let down by important others. People may have reached out for help and support, but the person they reach out to may not know how to help them. In the event of not being able to help and when faced with the possibility of suicide, the helper may feel overwhelmed and 'move away'. This can sometimes be misinterpreted as the person not caring. In such situations, it is important to help people reach out to those who have been of importance in their lives and reconnect with them where possible.

Social connectedness and isolation is an important factor for men. After the age of 30, men's relationships narrow and shrink. The reasons for this could be related to the role of emotions in forming and sustaining relationships or potentially due to attachment styles. Either way, improving social and emotional connectedness is an important intervention, as it is believed to be a protective factor in suicide prevention.

It is possible then for people to have a relatively small social network and feel connected or have a large social network and feel 'lonely but not alone'. It is therefore important to emphasise quality over quantity; a meaningful connection with people is crucial to feelings of connectedness, and it should be prioritised over the number of one's social interactions. Likewise, it should not be assumed that having frequent social interactions precludes one from feelings of loneliness.

Follow-up, Self-Help and Ongoing Support

For some people who present in crisis, there may be a need for referral on to other services for additional support, where there is an identifiable need. There may be some pre-crisis mental health difficulties, histories of unhelpful and maladaptive coping, unresolved distress from the current crisis or other issues activated by the crisis that require further intervention.

The types of services available will be dependent on the local service provision both within and outside of the NHS. This may involve care-coordination, medication management, practical social support or psychological interventions. For some people, it may be appropriate to discharge them back to their GPs with no further follow-up or a link to IAPT services. Some additional work may be required to support men in making use of follow-up services.

Psychological therapy in the UK from the NHS can involve a long wait. It is worthwhile encouraging and directing people towards self-help material to build on their learning during their crisis. Self-help material is effective in treating common mental health problems and prepares people for psychological interventions when the opportunity comes around.

For many people, this may be the first time they have been in contact with mental health services. It may also be the first time they have considered that they might be experiencing a psychological problem. Encouraging people to further develop their understanding of the problems they have been experiencing should be part of their discharge planning and can be continued as they progress to other services.

The intensive nature of HTT intervention and the difficulties people present with at the time of crisis means that stepping down into less intensive community service requires sensitivity and thoughtful planning. Attachments will be forged in the relationship with crisis services, and preparing people for leaving is an important aspect of the work as this can be a time of increased risk.

Relapse Prevention and Crisis Contingency Planning

Throughout a CRHTT contact, it is important to help people develop their understanding of how to respond in the event of further relapse or mental health crises to increase the likelihood of greater self-management. A good crisis plan should include information on relapse indicators, things that are helpful during a crisis, calming and soothing techniques, reasons for living, ideas for others about how to support them, people and services to call and places of safety in the event of immediate risk. Crisis and contingency plans should be shared with people involved in the individual's care, and the aim should be for everyone to leave with one (Stanley and Brown 2012).

Discussion

Given the increasing rates of suicide and the dearth of psychological intervention in CRHTT, there is an urgent need for a psychological model for working with people in crisis who present with significant risks. This above model provides a framework for one such approach which may also be applicable in other settings.

In the UK, CRHTTs work directly with people in crisis. By developing an easy understandable and focused framework for working with people in crisis across the acute care pathway, it is hoped that psychological intervention becomes more accessible in this setting. It also helps to move away from ad hoc use of interventions from other settings and towards a more structured acute care specific model.

It is within crisis theory that we find a potentially useful model. By focusing on crises, we are able to identify trans-diagnostic psychological processes which are associated with suicide and crisis more so than mental health diagnoses. Focusing on crises also provides a more manageable approach to intervention given the range of diagnostic presentations seen in this setting.

NHS services and psychological interventions are effective for both men and women. However, there is evidence that a gender sensitive approach is beneficial when working and engaging with both men and women. When working with men, it is important to recognise that this may be the first time they have had contact with services. Their journey into services may have been challenging, and they may have less awareness of the problems they have been experiencing. When men do access services, it is important that the experience is one which encourages help-seeking and reinforces this as a strength. It is also important to meet me where they are at in their psychological journey.

Some of the challenges when working with men include access to services for men, helping men to identify and understand their psychological problems, adapting interventions to fit where men are at in their emotional psychological journey, legitimising help-seeking, promoting social connectedness and promoting the acceptance of help.

Evaluating the efficacy and effectiveness of psychological interventions in this setting has always been challenging. There are often many different interventions happening alongside each other and working our which are causal factors is often not possible. Nevertheless, a challenge is just that and together we may be ready to take this on. The proposed model offers a point of reference for the development of psychological interventions in acute care and more specifically CRHTTs. The interventions are orientated towards the shared task of crisis resolution and risk reduction. Many aspects of the model are also deliverable by other members of the MDT under the direction of the psychologist.

By creating distance and safety from the problem, re-establishing cognitive effectiveness and identifying more effective and acceptable resolutions, people can create the best conditions to put themselves in the best possible place to get the best possible outcome from difficult and challenging circumstances. This does not mean loss and harm will not occur.

With 72% of suicides occurring outside of mental health services, and many of these people may not meeting the criteria for a mental health diagnosis or even identify with having mental health difficulties, translating this model to other at-risk groups could be helpful. This model may be applicable to other settings and is currently being translated into a self-help guide. This may be particularly important for populations who may find it difficult to mental health services, including men.

A consistent approach for intervening psychologically within acute care services would allow for a common language to be used that reinforces evidence-based practices that are applicable within this setting.

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Masculine Identity and Traumatic Brain Injury

Ruth MacQueen and Paul Fisher

Traumatic Brain Injury

Traumatic brain injury (TBI) occurs when the head is significantly impacted by an external mechanical force. This causes the brain to be displaced inside the skull, and injury can also occur as the brain makes contact with structures within the skull. The acceleration and deceleration forces of the impact may also cause damage to tissues and vessels of the brain (World Health Organisation 2006). The severity of a brain injury is classified as mild, moderate or severe, a rating which is primarily based on the Glasgow Coma Scale score (Teasdale and Jennet 1974). Individuals with a more severe injury tend to have longer periods of unconsciousness, post-traumatic amnesia, life disruption and impairment.

A recent meta-analysis found that the incidence of TBI in Europe was 262 per 100,000 (Peeters et al. 2015), with falls and road traffic accidents being the most common cause. The incidence of TBI peaks at three different points within the life cycle: under 5 years old, between 15 and 24 years and above age 75 years (United Kingdom Acquired Brain Injury Forum 2016).

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The effects of TBI depend on the severity and location of injury as well as the individual's personal and social circumstances, both pre-injury and post-injury. The cognitive, emotional, behavioural and physical impairments can result in serious changes in functioning and lifestyle (Segal 2010; Tyerman 2009). These changes can restrict a person's independence, affect relationships with others and alter the person's experiences of being in the world.

Identity and Rehabilitation After TBI

Given the disruptive potential of TBI and its consequences, the day-to-day lived experience of being in the world can often be altered for the individual. This disruption can incorporate an impact on a person's very sense of self and identity. For all human beings, the sense of self and identity is created over time through years of development, relationship and activity. Identity is maintained through constant updating processes involving cognition, communication and memory. All of this may be disrupted by the impact of TBI (Ownsworth 2014).

Research consistently demonstrates that individuals experience a changed sense of personal identity after TBI (Levack et al. 2010) and that following TBI, changes to the self unsurprisingly tend to be viewed negatively in comparison to the pre-injury self (Carroll and Coetzer 2011). For a man, the sense of masculine identity can be threatened by such major changes in functioning which can lead to a loss of traditional male roles and capacities such as being a provider, being strong, protecting others, having physical strength and self-reliance (Addis and Mahalik 2003; MacQueen et al. 2018).

Why Is Masculinity Relevant to TBI?

Masculinity? Male gender may be considered to be a risk factor in itself for TBI as the prevalence of TBI amongst men is twice that amongst women (Key Facts and Statistics, Headway 2014). One theoretical explanation for this ratio is that for men the masculine ideal, whether this be an archetype or a stereotype, encourages risk-taking behaviour (Javouhey et al. 2006). Courtenay (2000) argues that it is through a process of socialisation that men are more likely to engage in risky behaviour, for example when driving, making them more likely to be involved in a road traffic accident.

However, in more simple and concrete terms, men are more likely to be employed in occupations which significantly increase the risk of serious or fatal injuries (Stergiou-Kita et al. 2015; Health and Safety Executive 2017). Men are also more likely to sustain injury playing high impact sports (Hollis et al. 2009). The causes of TBI reflect this variety of gender differences in social choices and behaviour as men sustain more injuries from falls, sporting activities, military service and vehicle collisions at higher speeds (Cassidy et al. 2004; Javouhey et al. 2006; Meyers 2012; Turner and McClure 2003).

Current research which has explored sex differences in outcomes after TBI yields conflicting evidence (Farace and Alves 2000; Ownsworth and McKenna 2004; Ratcliff et al. 2007; Thompson et al. 2006). For example, Renner et al. (2012) used ratings of independence and disability and found that sex did not have an impact on the course and outcome of TBI. However, it is possible that this study did not fully take account of the possibility that men are less likely to self-report or admit problems which may be perceived as weaknesses. Contrary to this, Colantonio et al. (2010) reported significant differences in difficulties experienced by men and women following TBI. They found that significantly more men reported difficulties in setting realistic goals, and in coping with high sex drive and restlessness. Men also reported that sensitivity to noise and sleep disturbances had a greater impact on their daily functioning compared to women. The variability of the findings within the literature may suggest that there may be a difference in how men and women experience or perceive the impact of TBI, even when objective outcome measures do not demonstrate a clear divide

Given that masculine identity and its expectations may influence a man acquiring a TBI in the first place, it is particularly important to consider how masculine identity is experienced following injury and how this may affect rehabilitation. The literature suggests that masculinity and disability are in direct conflict with each other because of the divergent cultural expectations associated with them. Cultural expectations about masculinity include physical strength, emotional toughness, self-reliance, competitiveness, risk-taking, aggression, and power (Addis and Mahalik 2003; Connell 2005). In contrast to this, disability is often associated with vulnerability, weakness, dependency, helplessness and even being childlike (Barrett 2014; Shuttleworth et al. 2012). This conflict between masculinity and disability can result in "a dilemma of disabled masculinity" (Shuttleworth et al. 2012).

Masculinity also becomes even more relevant given the high prevalence of male suicide within the general population as well as specific evidence

that TBI is a predictor of suicide, even when psychiatric comorbidity is accounted for (Brenner et al. 2011). It therefore follows that men with TBI have a particularly elevated risk of suicide and this makes it even more important to consider how the interaction between masculinity and TBI can have an impact on well-being.

Men's Lived Experience of the Consequences of TBI

It is well known that TBI can alter cognitive, physical, emotional, behavioural and communication abilities. For men, any of these impairments may affect the ways in which their identity as a man is experienced individually and expressed within interpersonal relationships. Therefore, roles which men occupy that reinforce their masculine identity can be lost or changed as the result of TBI, and men may face challenges in coping with such losses and adapting to changing roles. Exploring how men experience TBI can help clinicians to achieve better outcomes with men by better understanding the meaning that TBI has for them in terms of their identity as a man.

Cognitive Factors

Cognitive impairments such as memory loss, difficulties in problem-solving and poor executive functioning can all affect a man's ability to carry out day-to-day tasks which are ways in which he expresses his identity (Brewin and Lewis 2001). For example, cognitive difficulties may mean that a person is unsafe to complete day-to-day tasks such as driving. This can result in a loss of independence which can conflict with masculine ideals about independence and self-sufficiency. The consequences of TBI for more complex tasks such as managing money or skills used at work can mean that in addition to a loss of autonomy, men's experience of TBI conflicts with ideals that a man should be able to make decisions, provide for others and manage responsibilities.

Changes in cognitive functioning may contribute to loss of employment, and therefore, a change in roles may be experienced (Jones and Curtin 2011). Cognitive impairments and the resulting consequences may therefore lower self-confidence and result in a feeling of being less of a man.

Physical Factors

Physical impairments can reduce independence, consequently causing an increased reliance on others. This loss of independence and changes in physical ability can conflict with ideals about autonomy, being physically strong, or being in control of one's own body (MacQueen et al. 2018). In addition, following a TBI, the brain is more vulnerable and individuals are often advised by medical professions of the potential risks, including death, should they encounter further injury. This heightened risk can mean that even if a man is physically mobile and active after TBI, he may feel more vulnerable and less able to physically protect or defend himself or others due to the increased risk.

Fatigue is frequently experienced following a TBI and can reduce a person's engagement in meaningful activity. Maintaining a similar amount of activity post-injury may be particularly challenging. Activities such as working, driving or taking care of children may no longer be possible for a temporary period or permanently post-injury. Individuals may require more frequent rest periods and find activity later on in the day difficult (Cantor et al. 2008). This can reduce opportunities for social interaction with peers as well as reduce occupational options, resulting in losses which conflict with an individual's sense of male identity. Importantly, the need for rest can directly conflict with masculine ideals and may be viewed as a weakness. In addition, sensory processing may be affected and both "hypo" or "hyper" sensitivities may mean that making sense of environmental and social information can be difficult. Consequently, even simple social activities, for example going out for a meal or day-to-day environments such as supermarkets can be a significant challenge.

Communication Factors

Being able to communicate effectively is a key component for the expression of identity (Shadden 2005) and can be one of the most obvious consequences of TBI to others. For men who experience communication difficulties, this can challenge ideals about masculinity, not only about independence, but also about the way in which the self is judged by others. This may result in experiences of embarrassment and shame because of a fear that others will view them as having something wrong with them and therefore as being weak or vulnerable.

Emotional and Behavioural Factors

Emotional and behavioural changes may be a direct consequence of changes in the physiology of the brain (Fisher et al. 2015). In addition, secondary anxiety and mood-related difficulties can be experienced, often as a result of the loss of identity and difficulty in adjusting to the changes which have been a consequence of the injury.

In interviews with men who had experienced a TBI, Freeman et al. (2015) identified a pattern of emotional experiences including a sense of "abnormality", "the hidden nature of brain injury", "others treat me different" and "the old me- new me", all of which they suggest contribute to a sense of emotional threat including loss of self, blame, guilt, shame and loss of pride. It was identified that the response to these emotional experiences included self-criticism, trying to live up to the expectations of others and emotional or social withdrawal. In addition, using humour and differentiating oneself from one's injuries were also recognised as being a response to emotional threat. Such responses may therefore hinder adjustment and increase vulnerability to low mood and social isolation. Research also suggests that there is an additional stigma of being in the "brain injured" group which can be perceived as socially unfavourable (Freeman et al. 2015).

In the exploration of emotional outcomes, Schopp et al. (2001) report that men and women experience psychological distress following TBI in different ways. Questionnaire responses highlighted that women were more depressed, but that men had higher levels of emotional distress. In line with this, experiencing anger after TBI is common and is often associated with depression (Baguley et al. 2006). Anger difficulties and irritability are common following TBI as are problems with regulating emotion, disinhibition and increased impulsivity. Irritability may be partly a direct result of TBI and partly a secondary consequence of fatigue and an increased difficulty in tolerating sensory stimuli or processing information. Anger may also become a secondary response to the losses and changes to identity which are being experienced. Aggression is widely considered to be more normative socially for men (Mahalik et al. 2003), and therefore, it may be that anger is one form of emotion that men feel able to express because it remains in line with masculine ideals. Expressing anger may in some ways be protective of masculine identity after TBI in that men may feel this is one way in which their identity as a man can be expressed when others are lost. However, expression of anger may also cut men off from the beneficial and important support that may be required following TBI.

Other behavioural changes which can occur as a consequence of cognitive impairments resulting from TBI or from the emotional impact of TBI may also lead to conflict with masculine ideals. For example, difficulties such as impulsivity, loss of anger control and disinhibition may change how a man is perceived by others and also impact on his relationships with others or on his role within a family or peer group.

Interpersonal Relationships

Being able to maintain social connections may be more difficult due to the physical, psychological and social consequences of TBI. This can impact on personal, family, social and work relationships. The psychosocial impact of shame and negative self-perceptions may particularly lead to difficulties in relationships with others. Freeman et al. (2015) found that all of the participants in their research talked about how they felt they were treated differently in their close relationships with friends and family. Men also described feeling reassured when they felt that others treated them the same as before the injury. When men did receive feedback about differences, Freeman et al. (2015) highlighted that this tended to be interpreted as a criticism.

Men with TBI commonly describe feeling like a burden in relation to their partner (Freeman et al. 2015). It appears that the loss of "the provider" role or a loss of income and standard of living can contribute to a sense of inadequacy as a man. The traditional masculine role of "breadwinner" is suggested to be particularly salient, even when men do not adhere to other "traditional" masculine ideals (Dolan 2014). In line with this, research suggests that men who do return to work after TBI consider their work role, the importance of paid work and being a breadwinner as critical in relation to their self-worth and identity as a man (Stergiou-Kita et al. 2016).

Similarly, men with TBI whose parents may resume a caring role or provide financial and practical support may feel childlike. This state of dependency on parents or caregivers can be considered as being more aligned with the societal expectations of disability (Lindemann 2010) and conflicting with ideals about masculinity such as independence, personal control and self-reliance (MacQueen et al. 2018).

In the case of fathers with TBI, Evans-Roberts et al. (2014) highlight that there can be multiple losses of the parenting role following brain injury. Morriss et al. (2013) provide a framework for considering how brain injury impairments may have an impact on different aspects of participating in a fathering role and highlighted that fathers often had negative perceptions of

their own ability to be a father in comparison with the perceptions of others. However, the role of father may also provide a purpose and motivation for adaptation and rehabilitation (MacQueen et al. 2018).

Sexual Relationships

Changes in physical abilities, in energy levels and in mood can all have an impact on sexual relationships after TBI. A greater percentage of men than women report dissatisfaction in sexual relationships after TBI (Sander et al. 2012). In comparison with gender-matched groups without disability, men with TBI report less frequent involvement in sexual activity and relationships (Hibbard et al. 2000). Depression has been shown to be a particularly sensitive predictor or correlate of sexual dysfunction for men following TBI (Hibbard et al. 2000). Fatigue has also been evidenced to affect the subjective experience of sexual activity for men and women with TBI in comparison with those without brain injuries (Goldin et al. 2014).

Research also suggests that body-image concerns have a negative impact on sexual functioning and sexual desire for men with TBI (Hibbard et al. 2000). Following brain injury, men report a reduction in satisfaction with body-image, in particular sexual aspects of body-image (Schopp et al. 2006; Howes et al. 2005). Schopp et al. (2006) suggest that for men who subscribe to ideals about a "playboy image" their lack of satisfaction was due to the ideal of sexual desirability no longer being met.

Masculine Identity and Adjustment

Experiencing a TBI can mean that individuals have to integrate their new lived experiences and consequently reconstruct their sense of self (Lennon et al. 2014). It is therefore important for clinicians to develop an understanding of how masculine identity may relate to the process of adjustment. The complex process of adjustment is a way in which individuals endeavour to accept change, make sense of their experiences and restore self-esteem through regaining a sense of control (Ownsworth 2014). Gerschick and Miller (1994) theorise that in response to experiencing disability, some men continue to rely on "traditional" masculine ideals for their sense of self, whilst some reformulate these ideals in line with the changes they have experienced, and others reject traditional masculinity, formulating an alternative masculinity. Within TBI, these concepts may be understood as being

changeable and complex because no man pre- or post-injury is identical in terms of how he makes sense of different aspects of his identity as a man.

Masculine Identity and Difficulties in the Process of Adjustment

Gutman and Napier-Klemic (1996) interviewed two men and two women six times within two months post-injury, exploring changes in perceived masculinity or femininity, intimate relationships, gender roles and engagement in activities which support gender identity. Their findings suggest that men experience greater gender role conflict than women and that men tend to rely more on gender-specific activities pre- and post- injury to maintain their gender identity. The researchers suggest that for men, it was important for activity to be retained at pre-injury performance levels and that failure to meet these standards resulted in feeling like "less of a man" (p. 542). This early research therefore suggests that for men, integrating their new lived experiences may pose challenges to adjustment.

Evidence generally suggests that adherence to masculine ideals can be negatively associated with rehabilitation outcomes in TBI (Meyers 2012). These relationships tend to have been considered by examining the relationships between factors on scales such as the conformity to masculinity scale (Mahalik et al. 2003) and rehabilitation outcome measures. For example, Meyers' (2012) research with male veterans suggested that traditional masculine gender roles had an inverse relationship with factors such as community reintegration, relationships and living skills. Similarly, Schopp et al. (2006) found that adherence to masculine ideals about roles and relationships with women negatively affected life satisfaction.

However, qualitative research illustrates the complexity of the responses of masculine identity in relation to adjustment following TBI. For example, Jones and Curtin (2011) specifically focus on experiences of changed domestic roles such as caring and household duties in relation to reformulation of masculine identity. Participants described either rejecting the reformulation of their masculinity, accepting it for the sake of others, or personally valuing their changed masculinity. The authors suggest that some participants demonstrated a rejection of reformulating masculinity as traditional masculine ideals were maintained within new roles. Similarly, participants in a study by MacQueen et al. (2018) had engaged in new activities such as growing vegetables in order to fulfil a value of providing for others. This may

be a way in which masculine ideals are maintained by adapting the *expression* of those ideals in the line with the changed resources available. Whilst for some, this can create a positive perception of quality of life, Jones and Curtin (2011) suggest that some men who take on a less traditionally masculine role and reject such a reformulation may come to view themselves as having less self-worth. These complex findings illustrate that the *meaning* of the loss of the traditional breadwinner role will be different for different men depending on the context.

Masculine Identity and Promotion of the Process of Adjustment

Research which explores adjustment to TBI also evidences factors which promote well-being in adjustment and highlights that individuals can experience *post traumatic growth* which is considered to be a positive change in response to the effect of trauma (Hefferon et al. 2009). This includes evidence that highlights different ways in which making sense of a changed identity can promote well-being in the aftermath of TBI for men.

Existing research suggests that adherence to traditional masculine ideals such as higher success, power and competition is associated with the perception of fewer barriers to community functioning (Good et al. 2006). Similarly, Schopp et al. (2006) found that there was a positive effect on functional outcomes for men who adhered to ideals such as winning and seeking status, and the authors suggest therefore that drawing on these values can promote positive outcomes after TBI.

Hutchinson and Kleiber (2000) suggest that views of masculinity can enable men to overcome difficulties and conceptualise this as "heroic masculinity". This concept, which has primarily been considered within spinal cord injury, suggests that masculine ideals can contribute to men striving to transcend injuries and grow. The idea of "that which doesn't kill us makes us stronger and more satisfied with life" is discussed in Jones et al.'s (2011) study of participants with various brain injuries including TBI. This suggests that the experience of TBI can potentially lead to some individual men gaining a sense of personal growth. For men, this may reflect the possibility that the masculine ideal of being able to demonstrate strength and control through striving can actually help to overcome the limitations which they face.

Masculine Identity and Rehabilitation

It has been seen that changes in masculine identity can be critical to the experience of adjustment for men following TBI, and this has been recognised as an important factor in rehabilitation (Gutman and Napier-Klemic 1996; MacQueen et al. 2018). Existing literature indicates that adherence to masculine ideals can have both a negative and positive affect on rehabilitation outcomes in TBI (Meyers 2012; Schopp et al. 2006). Specific issues relating to masculine identity within rehabilitation may include engagement in rehabilitation, maintaining psychological well-being, engaging in occupational activities as well as participating in social roles and interpersonal relationships. Given this, it is important to understand how masculinity may affect these issues and how clinicians working with men in a rehabilitation setting may adapt their practice to better suit the needs of men.

Engagement with Rehabilitation Services

Barriers to engaging in rehabilitation services may include the belief amongst men that working with professionals is seeking help and therefore implies an admission of weakness and failure. Viewing the self as being reliant on care providers can therefore lead men to experience shame and a loss of masculine identity. This may mean that developing therapeutic relationships may also in itself directly conflict with masculine ideals of independence (Good et al. 2006; Sullivan 2011).

Self-comparisons to others with TBI may also prevent engagement in rehabilitation. Those who view the consequences of their injury as less severe may experience guilt and shame in seeking support. This may further reinforce beliefs about the self as weak. This may be particularly prevalent within group settings, but can also be experienced in individual rehabilitation. Men who believe that they shouldn't need support from professionals will therefore inevitably find it that much more difficult to engage in rehabilitation.

Other aspects of rehabilitation may highlight impairments which may be particularly meaningful for a man. For example, assessments or interventions around money management may accentuate a feeling of not being able to provide for self and others or be self-sufficient and independent. Similarly, feeling self-conscious can be a barrier to physical exercise after TBI (Driver et al. 2012). It may be that this aspect of rehabilitation particularly presents challenges to ideals such as physical strength and the ability to physically protect self and others.

How Services Can Promote Engagement

All of the above evidence indicates very clearly that gender is a highly relevant factor in terms of how brain injuries are acquired, what that they mean to people and how they engage in rehabilitation. This means that taking account of gender is vital in designing and providing brain-injury rehabilitation services.

Providing a gender-sensitive service should begin during initial discussions when men are first referred to a service. When providing information about a service, emphasising an active and expert role rather than a passive and dependent role in rehabilitation may particularly promote a service that is in line with masculine ideals rather than in conflict with them.

Similarly, it has been suggested that in order to defend against shame which may be associated with receiving support, intervention should facilitate men playing an active or leading role (Kingerlee 2012). This approach may then promote pride rather than exacerbate feelings of shame. Within rehabilitation, this could be facilitated by emphasising the value of the individual's lived experience and the role of being an expert through experience. In addition, encouraging feedback from the individual within therapeutic relationships may provide a sense of having more control as well as a sense of making a valued contribution to the therapeutic relationship. These aspects can contribute to a positive sense of masculine identity and may therefore promote engagement, empowering men to take active roles in rehabilitation and increasing their involvement in decision-making.

Encouraging rehabilitation and help-seeking as a demonstration of resilience or strength in facing difficulties may encourage men to engage in rehabilitation. This male-friendly approach can build on motivation to overcome potential resistance to engagement in rehabilitation, utilising rather than undermining masculine ideals of strength, self-reliance and control.

Promoting Psychological Well-Being in Rehabilitation

Given the higher prevalence of mental health problems in the TBI population (Seel et al. 2003), it seems particularly important to work with individuals in reducing the stigma of mental health problems after brain injury. A masculine identity can more easily be protected by normalising and validating in masculine terms (action, control, mastery) the reasons for seeking support from health professionals (Rochlen 2005). One way of increasing

the acceptability of engaging in neuropsychological services may be for men to attribute their need not to their own weakness but to the serious nature of injury and also the biological basis of it. Normalising the negative impact of TBI on mental health may therefore help to reduce stigma and promote engagement.

Given the evidence of gender-related barriers and stigma in relation to men seeking support for mental health difficulties, there is a greater risk of men turning to dysfunctional coping strategies which promote escape and avoidance. For example, in research with men who had either a TBI or a spinal cord injury, masculine ideals including valuing competition and power were associated with a higher number of alcoholic drinks per drinking episode (Good et al. 2008). Therefore, assessment and formulation should also consider how masculine identity may also in some contexts relate to *un*helpful coping strategies.

A prominent theme within the existing literature is that men experience feelings of shame which appear to be linked to a sense of inadequacy as a man and a loss of masculine identity (MacQueen et al. 2018). Given the shame that is experienced in relation to loss of roles and changes in masculine identity, it can be difficult for men to introduce this experience into therapeutic discussion and this may therefore require skilful exploration directed by the therapist. Both shame and aspects of growth are vital within the compassionate mind approach following TBI (Ashworth 2014) and may therefore be particularly relevant when working with men.

Assessment and psychological formulation should also explore how narratives of masculine identity may provide positive functions such as being able to maintain social relationships and roles and promote new occupational expressions of identity. Approaches which focus on meaning, values and identity may therefore be particularly relevant in supporting the development of new narratives about masculine identity. For example, drawing on Acceptance and Commitment Therapy (Hayes et al. 2011) may encourage flexibility in narratives and behaviour through consideration of values. Similarly, Narrative Enhanced Cognitive Therapy is an approach which targets the negative impact that self-stigma can have on identity, self-esteem and social relationships (Yanos et al. 2012). Within this approach, there is an emphasis on the redevelopment of themes of agency and strength in individuals' narratives (Roe et al. 2014), which may create better alignment with masculine ideals. In addition, compassionate mind concepts such as strength, wisdom, resilience and responsibility may add to the positive value of any given therapeutic approach by promoting healthy flexibility and enhancing a sense of masculine identity.

The application of positive psychology constructs has also been explored in acquired brain-injury rehabilitation (Cullen et al. 2016). Initial research indicates that the application of positive psychotherapy can promote well-being in neuro-rehabilitation. The ethos within positive psychotherapy of focussing on growth, strength and resilience rather than on symptoms and deficiencies may particularly offer a more gender-friendly approach to adjustment for men.

Promoting Engagement in Occupational Activities

Within rehabilitation, exploring the meaning which men may give to their position and roles within their own social context should be considered in working to redevelop their occupational activities. Clinicians and clients may need to explore new ways of expressing their masculine identity in meaningful roles. Gutman and Napier's (1996) research found that men who had experienced a TBI considered their activities in "black and white" terms as either success or failure, highlighting a further barrier to potential engagement in therapeutic activity for men.

Encouraging activity which may be considered to be masculine, such as sport, can provide not only benefits to cognitive health after TBI (Grealy et al. 1999), but also may provide a new expression of identity. Exercise has been shown to promote emotional adjustment and positive self-identity in relation to masculinity after TBI (Wise et al. 2012). In addition, promoting new activities which can be aligned to masculine ideals may protect against unhelpful externalising or defensive behaviours such as alcohol consumption which may be associated with anxiety about losing masculine identity (Good et al. 2008; Rochlen et al. 2008).

A key part of rehabilitation is helping men to return to work, an aspect of their life which can be a primary part of their identity as a man. Evidence suggests that in returning to work, men reported that they avoided sharing difficulties associated with TBI with others in the workplace (Stergiou-Kita et al. 2016). Research also suggests that the gendered culture of a workplace also impacts upon the experience of returning to work for men. Traditionally, male-dominated working environments tended to be experienced as less supportive both by men and women (Stergiou-Kita et al. 2016), and a more nurturing environment was generally preferred.

Clinicians working with men who are returning to employment after TBI may therefore find it beneficial to consider the context in which a man will be employed and how this might impact upon his masculine identity. This may help to anticipate difficulties which may arise and create more effective plans for managing them.

Promoting Social Engagement and Interpersonal Relationships

There is a complex interaction between the self and the social context in the process of adjustment following TBI. For example, the age and life stage of a person are important contextual factors in how identity is experienced after TBI. Men in early to middle adulthood may be striving to form their own identity, completing education, developing careers and establishing new relationships. In relation to social norms about masculinity, issues which may be particularly prominent for men within this age group who have had a TBI may therefore include dating, consuming alcohol and physical strength. However, for men in middle to later adulthood, the impact of illness or injury can directly conflict with social roles such as being a father or a partner (Ownsworth 2014). Considering age and life stage can therefore be important in understanding the meaning of the injury in relation to the social context and ideals which may be active in the mind of an individual man at any given time.

For many men, their partners take on a caring role in some form. Whether this is household management or personal care, this can change the ways in which masculine identity is experienced and expressed. Working with couples to explore these changes in roles can therefore be an important part of rehabilitation.

Similarly, changes in the parenting role may be particularly significant for men as fatherhood constitutes a significant part of masculine identity. Following TBI, negative perceptions of the capacity to fulfil the fathering role may be particularly detrimental to masculine identity. Within rehabilitation, therefore, it is important to help men with children to find creative ways of renewing and developing their fathering role and retaining their identity and confidence as fathers.

Exploration of opportunities for new roles and relationships within the wider community is also important within rehabilitation given that

masculine identity also relates to a man's sense of being able to make a valuable contribution with his skills. Groups or organisations such as "Headway" or "Men's Sheds" have shown that it is possible to provide an environment where men feel more accepted by others in the community and more able to be themselves (Freeman et al. 2015). These kinds of opportunities, rather than conflicting with masculine identity, may promote the development of flexibility about masculine identity for men who have had TBI.

Summary

Sustaining a TBI can significantly change the ways in which a man experiences and expresses his masculine identity. Often, the changes and losses brought about by TBI conflict with social norms and expectations about masculinity. Negotiating this conflict can result in difficulties in adjusting to new ways of being in the world because men who have experienced a brain injury can view themselves negatively in relation to societal and their own masculine ideals. In particular, loss of roles, changes in relationships and occupational capacities can result in masculine shame. However, some masculine ideals such as resilience and strength may also be helpful in adjusting to the impact of TBI.

It is important to consider that the significance and meaning of masculine identity is specific to each individual man. An individual's narrative about what is important or meaningful to him as a man should therefore be considered within assessment, in addition to his personal narrative around help-seeking and receiving support. Exploring masculine identity and associated narratives should always be done in a sensitive manner given the shame that may be associated with TBI for men during rehabilitation.

Working with men to explore the values and beliefs that underpin their own masculine identity and helping them to rework this in a new context is therefore a vital aspect of rehabilitation following TBI. Encouraging active rather than passive roles for men in rehabilitation is particularly important as well as utilising masculine qualities of strength, fight, determination and competitiveness to enhance the rehabilitation process as a new challenge and achievement. In this way, by stressing the success of men's strength in fighting, confronting and overcoming the consequences of TBI, damage to their masculine identity may be minimised and a more positive treatment outcome achieved.

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Dignifying Psychotherapy with Men: Developing Empathic and Evidence-Based Approaches That Suit the Real Needs of the Male Gender

John A. Ashfield and Dennis S. Gouws

Contending with a Legacy of Distortions About Male Gender

The view of men and masculinity currently embedded in popular culture is decidedly negative and at times even derogatory. *The Washington Post*, for example, recently published an opinion piece that asked 'Why Can't We Hate Men?' The author was a respected University professor, a lecturer in sociology and a director of a University-based Women, Gender, and Sexuality Studies Program. The publication of such an article in a respected newspaper indicates how seriously such attitudes are now taken in the western and English-speaking world and is symptomatic of a mainstream gender narrative based more upon sociological and political theory than on empirical or experimental evidence (Pinker 2002). A culture of blame towards masculinity has been fostered in gender research and therapy that may even be said to undermine basic scientific, ethical and humanitarian values. Judgmental theories such as 'toxic masculinity', for example, have gained widespread and uncritical acceptance without being tested empirically (Barry and Seager 2019 in this volume).

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Because of this academic climate, there has been little proper research into the actual life experiences of ordinary men, how they think, feel and make sense of the world. Policies and attitudes towards the male gender, even within centres of learning and government, have been based around frequently negative assumptions, myths and stereotypes relating to men and boys. Because of a predominantly sociopolitical ethos, the current literature relating to the psychology of the male gender tends to neglect or even deny the role of biologically based sex differences within the human species. In such an academic climate, research that attempts to look beyond psychosocial factors and redress potential distortions and biases becomes that much harder to fund, undertake and publish. This then amounts to a self-fulfilling prophecy of negativity about men that cannot be questioned or disconfirmed (Nathanson and Young 2001; Goldberg 1991; Ashfield 2003). It has been argued that such an ideological climate even poses a fundamental danger to the pursuit of knowledge and to a genuine spirit of enquiry (Kipnis 1995).

As psychotherapy practitioners, wishing to follow standards of ethics, science and humanity that derive from our professional training, we have found ourselves at a great disadvantage from the outset in trying to take an inclusive and empathic approach to men. So much of the necessary evidence-base for our work appeared to be either distorted or absent. Because much of the culture of counselling and therapy itself that we inherited was arguably 'feminised' (Morison et al. 2014) or based upon a model of female psychological functioning, we found ourselves in the position of having to start almost with a blank sheet of paper, developing our own methodology after attempting to separate the bias from the reality in the available knowledge-base which had the weight of authority but seemed to be rooted in generalisations and assumptions about men rather than detailed knowledge of their actual lives.

As psychotherapy practitioners, we needed to exercise basic skills of critical analysis—checking for evidence and theoretical consistency, whilst and all the time referencing our thinking to the lived reality of men's experience and men's lives in the context of wider relationships and culture.

Foundational Concepts of Male Gender: Masculinity and Manhood

The concepts of *gender*, *masculinity* and *manhood* are unquestionably essential to understand male experience, the place that men occupy in the world and what is demanded of them by society. A brief exposition of these

factors and their relation to biology and behaviour will be provided as a useful interpretive framework for our consideration of clinical issues relating to men's needs and experiences.

It is important from the outset to understand that, in referring to men's experience and behaviour, we are making observations from our clinical sample about men *on average*, not about all men universally. Not all men are alike, but we can say that men are *on average* more likely to behave in certain ways and more likely to exhibit characteristically male preferences, aptitudes and abilities.

Are Gender Differences a Product of Biology or Culture?

This is perhaps an age-old question to which the answer should probably be *both*. However, for decades, the literature and research on gender has been rooted in social constructionist assumptions that observed differences between men and women are primarily the product of social culture and learning. Such assumptions entail the 'blank slate' (Pinker 2002) idea that men and women are at birth not different at all and, unlike in other mammalian species, inherit no biological or evolutionary instincts, qualities, behavioural tendencies or characteristics. Any differences that do emerge are according to this theory presumed to be the product of experience alone.

According to this prevailing view, gender can be reduced to a collection of social roles that are 'fluid' and changeable. It follows from this assumption that if gender roles are socially and culturally constructed 'from scratch', they can therefore be socially deconstructed. Such views have also incorporated the related theory of 'patriarchy' (e.g. Meagher 2011) to define the sort of culture by which it is assumed male behaviours and attitudes have to date been shaped. The notion of 'patriarchy' itself reflects a further global assumption that the culture in question is controlled by men and disadvantageous to women (Nadeau 1996).

No empirical evidence has been produced to support a social constructionist model of gender in general or a patriarchal mode of culture in particular. A single study by the anthropologist, Margaret Mead (1935) is the only piece of investigative research that is widely cited to this day in support of the hypothesis that gender differences are completely fluid and reversible. It has been claimed that Mead found an example in one primitive society (the Tchambuli) where what in the western world we typically regard as

male roles were performed by women and vice versa. Mead herself stated many times that she had exaggerated her conclusions to challenge what she saw as highly rigid gender roles in the west (Goldberg 1991; Wood 2003; Freeman 1983; Roscoe 2003). Over several decades, she went on to publicly state that her research had never found or proven any such thing, but to no avail. These findings have been used against the expressed views of their own author to justify even in more recent times (e.g. Goldberg 1991; Roscoe 2003) the assumption that there are no biological or universal gender differences in our human species and that the psychology of gender is essentially separable from biological differences. Of course, leaving aside the question of this one tribe, no other societies where 'traditional' gender roles have been reversed have been found by any other researcher in the 80 years or more since Mead's original paper.

Despite being fundamentally flawed and without empirical evidence, these assertions are still predominant in gender discourse in many university courses and publications, and they have become widely accepted in the fields of education, humanities, health and social services. Such systematic bias may be considered to meet the standards of 'propaganda' as defined by Jacques Ellul in his classic treatise:

> … a complete system for explaining the world … provides immediate incentives to action… propaganda imposes a complete range of intuitive knowledge, susceptible of only one interpretation, unique and one sided, and precluding any divergence… It stimulates in the individual a feeling of exclusiveness, and produces a biased attitude… Once accepted, it controls the whole of the individual, who becomes immune to any other influence. (Ellul 1974)

Though support for social constructionism in the field of gender may be said to be in some decline, it remains relatively entrenched and resistant to disconfirmation or refutation (as described by Karl Popper from the 1950s onwards). Fortunately, such a closed-minded climate of scholarship is increasingly being eclipsed by compelling evidence from a whole range of academic disciplines, including Biology, Anthropology, Neuroscience, Endocrinology, Psychiatry, Psychology and even Feminist authors such as Camille Paglia (Weiss 2013).

By using available multidisciplinary knowledge for making sense of gender and its interrelationship with biology and culture, a previously unavailable understanding emerges that is at once coherent, grounded and useful—an understanding congruent with men and women's lived

experience and that can provide a more realistic basis for agendas of social and cultural transformation. This knowledge now compels us to postulate that differences in male/female brain and hormone physiology 'result in behavioural tendencies that on average correlate with statistically significant differences in behaviour on the group level' (Nadeau 1996). We can also now say, based on available evidence, that biology is the *primary* (though not exclusive) determinant that drives and orientates human gendered behaviour. Sex-specific abilities and behaviours are grounded in male and female biology, and 'all social systems conform to the limits imposed by this reality' (Goldberg 1973, 1991; Pinker 2002; Baron-Cohen 2003; Sax 2006; Nadeau 1996).

For example, the reason why men and women are attracted on average to different occupations and domains in society (e.g. males to mechanical roles and females to nurturing roles) is not because they have been collectively socialised to do so from birth, but because society recognises and reflects genuine motivational differences that have their basis in evolutionary biology (Goldberg 1973; Ashfield 2003). This should not be taken to mean that biology determines or defines people or that children should not be encouraged openly and equally to find their own path in life regardless of gender. It simply means that there are *on average* certain inherited predispositions, scripts, drives and instincts which make certain choices more likely than others. Biological sex is the fundamental originator of gender, with social conditioning reinforcing, accentuating, limiting or refining gender characteristics to fit in with (and meet the demands of) particular cultural and environmental contexts (Ashfield 2003). This bio-behavioural and bio-cultural perspective—the antithesis of the current gender paradigm—holds a great deal of promise and offers a more positive prospect for including masculinity in the spectrum of healthy and natural human identities.

Masculinit-*y* or -*ies*?

The bulk of current literature dealing with the subject of masculinity does little but reinforce a deficit view of the male gender. It almost exclusively represents social constructionist attempts to make sense of gender and behaviour, in the absence of the necessary knowledge to do so (Murphy 2004; Kimmel et al. 2005; Smith 2007). Its denial of biological reality must be counterpoised with a highly selective and reductionist view of social reality. Discussion or assertions about masculinity in this literature are commonly associated with the terms *masculinities* and *masculinities*

discourse—which are partly a way of seeking to avoid viewing all male kind as a meaningful category of humanity with a shared biological heritage.

However, masculinity, far from being interchangeable with femininity, or capable of being deconstructed, has an explanatory value and validity as a bio-psycho-social concept. Such an integrated model of masculinity best describes a range and pattern of physical, psychological and social differences that can be seen universally and cross-culturally but which are often misinterpreted as stereotypes (Ashfield 2003). Masculine *sex* is biologically innate but is expressed socially as masculine *gender* and can at that level be influenced by learning and experience.

Manhood: How Culture and Society Use Masculine Potentials

Through a process of childhood and adolescent development, masculinity or male masculine potentials are configured (reinforced, exaggerated, limited or downplayed—as far as they can be) through social learning and cultural conditioning, to fit with the particular demands of a specific culture and environmental setting. The effect or result of this configuring (in adult males) is best described as *Manhood*. Manhood in any particular culture exhibits what is generally considered to be manliness (Gilmore 1990). *Manhood*, then, in its various forms, describes what happens when biological masculinity is configured to meet the particular demands of a specific culture and environmental setting (Gilmore 1990; Ashfield 2003).

For example, the *average* male brain and hormonal physiology provides a male individual with a capacity for the forceful and single-minded pursuit of goals, stoicism, risk-taking and persevering competitiveness (Pinker 2002; Baron-Cohen 2003; Sax 2006; Nadeau 1996; Goldberg 1973). Though these capacities can be misused or misdirected (and may become toxic in damaged men), they are exploited and reinforced in our culture, because they are indispensable to the kind of roles men, particularly working-class men, must perform to keep us all in the standard of living, safety and security we have come to expect. Cross-cultural studies have consistently observed that the harder, more demanding, threatening, competitive or dangerous life is, the more stress appears to be placed on a manhood ideal that is tough, aggressive, competitive and stoical. Conversely, in circumstances that are comfortable, less competitive and pose little threat to health or well-being, the manhood ideal is relaxed and much more liberal (Gilmore 1990).

Manhood and Male Development

Boys don't achieve a sense of male gender identity or manhood merely through biological maturation. Unlike girls, they must break away from their first attachment usually to a mother, to be able to achieve a sense of identity recognised by society as manly. A boy must break his bonds with his mother to achieve an independent social status and identity, distinct from hers. Of course, this can be a difficult and lonely process when it is not cushioned by appropriate male support, mentoring and male role modelling. Nevertheless, it is essential if a boy is to attain a viable male identity and achieve the best place possible for himself in the male dominance hierarchy, and in the world of men—men of whom much will be demanded by society (Moxon 2008). This will also mean resisting at times the tempting comfort of 'puerile regression'—running back to 'mother' or the world of women for comfort or protection. Male gender identity forms in contradistinction to mother and women so that difference and differentiation is vital in identity formation (Fogel 1986; Stoller 1974; Hallman 1969; Gilmore 1990).

This may explain why boys are often more attentive to the slight encouragement of men than the lavish affirmation of women; a matter in need of more observation and research—especially when it comes to the gender of therapists and school teachers who must work with boys. Both need to adopt a gender-sensitive approach in their dealings—especially with older boys—if boys are not to view their counsel and efforts as contrary to their male quest for independent masculine identity. It may therefore be that some efforts of female professionals are perceived as a perturbing invitation to puerile regression. Alongside female influences, there is a genuine need for a 'man about the house', in the school and in the therapy room to facilitate the development of boys (see Farrell and Gray 2018).

Manhood and the Hovering Threat of Its Confiscation

The attainment of manhood and a sense of masculine social identity are also very difficult for other important reasons. Society requires male strength and risk-taking to provide the physical security and infrastructure upon which all citizens depend. Manhood is a culturally imposed ideal to which men must conform, and therefore, there is always the hovering threat of it being taken away (Gilmore 1990; Ashfield 2004). Masculinity ideals, far from being a

sign of individual pathology in men, reflect a collective cultural device that provides the immense leverage required to get the majority of men to occupy the majority of the most stressful, health diminishing, dirty and dangerous roles and occupations in service to society. This can be shown by a simple analysis of the statistics for deaths at work where men almost universally account for the vast majority. For example, recent figures for Australia show that out of a total of 182 work-related fatalities, 168 or 92% were men (Safe Work Australia 2017). And it works because human well-being depends so heavily on having a viable gender identity and on social inclusion. For men, it seems, it is better to die than to be considered a non-man. Manhood is a code (Farrell 2001) which demands risk-taking, emotional detachment, stoicism, toughness and strength; it demands that men ignore even life-threatening consequences in order to ensure material production and provision, and to protect community and family—attributes essential to human survival and prosperity.

Again, we would do well to pause and ponder how unjust and contradictory it is, to demand of men the kind of roles that often lead to greater ill health and an earlier death than women, whilst at the same time demanding that they behave more like women.

An irony of contemporary relationship expectations is that many women have identified their husband's unwillingness to share emotions and communicate as a significant reason for divorce (Wills et al. 1974; Riessman 1990). However, studies have also revealed that women consider men whose behaviour does not reflect traditional manly characteristics as too feminine and poorly adjusted (Robertson and Fitzgerald 1990). Though these apparently ambiguous and contradictory expectations appear to be a luxury of modern affluence, they may in fact have always perplexed men, since they probably also reflect the reproductive agenda of women, an agenda that requires male protectiveness and toughness, as well as the capacity to exhibit fidelity and familial bonds in order to enhance the survival of offspring.

Manhood and the Male Dominance Hierarchy

When we consider manhood, we must also see it in relation to the male dominance hierarchy. Much research indicates that male status in the human male dominance hierarchy is the basis of female choice in selecting a male partner (Buss 2003; Okama and Shakelforth 2001). As with other species, the human male is challenged in various ways that test his 'rigour' which may be gauged on the basis of evident physical characteristics or

competitive determination. Yet status in the human male dominance hierarchy is also what is being considered even when a man is being judged on personality. As Moxon points out:

> For example, a sense of humour shows self-confidence and social intelligence… women choose men also because of education and/or intelligence, and if they are dependable and/or stable… intelligence is an attribute key to gaining status. Likewise, status translates in calm dependability and an established lifestyle. (Moxon 2008)

All are preferences that fit with female reproductive criteria. Of course, money is a proxy for status. And though men may frequently seem to pursue wealth as an end in itself, it is more likely that they are less concerned with what money can buy and more concerned with how through wealth they might be valued. Interestingly, women who are wealthy high achievers still overwhelmingly choose men with higher incomes than their own, despite having no need for a male provider (Moxon 2008).

It is stating the obvious to say that men can never be like women, but the evidence indicates that women on average would not be attracted to them if they were. But that is not to say that men and women cannot benefit their relationships by exploring and negotiating a whole range of refinements and compromises in the way in which they communicate, express affection, exhibit commitment, constancy and fidelity, and in the way they seek to understand, appreciate and value each other.

Manhood and Men's Health and Well-Being

The cultural phenomenon of manhood along with the masculine ideal within society helps to explain why men are scripted not to pay much attention to their health. This means that where men respond poorly to the promptings of men's health promotion, their response actually makes sense in the context of cultural expectations, and therefore, it is not appropriate or helpful to blame men individually for not seeking help. However, when given the right support in doing so, men can and do take responsibility for their health and well-being, no less than women. They also respond positively to health promotion messages that are male gender appropriate and respectful (RACGP 2006). This means that there are positive ways of helping men to get the help they need as long as services and health messages are designed to be appropriate for a male way of thinking. Trying to change

male characteristics does not work, but tailoring approaches to fit male characteristics does. Dignifying psychotherapy with men therefore involves understanding how men experience emotions, understanding how they communicate and understanding how they cope.

Understanding Men and Emotions

Human biology has evolved in a way that has served the continuity and survival of the human species remarkably well. Sex-specific biologically based differences have undoubtedly influenced (and continue to influence) the kind of roles that men and women generally gravitate towards at home and in society. Women on average are more likely to favour roles that are concerned with relationships, nurturing, family and social bonds. Men on the other hand are more likely to favour roles that are more concerned with material production, provision and protection, roles that are predominantly task and action oriented and outside the home. As one might expect, consistent with these differences in role orientations, men and women correspondingly exhibit significantly divergent ways of thinking, processing emotions, coping, help-seeking and communicating.

Gender Differences in the Expression of Emotion and Emotion Memory

Consistent with their role orientation and demands, women are on average better at expressing and verbalising emotion than men. They have also been found on average to be better at remembering the emotional content of experiences (Canli et al. 2002).

Though men are on average less verbally emotionally expressive than women in social and personal situations, they are not in any sense unfeeling. In men, emotion tends to be more local to the right hemisphere, which has been found to collaborate less with the verbal capacities of the left hemisphere (compared with women). This reflects a *functional difference* rather than a behavioural deficit. Men simply function in a way that reflects their sex-specific biological 'hardwiring' and cognitive orientation, suited to the kind of roles they are predisposed to gravitate towards and are generally expected to perform (Ashfield 2003).

Men are more likely to exhibit their emotional experiences in terms that are *action* oriented, because they are much more behaviourally oriented in

their emotional expression than women. Men also on average are more likely to regulate their emotions in an automatic behavioural fashion rather than verbally and reflectively (Barrett et al. 2000).

Gender Differences in Sexual and Emotional Intimacy

Men's bias towards action and away from emotional intimacy is commonly exhibited in male group humour. Such humour is commonly expressed between men in group situations and typically entails poking fun at others, 'horse play' and banter, often being accompanied by physical gestures and movements (Crawford and Gressley 1991). This behavioural pattern may also be exhibited in male perception and experience of sexual intercourse. A powerful biologically based perceptual sense for men is vision. Men picture in their minds what they might *do* sexually because, to men, sex is 'largely a matter of objective things and actions' (Moir and Jessell 1997).

When men are deprived of sexual activity, they can become on average more moody, ill humoured and irritable than females. Females do not generally 'experience the same feeling of deprivation in a celibate state' (Moir and Jessell 1997). Let us consider that for men sex may be *emotion in action*—resulting in intimacy, and whilst it may not reflect the more complex requirements of female emotional intimacy, there is no basis for suggesting that it is any less emotionally meaningful. A number of men, when questioned about the meaning of sexual intercourse for them, indicated that it is in fact the main way in which they meet their emotional intimacy needs. Whereas, though sex is important and meaningful for their female partner, it is only one of a range of means by which she meets her emotional intimacy needs (Ashfield 2002). This is a common source of conflict between men and women in intimate partner relationships. A man may feel hurt and rejected if his partner is not amenable to his sexual advances, because he feels that his need for emotional intimacy, largely tied up in the *action* of sexual intimacy, is being ignored and misunderstood (and it is likely he doesn't understand it himself). When there is conflict or tension in an intimate partner relationship, or when life circumstances pose emotional challenges or cause psychological stress, men may seek sexual activity as a way of re-establishing intimacy and restoring their sense of emotional equilibrium. Recognising these potential gender differences is vital for knowing how to assist couples in negotiating workable compromise and mutual understanding in their relationships.

Men Favour Action Metaphors in Describing Feelings

The action-orientation of the male brain also explains why males also tend to favour action metaphors in describing feelings. This should be considered less as an emotional deficit than as a different form of emotional literacy or language. For example, men experiencing depression and who do get as far as talking about it in counselling or therapy, typically 'rush through' giving any account of their emotions, and characterise their depression with action metaphors (such as: 'I've fallen in a hole'; 'I'm struggling to stay afloat'; 'I've been dragging my feet for weeks now'; 'What I'm experiencing has really stopped me in my tracks'; 'I've been sliding into a very dark place'). In such metaphors, men's emotion is encoded and can be expressed without so much danger of their manhood being compromised by a public show or declaration of vulnerability (Reissman 1990; Ashfield 2002). Men are therefore often portrayed negatively as failing to express their intimate feelings directly. Traditional therapy services are equally designed with the primary purpose of eliciting direct verbal expressions of emotion, and this may unintentionally favour women and disadvantage men.

Emotion Rumination and Emotion Suppression

Men on average are more likely than women to adopt a *ruminative* cognitive style of coping (Nolen-Hoeksema et al. 1999; Tamres et al. 2002). This tendency to dwell on a problem, its perceived cause and the negative emotions associated with both, readily lends itself to a self-defeating vicious cycle of anxiety and/or depression. However, men have also been shown to be more likely to engage in distracting activities that divert attention away from negative emotions (Nazroo 2001; Jick and Mitz 1985). This can be seen as men being more likely to have their emotional switch 'full on' or 'full off'.

Masculinity is also associated with some more protective cognitive biases. Women have been shown to be more likely than men to feel helpless and powerless to change anxiety-provoking situations (Nolen-Hoeksema et al. 1999) and more likely than men to discount their successes and personalise their failures, thus enhancing their vulnerability to depression (Deaux 1979; Seligman 1975).

The Intensity of Male Emotional Experience

Men are generally less emotionally expressive than women and conversely women appear to have a more elaborate emotional repertoire. However, this does not mean that men and women experience emotion differently in terms of intensity. Research has shown that men characteristically tend to mask their emotions (e.g. Gross and John 1998). When it comes to expressing confidence, however, there is no reported difference between men and women. This suggests that, rather than lacking confidence in expressing their feelings, men simply contain and limit emotional displays. Research has also shown that women report experiencing no more emotion than men, despite being more emotionally expressive. This suggests that, though cultural conditioning may contribute to greater emotional expressivity in women, it appears not necessarily to reflect a greater internal capacity to experience emotions (Gross and John 1998). The evidence suggests that men on average have a higher threshold for expressing emotion. In other words, men need on average to experience a higher level of emotional intensity before externally expressing any given emotion (Kring and Gordon 1998).

Men and Communication

Male and female styles of conversation and communication appear to reflect quite accurately 'the conditions of survival for single-sex groups of hunter-gatherers'. Men are more likely on average to use conversation to 'preserve their independence' whilst women use conversation to establish connections and negotiate relationships. It appears that these differences contributed to better survival in the evolutionary history of our species by creating a collaborative and differentiated system of emotional and task-related performance. The conditions of a hunter-gatherer existence therefore may be said to have occasioned the 'evolution of sex-differences in brain regions associated with sensory and motor skills' (Nadeau 1996).

It is well known that in the male brain the cerebral hemispheres function in a less collaborative way than is observable in females. Male linguistic constructions of reality are more specific to the left hemisphere and with fewer inputs from the right hemisphere. Male linguistic constructions are consequently more likely to be characterised and constrained by 'lineal, categorical and causal cognitive processes of the left hemisphere'. A limited contribution from the right hemisphere explains why such constructions

appear to exhibit 'less awareness of coded meaning in spatial relationships, emotional nuances in behaviour, and vocal intonations that alter the literal meaning of words' (Nadeau 1996).

There are also significant differences on average in visual capacities between the male and female brain. Men on average have better visual acuity and specificity of sight in the middle of the visual field. This means that men:

> perceive reality in terms of individual objects … construct reality in terms of vectors marking distance and direction in map space …. (Nadeau 1996, p. 87)

Male conversation and group behaviour also tend to focus on objects, action and activities. Males tend to use less refined or nuanced sensory language, preferring abstract metaphors to express experience and are usually carefully measured in their self-disclosure, ensuring personal 'space' that allows for the preservation of autonomy.

Understanding Men and Coping

Human coping is a complex concept which has given rise to a number of classic definitions, perhaps the best known of which is that of Lazarus and Folkman, who define coping as 'constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person' (Lazarus and Folkman 1984). As these authors point out, there is a difference between coping as a *process* and coping as an *outcome*. Coping is best understood as an interaction between predisposing bio-behavioural and unique cultural determinants. Sex or gender-specific processes and outcomes of coping, though serving to ensure the survival of *individuals*, more fundamentally are doing the bidding of the wider agenda of social adaptation and survival of the *species*. Observing the processes and outcomes of coping can enable us to mitigate some of the undesirable effects of our biology and of cultural expectations. What it cannot do is support an argument suggesting that one gender is *generally* better at coping (by virtue of process or outcome) than the other, though there are gender differences in both directions depending on the context. Since coping is inseparable from biological imperatives of survival and social adaptation, it is better science to examine *gender difference* alongside *gender complementarity*.

In examining men and emotions, we noted how men are on average less verbally expressive of emotion than women and use expressive suppression

as a preferred regulatory strategy. Because emotional suppression is a primary coping strategy for male role performance and because it has been seen as an emotional deficit and a barrier to health, it bears closer examination. The constant refrain of those who urge a reconstruction of masculinity is that 'men need to get in touch with their feelings'. Certainly, it is true that some men do become disconnected from their emotions just as some women get overwhelmed by their emotions. Yet when we consider the imperatives of biology and culture, and male and female role demands, the sex-specific 'signature' coping styles of suppressive emotion regulation and ruminative language-based emotion regulation, make more sense. Used appropriately, they contribute inestimably to human well-being and survival. Employed with global rigidity, however, they are undoubtedly problematic.

Suppression as a Male Coping Strategy

Suppression differs from *repression*, though these terms are frequently used synonymously. Repression describes putting painful (or unacceptable) thoughts, memories and emotions out of mind and forgetting them. All psychological defences are thought to do this to some extent, but repression is a more *unconscious process* of 'forgetting' and not even realising it, and having no conscious memory or knowledge of the elements that have been repressed. Unlike repression, *suppression* is a more conscious choice not to indulge a particular thought, feeling or memory. 'Not to indulge' means that though we are aware of a thought or feeling, we choose neither to dwell on it nor to express it. We do this because a thought, emotion or impulse may not be helpful to the situation we find ourselves in, and/or because of time constraints in which 'we just can't deal with that right now'. Suppression is a useful psychological mechanism which permits us to concentrate without distraction on what we are doing. To be distracted by impulses, thoughts or emotions which arise, or to feel the need to act on them, could in many situations be unhelpful, hazardous or even dangerous.

The effects of this more characteristically male response (and therefore the utility of suppression) in relation to coping and mental health include: a reduction in negative emotion/affect, a reduction in emotional awareness and rumination and a reduction in the strength and/or duration of these emotions (Sawrikar and Hunt 2003).

Coping with Powerlessness: An Important Key to Understand Men's Experiences and Mental Health Issues

Men's perception and experience of powerlessness is a complex phenomenon. It is one that represents a confluence of factors: physiological, sociocultural, psychological, interpersonal and existential. Men's susceptibility to the experience of powerlessness and its deleterious effects is deserving of consideration as a significant mental health issue. It is accepted that the male brain is tuned for potential aggression (evident in the effects of male hormones acting upon a predisposed male brain). It is also accepted that a capacity for aggression, competition, imposing order, exercising control where there is distress, threat or perceived danger has, throughout human history, been genetically rewarded for its survival value. Such survival value has ensured that this capacity has evolved in males (Daly and Wilson 1985).

In evolutionary terms, it can also be seen that manhood, forged out of masculine biological potentials, is culturally constructed and imposed primarily to benefit and serve the collective and perceived best interests of society. The drive to take risks and place the self in danger for the protection of others has a general utility for the social group but puts the individual man into situations of potential powerlessness with which he must try to cope. There is always therefore also a threat of failure and of loss of manhood (Gilmore 1990; Ashfield 2004). Gilmore rightly observes that

> Men are compelled by moral codes and norms, through psychological and material reward and punishment, to conduct their role principally to ensure the replication of society's primary structures, to defend against 'entropy, human enemies, the forces of nature, time, and all human weaknesses that endanger group life'. (Gilmore 1990)

Men are biologically constituted and culturally orientated for dangerous roles, sometimes with a great risk to personal health and survival. That men continue to face these life-threatening situations is part of an ancient script of masculinity that has the force of a biological instinct but is also shaped and reinforced by cultural expectations. What is so often wrongly named ego, is the will to survive, to be accepted, to qualify—to be worthy of manhood. Modern mantras of 'personal freedom and choice' and 'biology is not destiny', ring rather hollow in the lived experience of many men.

Powerlessness and Perceived Male Role Failure

Against this background, we can understand why men experience the distress of powerlessness when they are placed in circumstances which lead to a sense of role frustration—at worst, role failure—such as being unable to adequately provide for or protect others or calm the distress of others through practical interventions, problem-solving or physical effort. It is not surprising that men do particularly poorly when unemployed (some research suggests that up to one in seven men who become unemployed will develop a depressive illness in the following 6 months) and on entering retirement (Royal College of Psychiatrists 2008). Certainly, loss of social interaction may be a significant factor here, but so too the loss of opportunity to exercise the dignity of autonomy, activity, purpose and usefulness. We particularly need to understand why men experience the distress of powerlessness when they are directly blamed for their inadequate help-seeking and self-care at the same time as being expected indirectly to live up to standards of male status, strength and attractiveness. This isn't a litany of victimhood but the reality of men's lived experience. We cannot, with any sense of intellectual integrity, continue to ignore it or the evidence that confirms its validity (Farrell 2001).

Powerlessness as a Significant Mental Health Issue

For men, powerlessness or a sense of 'impotence' can be particularly debilitating. It may cause impairment of executive brain function, chronic anger and it is commonly a precursor of depression and suicide (Smith et al. 2008; Royal College of Psychiatrists 2008). Diagnosing depression in men isn't always straightforward, nor is its difficulty always overcome through the use of available psychometric screening tools. We still lack a satisfactory male gender-specific approach to depression diagnosis. Though there is no current evidence of a completely separate type of depression for men, some recurrent gender differentiating symptoms have been observed. These are symptoms suggestive of the presence and experience of powerlessness, including irritability, anger, feeling out of control, aggression, greater risk-taking. Whilst in any given case these symptoms, along with others, may suggest a depressive syndrome, a hasty diagnosis may miss the more accessible and treatment-amenable phenomenon of powerlessness.

To ask the simple question: 'Are there some ways in which you are presently feeling powerless?' can immediately identify target issues for intervention and, in the process of disclosure, ameliorate the experience of powerlessness, commonly associated with feeling 'overwhelmed', or 'really stressed'. Indeed, it is often the case that, if powerlessness is addressed, chronic stress, irritability, expressions of anger and other symptoms quickly abate, and this can also reduce the negative impact on interpersonal relationships. The gender-specific bio-behavioural response of males to stress appears to link anger and irritability with the 'fight or flight' response. Though unrelenting stress may certainly lead to the experience of powerlessness, it is arguably more likely to be *symptomatic* of the experience of powerlessness. Consequently, stress reduction and management interventions need to include an enquiry into perceived powerlessness. Powerlessness may be considered a precursor and in some ways a useful early warning signal of impending deterioration in mental health. Identifying and responding to powerlessness also puts our attention where it most needs to be: prevention and early intervention, rather than on waiting for full-blown mental health problems or illness to develop.

Dignifying Psychotherapy with Men: Foregrounding Male *Aptitude* not *Ineptitude*

Based on available evidence, biology can be considered the primary (though not exclusive) determinant that drives and orientates gendered behaviour. Sex-specific abilities and behaviours are grounded in male and female biology, and 'all social systems conform to the limits imposed by this reality' (Goldberg 1973, 1991; Pinker 2002; Baron-Cohen 2003; Sax 2006; Nadeau 1996). Biology tends to differentiate men's and women's behaviour, responses, aptitudes and abilities in a broad range of significant areas including emotional processing and expression, language, cognitive abilities, communication, intimacy, motivation, attitudes, career choices and sexual behaviour. The list goes on (Pinker 2002; Baron-Cohen 2003; Sax 2006; Nadeau 1996; Goldberg 2003).

Health authorities responsible for male clients need first to have an informed model of manhood and the demands that are made on men. This model needs to be informed by comprehensive scientific evidence including biological factors and above all by humanity and a desire to connect with men in an empathic way. The pressure on men to preserve the

integrity of their masculine identity or manhood is not a case of 'Male ego' or 'machismo', as is so often mistakenly and judgmentally believed. It is a matter of self-preservation in the face of unchanging social expectations that are calibrated to fit the evolutionary heritage of the male of the species. The greatest enemy for a man is shame, and it is only societal change that can ease that burden, not naïve pressure on individual men to 'open up'.

Men generally need not to be persuaded but to be given social licence to take active public steps in tending to their health and well-being. A sense of shame and dishonour at becoming the protected rather than the protector is what lies behind much of male help-seeking behaviour. This is where collective social and cultural attitudes really do matter. Such negative attitudes in society as a whole towards male victimhood explain why men are so reluctant to see a doctor or put themselves in a vulnerable position even after much prompting from a female partner (Ashfield 2016). Blaming this upon the stubbornness of individual males is missing the point. It has also been observed that, if self-care and health care can be promoted and accepted as a group norm within an all-male group, individuals within such a group will often alter their individual help-seeking and health care behaviour positively. This is simply because they've been given licence and permission to do so by a sufficiently credible social peer group (Rees et al. 1995; Ashfield 2002).

Some acknowledgement is now being given to the need to address the nature of service delivery environments and methods for men—to affirm male dignity, to ensure that they are appropriate to men's particular need of confidentiality, psychological safety, and availability due to work demands and shift schedules (RACGP 2006). It is difficult for men to have to sit on public display in waiting areas mostly used and characterised by female and child patients or clients—areas which for men symbolise weakness and vulnerability. It is also difficult for men to fit in with service availability that is mostly orientated to cater for women. Health and psychological service providers also need to be aware that it is still largely the case that male workplaces are generally unsympathetic to them taking time off work to attend appointments. Except in the most accommodating of male workplaces, insinuations of malingering, of being work-shy or lazy are, for men, commonly associated with taking time off, and so discourage help-seeking. Again, this is not a simple case of 'Male ego' or 'machismo'. It is a more complex issue of seeking help whilst preserving the social asset and personal necessity of masculine dignity. Venues, times, and modes of service delivery need to be able to cater for men's circumstances and gender-specific needs as well as they do for women and children (Woods 2001; Tudiver and Talbot 1999; NSW Department of Health 2000; Buckley and Lower 2002).

The concepts of *gender*, *masculinity* and *manhood* are an essential key to understand male experience and psychology, the place and role that men occupy in culture and society, and what is demanded of them by society. They provide a vital interpretive frame of reference for our consideration of clinical examples of some men's issues and experience (Ashfield 2011). They are foundational for the knowledgeable practice of psychotherapy with men, of a kind that has a genuine regard for therapeutic efficacy and for doing no harm. In using this frame of reference, we will discover not emotional *deficits* in men but real and important emotional *differences*. We will also discover not the much publicised male *ineptitude* but rather a gender-specific *aptitude*.

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Reconnection: Designing Interventions and Services with Men in Mind

Roger Kingerlee, Gabriel Abotsie, Andrew Fisk and Luke Woodley

Frustrated Attachment: Explaining Male Avoidance of Psychological Help

As discussed earlier in this volume, boys and men are subject to a constellation of factors that affect male psychologies in specific ways. Developing this line of thought, the cumulative impact of neurological, hormonal, psychological, social, and cultural factors tend—especially when men face stress in their lives—to bias men away from psychological reflection, and towards actions including antisocial behaviours, substance use, violence, and other forms of avoidance. This can lead men to avoid and/or disconnect from potential sources of help. This process has been termed the reflection abandonment mechanism (RAM) (Kingerlee 2012).

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At the same time, similar processes are re-enacted with those around men, including family members and services—which often have a majority of female staff (Morison et al. 2014). Here, too, a combination of factors—not least powerful cultural expectations of men to be stoic and not to show vulnerability (Connell 2005)—can conspire, in effect, to propel the man *away* from the possibility of psychological reflection. In short, the RAM affects both men and those around them in such a way that men in distress feel blocked and are less likely, on average, to seek, and eventually to access, psychological help (Addis and Mahalik 2003). In this way, unless these patterns of unwitting and collusive mutual avoidance are addressed, men can—and do—remain unhappily isolated, and their distress goes unresolved. Sometimes, this ends in tragedy.

It is increasingly recognized, too, that psychosocial dislocation and disconnection can leave individuals more vulnerable to various issues, including different types of addiction (Alexander 2008). All too often, this is the position in which men find themselves when they encounter psychological distress—and the barriers to their internal and external worlds go up. This, in effect, leaves the men in a state of what we call 'frustrated attachment'. Sensing distress, but feeling unable to turn to significant others—family, friends, or health professionals—for emotional support and containment, men often use alcohol, drugs, work, or other self-soothing possibilities.

On the other hand, once men's preferences for help are better understood (Liddon et al. 2018), more adaptive opportunities can arise for addressing and ameliorating these issues, both in boys and men themselves and in services around them. In this chapter, we will show how the potential impasse between men and services can be usefully circumvented, and how men can re-attach with others. At best, in our experience, this can mean that men's lives are saved.

Speaking to Men's Needs

Given what has been established about men's views of, and interactions with, health services, certain patterns are noteworthy. First, it is clear that *some men* have little or no difficulty in accessing health care, including psychological health care, via standard routes. Indeed, recent evidence from national IAPT services in the UK (NHS Digital 2018) suggests that a significant proportion of men (typically around a third of the total) do indeed complete IAPT interventions, including (among other things) cognitive behavioural therapy (CBT) and eye movement desensitization and reprocessing (EMDR).

Second, another group of men (the majority, according to IAPT statistics) feel less comfortable with regard to accessing health care and mental health care particularly. This group appears to feel a sense of psychological and/or social threat from the prospect of help-seeking and/or disclosure, and so—in the short or long term—avoid it (NHS Digital 2018).

Third, clinical experience in the UK suggests that a third group of men have a high level of psychological need and may be at high risk of suicide—but are also extremely reluctant to access help via traditional routes, NHS, or otherwise. Clinical practice and research evidence suggest that such men—who often also show a number of other risk factors including life stage, loss, illness, social isolation or disability—sometimes end their lives via suicide. Indeed, it is a sobering thought that statistics suggest that during recent years in the UK, around three-quarters of all suicides in the UK were male; and in the UK, around 1 man dies by suicide approximately every 2 hours (ONS 2017). Overall, the evidence suggests that traditionally organized mental health services—that is to say services that take a one-size-fits-all approach to the sexes—do not optimize male engagement with psychological health care.

The Male Connection Continuum

On the basis of clinical observation, we propose a continuum of male connection with relevant services and other individuals and institutions who could help them, as follows (Table 1).

Often, but not always, these phases occur in sequence. In clinical practice, men may not have to progress through all phases for a significant and 'good enough' lift in well-being to ensue.

Table 1 The male connection continuum

Disconnection: The man is disconnected and isolated, outside the remit of services. Barriers to the external and internal worlds are in place
Behavioural Connection: The man changes his behaviour in the direction of connection, for example visiting his GP, exploring help online, or attending a helpful activity like a local Men's Shed. The barrier to the external world has been lifted. The barrier to the internal world remains in place
Emotional Connection: The man begins to connect emotionally with others, individuals, and/or a service. The man is also in emotional contact with himself. The barriers to the internal and external worlds have been lifted
Reconnection: The man shows signs of being fully reconnected to others, and to himself, and Recovery and change processes are underway

With these points in mind and the attendant risks, we suggest that interventions and services for boys and men need—to be maximally effective in the current social and cultural climate—to speak to men at different levels. In practice, this means the following.

Indirect interventions and services aim to help men, but do so obliquely. As outlined below, these interventions often base themselves around a traditionally male activity, in which men can involve themselves. In the male perception, experience suggests this offers the benefit of activity and involvement or inclusion—but without the perceived cost of self-disclosure. In such arenas, there is no expectation or pressure, often, to say how one is feeling, or why. The perceived lack of judgement here can help men in the engagement process (Kivari et al. 2016).

Direct interventions and services, on the other hand, offer clear and specific help to men on key issues. In such interventions, content may or may not be tailor-made, in effect, to help address the men's issues in hand. Often, the intervention will be advertised as such, and its intentions will be explicit. In some cases, the content of the intervention may be more or less directly derived from men's experiences or reflect in very closely. One such is Alexithymia Reduction Treatment (ART) from the USA. ART is a short-term therapy that aims to help men further develop their emotional repertoire and skills, in a group format. Elements of the intervention include socialization into male emotions, developing a language for feelings, reading the emotions of others, and logging one's own emotions through time. Deeper emotional issues are also considered. Emerging evidence suggests that ART can be effective in helping men in this domain (Levant et al. 2009)—in terms of reducing alexithymia and increasing willingness to access appropriate help.

Electronic and online services offer men various and often innovative ways of accessing help in different forms (Bakker et al. 2016). Often, these have the benefit of being available 24 hours per day, which suits many men. One prominent example here is the Big White Wall (BWW 2017; www.bigwhitewall.com). Originating in the UK in 2007, BWW now operates also in the USA and New Zealand and offers an anonymous, online space for individuals to seek support, guided by professionally trained 'Wall Guides'. The service is open 24/7, 365 days a year, and while not free to everyone, some institutions (notably the NHS, and universities in some areas of the UK) pay for access for it; BWW is, moreover, able to be used free of charge by UK Armed Forces veterans and their families. BWW offers users different options, including self-assessment, talking to others on the site, doing creative work about difficult feelings, finding useful information, registering

for courses based on evidence-based therapies, and linking up with other members of BWW.

BWW's outcomes are impressive, pending randomized controlled trials that are underway. BWW's Live Therapy option has, for those referred to BWW by their GP Recovery rates of 57%, the comparable rate for IAPT being around 45%. Around 96% of those surveyed were also 'very satisfied' with their therapist. Finally, 46% of BWW users reported that they had shared feelings or experiences on BWW for the first time (BWW 2017). So, while not initially designed purely for use by men, BWW has features (anonymity, accessibility) that demonstrably appeal to them.

Finally, *crisis interventions and services* specifically for men are developed, again, with men and their needs in mind. This can mean that such services arrange themselves such that they are—at a psychological level—easily accessible to men in distress who may find engaging with traditional modes of help difficult or impossible. As we shall see, a vital aspect of such interventions and services is often the clear option of a low-key, light touch start to contact for the man. Clinical experience in the UK suggests that anonymity, or something close to it, can be helpful. This may be in part because anonymity serves to reduce the felt sense of threat in the perception of the distressed man in question. Put another way, anonymity, or something close to it seems to offer some men a perceived psychologically safe mode of engagement.

As discussed elsewhere in this volume, the UK-based organization Campaign Against Living Miserably (CALM; http://www.thecalmzone.net; @thecalmzone; facebook.com/thecalmzone) has been a major innovator in this area over the last 15 years or so and has had notable success in reaching men at risk of suicide. CALM was set up in the North West of England with the express intention of addressing male depression and in particular male suicide (Powell 2015). On the basis that, as noted above, many males find it difficult to access help through traditional routes, CALM has offered men a different path. Currently, CALM offers men various ways of accessing help, in what amounts to a multimodal package.

First, the CALM website offers regularly updated features, information, and useful links to men. The language used is deliberately straightforward, jargon free, and male-friendly (Robertson et al. 2015). Second, the CALM helpline (London: 0808 8025858; outside London: 0800 585858; and web chat) is free, confidential, and anonymous and open 365 days per year, from 5 p.m. to 12 midnight. Third, CALM does significant campaigning work, raising awareness that, among other things, suicide is the single biggest killer of men in the UK aged under 50. As part of this campaigning work, the

national media have helped publicize the issues—and what CALM is doing about them. Fourth, CALM provides authoritative information—written by highly qualified professionals—about issues pertaining to boys and men from abuse, through exam stress and hair loss, as well as coping with major life events like separation, divorce, and loss.

The available evidence, while not conclusive, suggests that CALM has been highly effective. Perhaps the clearest evidence of CALM's efficacy lies in its outcome data, which includes texts, calls, website views, and social media activity. Regarding contacts answered, in 2016/17 in CALM answered 63,536 (versus 55,946 in 2015/16), and 409 suicides were prevented (up from 139 in 2014/15) (CALM 2017). Given that the majority of CALM's users are male (up to approximately 80%), these are impressive figures.

It should be noted that other features of services aimed at men are important. In a major review of 9000 international research articles, Robertson et al. (2015) suggest that successful interventions for men can and do share certain key characteristics. These may include: care around the language used in the work; the appropriate use of humour to engage males; using, where appropriate, a setting that is male-friendly and at the very least will not alienate men outright; bearing in mind male interests so as to incentivize men and become, and stay, involved. Indeed, anyone considering initiating a new intervention or service for men or boys would benefit from absorbing Robertson et al.'s (2015) comprehensive work. In short, consensus is emerging that men and women may often have different preferences for psychological help (Liddon et al. 2018), and in order to be effective for men, who are unlikely to approach mainstream services, non-traditional routes to help need to be developed (House of Commons Health Committee 2016).

There are, then, various interventions and services that operate along these lines—in terms of content and style—internationally and offer men the opportunity for behavioural and emotional reconnection.

What Do Men Want? Reverse Engineering Services for Men and Boys at Local and Regional Level: The East of England, 2014–2018

In the light of the above, it will be clear that men through the lifespan may benefit from having various options via which to engage in care, from the anonymous and/or light touch, to the direct.

In our experience, furthermore, it is often the case that men who are less comfortable seeking help initially may start with an anonymous or indirect form of help, where disclosure is not required as they connect behaviourally, then progress, if necessary, to more direct options for help that can lead to full reconnection. In other words, men may 'dip a toe in the water' first and then—if the experience is a good one—progress on to other forms of intervention, some of them traditional forms of care. This, then, is a pathway into care that differs from that previously understood. Historically, men have frequently avoided care in its entirety, perhaps driven to self-medicate instead. This picture is changing, making it easier for men to engage in an initial form of care which, in their perception, feels safer. This new, phased pathway is exactly what we have experienced over recent years in our work with male civilians and veterans in Norfolk, in the East of England.

In what follows, we will show how services, both inside and outside the statutory sector, have been made more male-friendly during the past few years. This has meant:

- systematically re-engineering existing care pathways;
- extensive partnership working; and
- consciously utilizing new tools of engagement.

Above all, during these processes, we kept male psychologies in mind. This meant, and means, reverse engineering services for men and boys and starting with the question: in terms of help and how to access it—*what do men want?*

Developing Services for Veterans in Norfolk

Our experience developing services for veterans in Norfolk illustrates many, if not all, of the points in question. As such, we describe this journey in some detail here, since the work has been demonstrably effective and engaging and treating men. Within this work, there have been distinct phases that have targeted the veterans' specific needs (Kingerlee et al. 2016).

It is well documented that ex-military personnel can be vulnerable to psychological, physical, social, and adjustment issues that overlap with, yet also differ from, the general population (Hacker Hughes 2017). Clinical observation of this group, moreover, suggests that veterans may often be subject to a constellation of issues that might be termed Veterans' Disconnection Syndrome (VDS). VDS might include one or more of the following:

- Difficulties understanding and making the often challenging transition, from military to civilian life;
- Feelings of anxiety;
- Feelings of depression;
- Feelings of anger and irritability;
- Symptoms of psychological trauma, often though not always from operational stress injuries;
- Substance misuse or other addictive behaviours;
- Relationship difficulties; and a
- Sense of distance and alienation from others in civilian life.

Unaddressed, VDS symptoms and experiences can and do leave ex-military personnel in an isolated, disillusioned, and debilitated state—often a risk to themselves and others: a situation that one would wish to avoid.

Beginning with the End in Mind: Male Lived Experience of Recovery

The Founder and Director of the Walnut Tree Project, Luke Woodley (a co-author here), has significant lived experience of post-traumatic stress after serving with the UK Armed Forces on numerous operational tours. Luke's Recovery brought him together with another of the co-authors, Roger Kingerlee, clinical psychologist. Via a long, arduous, innovative, and circuitous route that took over a decade, Luke recovered his functioning such that—from around 2014—he felt ready to begin to help others in their own journey of Recovery (ImROC 2016).

As part of his journey, Luke, aided by formally learning meditation skills, engaged in significant introspection. Among other things, this involved developing a bespoke and personal understanding of how his own psychological issues were unhelpfully playing out, as well as their drivers and origins. To take two examples here, Luke was able to note how his military training and his post-traumatic stress overlapped (notably in the domain of hyper-vigilance). Luke was also able to identify some unhelpful psychological mechanics. One major engine of distress, he noted, was rumination which—often unidentified and unchallenged—had the effect of strongly amplifying other issues including low mood, insomnia, and intrusive thoughts and images. In Luke's experience, a psychological chain reaction could be sparked off that—if it's drivers were not understood—could last for days or weeks and have, at worst, multiple deleterious consequences

including an impact on existing supportive relationships and overall well-being.

In effect, this period of introspection and Recovery gave Luke insight into the psychological anatomy of combat-related post-traumatic stress disorder. Moreover, Luke's experience seemed to suggest that when this knowledge was applied, positive results could accrue. This hard-won, male, lived experience of Recovery was the essential starting point for what followed.

Utilizing Social Media: Establishing the Walnut Tree Project

In mid-late 2014, having returned from national and international travels to Norfolk, Luke established the Walnut Tree Project, a Community Interest Company. The explicit aim was to use the Project as a means of helping other former military personnel to engage with statutory services, especially with the NHS.

To do this, Luke—who had had extensive high-level business experience subsequent to his time in the military—drew on his marketing expertise as well as his own experience of Recovery. He determined that the key tool of engagement would be social media. This was wise, given that data suggest that younger men prefer to use smartphone technology including web chat to access help (CALM 2017). Consequently, Luke initiated a Facebook page for the Walnut Tree Project (http://facebook.com/walnuttreehealthandwellbeing; @Veterans_MH). Using social media in this way allowed key aspects to be enabled. First, social media allowed a high degree of psychological availability and visibility (Kahneman 2011) for ex-Forces personnel and their families. Second, social media allowed great open and ease of contact for this target audience. This was a deliberate contrast to traditional NHS services which can, in the eyes of men, often seem impenetrable as well as inaccessible. The Walnut Tree Project consciously aimed to change that.

From the outset, great efforts were made to make the Facebook page engaging and entertaining for veterans and their families. It was soon clear that the Facebook page was an effective engagement tool. Facebook analytics showed usage patterns that demonstrated how often the page was used, by whom, and where from. This data, coupled with qualitative feedback from users, enabled the page content to be further modified to make it maximally engaging. It should be observed, however, that Luke found the tastes of the largely veteran audience difficult or impossible to predict. Sometimes, 'random' postings or photographs were the most popular in terms of Facebook

'likes'. Above all, though, Facebook analytics through 2015–2018 showed that the page was successful as a means of engaging veterans, enabling them, in the first instance, to behaviourally connect with help.

Co-developing the Veterans' Stabilization Programme

In summer 2014, soon after his return to Norfolk, Luke emailed Roger (co-author here), and we decided—both having a similar idea at the same time—to co-develop an intervention for UK Veterans. This, we felt, should be a community-based treatment that would allow group members to attend while still living at home (often with their families) and, crucially, to apply new psychological skills developed in the group into practice in day-to-day life. When former service personnel are, as is sometimes the case, treated in groups in hospital settings, anecdotal evidence suggests that the transition home afterwards can sometimes be problematic. Our intention was to sidestep this issue via a community intervention and allow reconnection while living at home.

The development of the Veterans' Stabilization Programme (VSP) was careful and gradual (Kingerlee et al. 2016). Above all, in line with Recovery principles (ImROC 2016), the overall emphasis was *basing the VSP as far as possible on Luke's experiences of personal Recovery from combat-related post-traumatic stress*. In sum, lived experience of the issue was given primacy over received psychological ideas about what 'should' or 'shouldn't' help. While we shared our expertise in the different areas, Luke—rightly—always had the final say on points of content. Our colleague John King, mindfulness trainer, joined the discussions on these terms.

Perhaps inevitably, given this Recovery-centred approach, the VSP developed in unexpected ways and with—in Roger's experience of therapy groups in the NHS—some striking if not original features. Overall, building on Luke's lived experience and moving beyond the traditional notion of PTSD, combat-related PTSD symptoms are viewed in the VSP *as a disorder of speed*. Using Kahneman and Tversky's notion of 'thinking, fast and slow' (Kahneman 2011)—a body of research that itself derived partly from Kahneman and Tversky's own military experiences in the Israeli army of the 1970s (Lewis 2017)—emphasis is put on how the combination of military training (in which speed gives advantage and to some degree may become an automatized reaction) and PTSD symptoms (where hyper-vigilance can strongly feature) can produce, in effect, accelerated over-reactions to innocuous stimuli in the civilian world. As a simple example, the light of a camera

flashbulb at a party could produce a fast and strong reaction in a veteran with unresolved symptoms.

In the VSP, attention is drawn throughout to the matter of speed, the issues fast reactions can bring, and, above all, how to reduce the speed of reaction and 'go down the gears'.

The key themes of the VSP are as follows and are presented in order:

- Transitioning between military and family cultures;
- Psychological mechanics of post-traumatic stress;
- Trojan horses: depression, anxiety, 'paranoia', and rumination;
- Managing the external environment;
- Substance misuse;
- Slow thinking: becoming more mindful.

In the final section of the course, group members are introduced to the comprehensive, CBT-based Threat Reaction/Threat Response (TRTR) model. As Fig. 1 shows, this model shows how veterans' psychological issues can develop, via one's personal history, military training and experiences, gender script, and medical history, and how the issues can be driven and maintained by an unhelpful, accelerated, reaction-based stance which fuels hyper-arousal.

With the switch across to a more adaptive, responsive stance to perceived threats that the VSP teaches, however, significant clinical gains can be made. Opting for the more adaptive, responsive mode also seems, in our experience, to have a neurophysiological cooling effect that dampens chronic hyper-arousal and trauma- and stress-induced inflammation (Bullmore 2018). Via such means, veterans are often, by this stage in the VSP, able to think more clearly, more of the time. The negative feedback cycles of previous—where triggers, anxiety, low mood, and rumination fed each other—often to be replaced by virtuous circles, where increased well-being fosters further enhanced decision-making and subsequent activity. Emerging qualitative and quantitative evidence from the VSP indicates both validity and clinical effectiveness.

Finally, in late 2016, a 24-hour crisis service, the Veterans' Response Partnership (VRP) was established by Luke and colleagues. Accessed by social media, and initially using two specially equipped response vehicles (donated by a local benefactor), the VRP has proved very successful to date. In summer, 2018, the VRP was renamed the Community Response Team (CRT) to reflect its expanded remit.

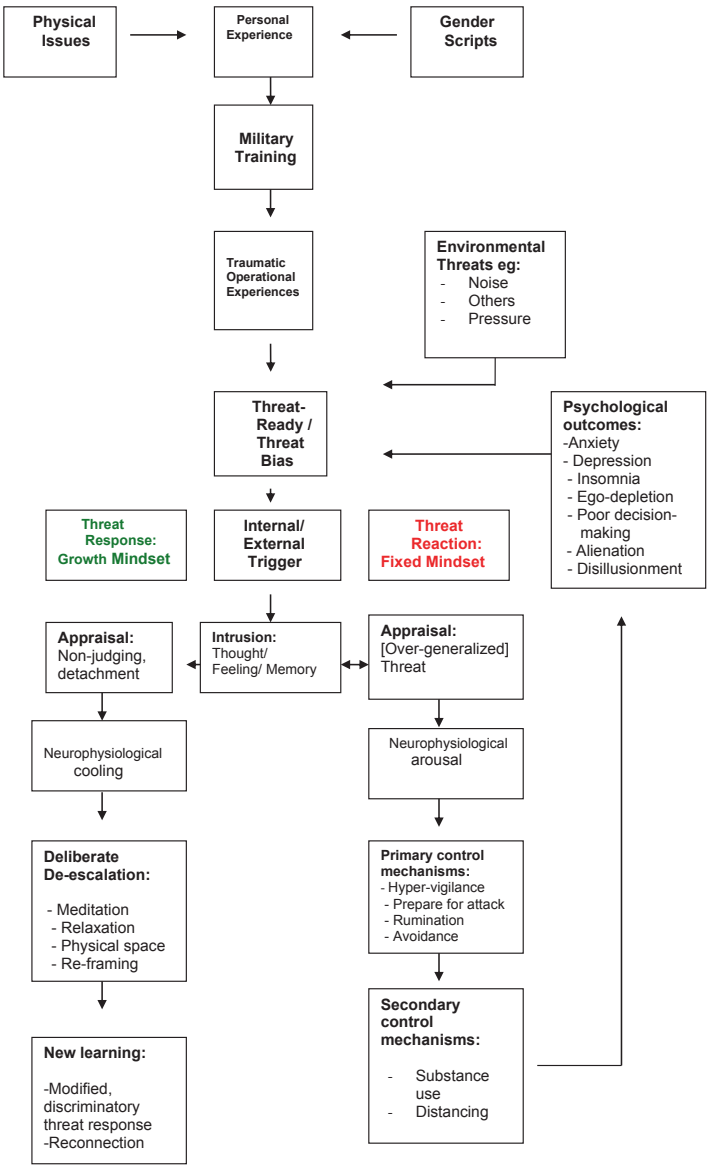

Fig. 1 The Threat Reaction/Threat Response model

Summarizing the Utility of the Walnut Tree Project, the Veterans' Stabilization Programme, and the Community Response Team

From the current perspective of designing interventions and services with men in mind, various points emerge here. First, it is clear that new, multimodal services for men can be constructed (Robertson et al. 2015). The Walnut Tree Project, VSP, and CRT offer something close to effective, wrap-around care for predominantly male veterans and their families. The needs of those served are closely met principally because the services were explicitly designed with the 'customer' in mind.

Second, very importantly, taken together, these services consciously (and effortfully) opened new, more accessible paths by which men and their families could ask for help. Here, social media was, and remains, central as a first point of connection.

From the time of the Walnut Tree Project being open for business on Facebook, certain patterns of engagement were noteworthy. Here, male veterans new to the Project—disconnected, perhaps needing and wanting help but as yet feeling unable to request it—would make very tentative, initial contact. This might be, for example, a text or Tweet sent late at night. This would be answered, then little or nothing would typically be heard for a day or two. Then another, longer, text or Tweet would follow. Gradually, then, the interchange would pick up as the veteran in all probability grew more confident that he was in reliable, safe, and trustworthy hands—and could behaviourally connect. Frequently, telephone calls might follow. A next possible step might be an informal drop in 'for a brew and banter' at the Walnut Tree Project HQ. Finally, the veteran in question could be encouraged or certain cases even helped to achieve a GP or self-referral to NHS services. Often, these would include the VSP—co-produced, of course, with the Walnut Tree Project. Full behavioural and emotional reconnection would be the frequent result.

As we were aware, veterans were therefore often accessing the new services via a ratchet effect, by which means tentative initial—and often anonymous—engagement was grown to the point where the male veteran felt able to disclose what the issues were and/or directly ask for help. This could take days or weeks. But, by deliberate and conscious effort on the part of the staff of the Walnut Tree Project, troubled men, some of whom had been stuck for decades, were helped to engage in the help they needed. So, rather than abandoning any potential engagement of psychological reflection as

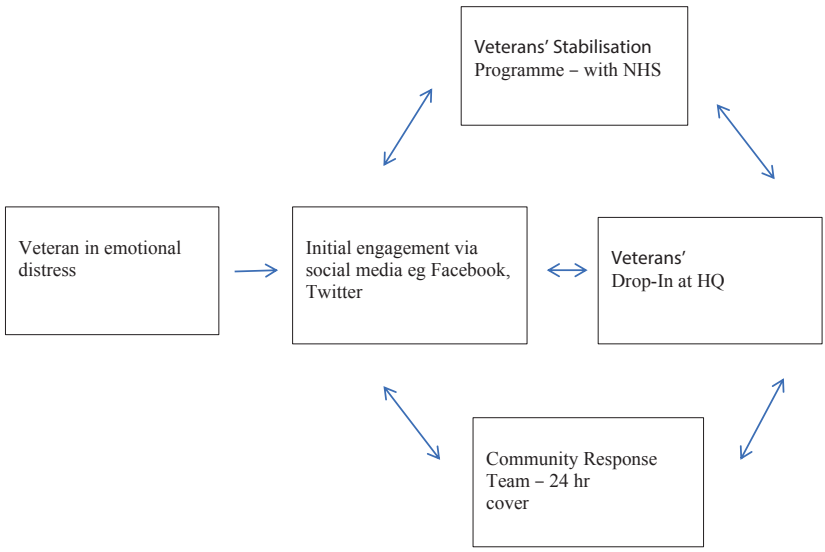

Fig. 2 The Walnut Tree Project: successfully engaging veterans in care

the reflection abandonment mechanism (RAM) predicts (Kingerlee 2012), conscious effort to connect with the individual male *on his terms,* paid off handsomely (Fig. 2).

Further Interventions and Services for Men in Norfolk

Beyond the work of the Walnut Tree Project, other interventions and services are available for men in Norfolk from statutory and third sector providers. These are disparate—deliberately so—and have been deliberately and systematically connected to aid men.

Recovery College Course: Emotional Health for Men

This course, part of Norfolk and Suffolk NHS Foundation Trust's Recovery College, was established in 2014 and runs 3 times a year in 3 venues across Norfolk and Suffolk NHS Foundation Trust (NSFT). The course was co-developed and is produced by the current authors and service user colleagues. The content for the course was co-produced during discussions

via 3 main sources: (1) the lived experience of psychological health issues of the man in question, (2) the clinical and research experience in the domain of a clinical psychologist, and (3) recent developments in the field that had come to our attention, notably around mind–body connections and the importance of taking care of physical health.

Once developed and approved, the course was co-delivered. From the outset, it was well attended (with around 8 participants) and has been to the time of writing. It is open to those who are in receipt of secondary psychological NHS health care, or who have been in the previous year. The course consists of four parts, which take place weekly, a half day per week for four weeks. The parts of the course are as follows:

- Week 1: Male Feelings: Introducing the CBT Model for Men;
- Week 2: Thinking, For Men;
- Week 3: The Male Body and Behaviours; and
- Week 4: Keep Safe Under Stress.

Over the 4 years since its inception, the Emotional Health for Men course has been consistently well attended and well received. Targeting men and meshing lived experience with specialist knowledge of male psychologies, it seems to provide a relaxed and useful forum for learning about male psychologies as they apply to male individuals and those in their lives.

Helping Older Men Reconnect: Men's Sheds

It is well established that older men face specific challenges and that these challenges can impact their physical and psychological health. Older men are, for instance, likely to experience loneliness and isolation which, in turn, can have very significant negative effects on psychological well-being (Berkman and Glass 2000). As part of this picture of societal disconnection, too, older men may feel—having left the world of work and perhaps having traditional views of gender stereotypes—that their lives lack purpose and routine. This is one reason why older men often experience a sense of loss (Cochran and Rabinowitz 2000).

Against this background, the Men's Sheds have found a niche over the last two decades (UK Men's Sheds 2015). Men's Sheds were founded in Australia in the mid-1990s, as an initiative that began after a conference about men's needs, and have spread internationally, with branches in such countries as Canada, Ireland, and the UK. While each local Men's Shed differs (e.g. in its precise physical setting), there are commonalities.

Men's Sheds offer men an open, physical space in which they can freely engage in the kind of practical work (often woodwork and/or metalwork) that they may enjoy. Bi-products often flow from this process. On the one hand, men who attend can rediscover a sense of meaning or purpose, including a sense of contribution to the community; at best, this can be transformative and life-changing, as the men exercise skills they already have or learn new skills. On the other hand, by virtue of the work they are doing, the men are brought into proximity with one another, such that their sense of isolation is reduced. In working at a Men's Shed, it is not the explicit aim (as might happen in the NHS) that 'therapeutic' conversations will occur. Instead, the main collective focus is on the work being done and the items being created. In this way—and while there is of course space for conversation of all kinds—talk about psychological well-being is often oblique. As the sociologist Richard Sennett argues in *The Craftsman* (2008), such men are brought more into relation, both with their skilled work and with one another, in a profoundly human process. In short, older men who may have felt disconnected can come, via an initiative that fits their interests and *on their terms* (versus those of a traditional model of care) to healthily reconnect once again.

This is the case in Norfolk, where there are multiple Sheds in Norwich and surrounding towns. The Norwich shed was opened in November 2013 and has been active since. The website describes the Shed as a 'place for blokes to be blokes, simple concept with great results, whether want to come and have cuppa and a chat, or if you want to get in the workshop area to create something. […] Everyone is equal. Everyone is welcome' (Norwich Men's Shed 2017). As this text suggests, the Shed is a warm, accepting environment. For men who have been or are stressed in some way, this can be ideal.

The evidence base supporting Men's Sheds is growing. This suggests that attending Men's Sheds can have a positive impact on psychological health and well-being and can produce a sense of achievement and engagement (cf. Robertson et al. 2015). So, with approximately 100 branches in the UK alone providing enjoyable and meaningful activity for older men—an often neglected, stressed, and hard-to-reach group of males—it is reasonable to conclude that—operating in male-friendly ways and settings, Men's Sheds hold promise in attracting, engaging, and helping older men within their community.

Drama-Based Intervention for Men: Action-Based Group Therapy

A further option for men in Norfolk is Action-Based Group Therapy (ABGT). ABGT is based on the Veterans' Transition Programme (VTP), developed by Professor Marvin Westwood and colleagues in Canada in the early 2000s, initially for use with military veterans (Shields and Westwood, this volume), and was introduced to Norfolk in 2017–2018.

The original VTP, as Westwood (2009, p. 1) comments, aims to:

> Bring about performative repair through therapeutic re-enactment by means of inviting people to enact critical events from their own life - enacting the narrative, going beyond language to express the self through action, movement, emotion and reflection. This process (…) is done in the context of a witnessing group of others who hold the space and create a safe container for mending parts of the self that have become broken, paralyzed, or separated from the person.

In the ABGT, a safe and mutually supportive environment is initially created within the group. Then, group members are invited to identify an incident that, they feel, has psychologically affected them. Such incidents can include childhood trauma of different kinds, a loss, or other unresolved psychological issue. Once the issue is identified, group facilitators and members devise a plan to enable the re-enactment of the trauma in question. This, in turn, can lead—at one level or another—to release or discharge of the trauma. As part of this process, significant abreaction can occur. During the re-enactment, others present play the roles of those people originally involved in the original incident. As part of the process, the person in question is able to relive the event, in one or more ways. Consequently, as Westwood (2009, p. 2) says, the person 'can change the script, re-story their lived experience, and finally, reflect on what emerges from the experience'. As can be understood from this account, the experience of re-enactment can be a powerful one, both for the person in question and those witnessing the process with them as they go through it.

ABGT covers salient material including the understanding and normalization of trauma-related difficulties in the wake of military experience, the learning of self-regulation skills, and psychological repair, enabling re-integration of the self, and of the self into community life. In this way, the adjustment process to civilian life is smoothed.

Practice and evidence suggest that this drama-based model can help ameliorate trauma symptoms, enable more pro-social relations with others, allow the release of sometimes longstanding traumatic residues, help individuals replace shame with pride, replenish energy, and offer people new hope for the future (Westwood 2009). External and internal connection often ensues. Moreover, research suggests that the original VTP has a high success rate, but a very low drop-out rate; Kivari et al. (2016) provide qualitative evidence that participants feel benefits from working with their peers and genuine facilitators on an equal footing and free from negative—and inhibitive—judgements.

In the light of which, a group of eight therapists were trained in the model, new to the UK, in the county of Norfolk in 2017, for the explicit purpose of working skilfully with both male veterans and male civilians. The first such course started in Spring, 2018, under the rubric of ABGT, and this initial pilot was highly successful, with participants reporting significant psychological breakthroughs, in a setting that felt psychologically safe.

The Men's Well-Being Project

Finally, an innovative project is underway within the NHS in Norfolk that involves the authors and, crucially, seeks to systematically integrate local work with boys and men for the first time. Conscious that boys and men can be difficult to engage in mental health care of all kinds and that a gender-sensitive approach may be more effective, NSFT—supported by a grant from The Burdett Nursing Trust—appointed a male nurse (GA of the current authors) to head the Men's Well-being Project (MWP) full-time, with a further male colleague (AF of the current authors) appointed on a part-time basis—the latter with a specific remit to develop sporting opportunities to engage men.

The MWP ran initially from 2016 to 2018 and, perhaps for the first time in the UK, aims to comprehensively address, and improve, the issue of male engagement and awareness in mental health issues, from an NHS standpoint, both inside and outside the organization. The objectives of the MWP include:

- Measuring and then—via implementation of a systematic training programme—increasing the knowledge and skill base of the staff within NSFT regarding male psychologies and male engagement in mental health care;

- Embedding an understanding of male psychologies in clinical care, and clinical pathways, versus the traditional (and not optimally effective) 'one-size-fits-all' approach to the sexes;
- Increasing the rate of engagement of boys and men in Trust mental health services, particularly in psychological therapies;
- Engaging with General Practitioners (GPs) on issues surrounding men's mental health;
- Raising the profile and challenging stereotypes of men's mental health—bearing in mind that the psychological availability and visibility can be crucial in individual decision-making, including in health care;
- Promoting male well-being at schools, colleges, and universities in the area;
- Collaborating with other statutory and third sector agencies (including the Walnut Tree Project, Men's Sheds, and Norfolk County Council) on male well-being and mental health;
- Organizing sports courses, events, and sessions that may be helpful to boys and men particularly (see below) and, if at all possible;
- Helping to reduce the suicide rates among males in the county of Norfolk.

In short, the MWP has an ambitious, multimodal 2-year programme that aims to (a) improve the experiences of boys and men within the mental health system; (b) emphasize the many benefits in this area of integration of, and co-production between very diverse providers, albeit with a common goal; and (c) perhaps begin to point the way towards new best practice in the UK, where male psychological needs are taken seriously, and services are designed with boys and men in mind. In our experience, a systematic approach, which links key organizations, can help.

One key offshoot of the MWP has been the All To Play For football group. This group, led by one of the co-authors of this chapter (AF), is a joint initiative by NSFT, Active Norfolk, and Premier Sports. Evidence, notably a randomized controlled trial (RCT) from Dublin, suggests the potential effectiveness of similar interventions in terms of engaging, and helping, men. The Dublin trial resulted in a significant reduction in depressive symptoms (approximately 45%)—an impressive outcome (McGale et al. 2011). In Norfolk, All To Play For offers men throughout the lifespan who have experience of mental health issues a weekly time to play 5- to 7-a-side football at sports centres in both Norwich (from September 2017) and Great Yarmouth (from March 2018). The weekly sessions, which are free and are consistently well attended, include a warm-up with a qualified

coach, a game, and psychoeducational sessions from various guests, including local clinicians, and current and former professional footballers who have an interest in mental health. The sessions are also used as an opportunity to increase participants' awareness of key support services of which they are sometimes not aware, including around addiction, employment, and finance. Attendees have said the following:

> No judgement is passed on your capabilities or your mental well-being. I attend as many sessions as I can. It has also boosted my confidence and helped improve my people skills and socializing - John.
>
> My mental state is more positive due to this group. It gives me something to look forward to and gives me a sense of purpose – Mauricio. (Active Norfolk 2018)

Attendance and evidence so far suggest that All To Play For has been very effective in engaging men, including those from relatively deprived areas. Interestingly, too, some participants heard about the intervention via word-of-mouth from friends, rather than via formal NHS or third sector channels. As a way of reaching men with psychological issues who would often be hard to engage, All To Play For has shown great promise.

Finally, as a key initiative, supported by the MWP and jointly driven with local partners including the MensCraft, the NHS, the Walnut Tree Project, and the Samaritans, among others, Norfolk MensNet was established as a way of connecting partners electronically for the first time and, above

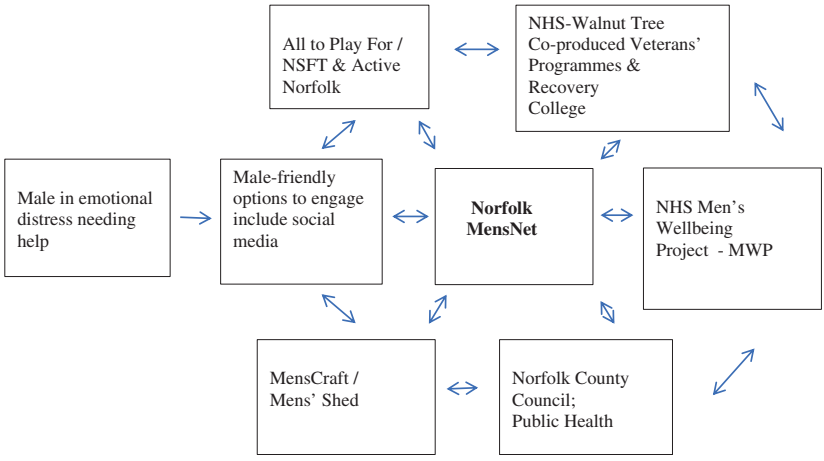

Fig. 3 Reconnecting men systematically: Norfolk MensNet

all, making services for men accessible via one single online location. The MensNet landing page (https://www.menscraft.org.uk/mensnet/), hosted by MensCraft, was launched in November 2017 and includes summaries of, and links for, each of the partners involved. Great efforts have been made to publicize this new option, and the early signs are that MensNet is being well used by local men. Operationally, MensNet works via the following links between partners, some of whom are shown below—the membership is growing (Fig. 3).

Conclusion: Men Can Reconnect

Nationally and internationally, it is clear that new interventions and services, specifically designed for men who have been disconnected from both themselves and others can be systematically created, often looking very different to traditional services in terms of accessibility, content, and form.

With sufficient collective creativity and determination, and with men's psychological needs kept in mind during the process, ongoing national and local experience in the UK and beyond shows these often innovative and effective pathways for men can be developed—and sustained. Men can come to take down the barriers to their external and internal worlds and reconnect in healthy ways. In doing so, reattaching again to others, men's lives are frequently made more enjoyable, and the lives of those men who—usually through no fault of their own, find themselves at temporarily high risk—can often be saved.

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What Are the Factors That Make a Male-Friendly Therapy?

Louise Liddon, Roger Kingerlee, Martin Seager and John A. Barry

Introduction

The importance of male suicide and men's mental health has become increasingly apparent in the past decade, as demonstrated by the increase in community support groups and other activities outside mainstream psychology. This interest is reflected in the recent publication of two systematic reviews (Bilsker et al. 2018; Seidler et al. 2018). The present chapter includes a further five papers not included in those reviews for reasons of being published too recently for inclusion (Liddon et al. 2017; Holloway et al. 2018), or not being in the databases searched, or not identified by the search terms used (Robertson et al. 2015; Russ et al. 2015; Lemkey et al. 2016).

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Men Need to Talk and Therapists Need to Listen

Kung et al. (2003) found that although men are more likely than women to take their own lives, men are less likely than women to seek mental health support. The mainstream discussion on addressing male help-seeking tends to focus, perhaps understandably, on changing men, so they are more willing to talk. On the other hand, men, like all human beings, benefit from talking to someone who is genuinely able to connect with their world, and is authentically listening. This means that there is also an urgent need to change social and cultural attitudes to enable men to be responded to with greater empathy and gender-sensitivity.

When it comes to therapy, existing evidence suggests that some approaches work much better than others for men. For example, the charity *Campaign Against Living Miserably* (CALM) has over the past two decades been offering telephone and online support, along with community support programmes, targeted particularly at younger men who are vulnerable to suicide. CALM still remains one of the few help organisations that has deliberately set out to create a gender-specific and male-friendly ethos (Holloway et al. 2018). Significant reductions in suicide rates for younger men in the Merseyside area where CALM was first launched, from above average rates to below average rates for the UK, could be interpreted to suggest that the approach is beneficial (Seager 2019 in this volume). On the other hand, some therapies have a reputation for being hostile to men, e.g. the Duluth model (see chapter by Powney and Graham-Kevan, and chapter on masculnity by Seager and Barry). The Duluth model is a therapy programme developed in the USA and aimed at male perpetrators of domestic violence. The ethos of the Duluth model can be said to be 'male-**un**friendly'. The approach inherent in the Duluth model is that domestic violence is the result of problems within masculinity. Men are therefore offered interventions based on the notion of reforming and re-educating presumed toxic male attitudes towards women that are believed to lead to dominating, aggressive and violent behaviours. Essentially, this approach overlooks the issue of childhood victimhood in adult male perpetrators (Murphy 2018), overlooks the evidence that women can be equally aggressive in interpersonal relationships (e.g. Archer 2000) and denies complex interpersonal dynamics between intimate partners who have mental health problems and vulnerabilities. The Duluth model appears to operate outside the therapeutic principles of empathy and collaboration and in reality is closer to a corrective and coercive model, being closely allied to the penal system. Perhaps not surprisingly, though the Duluth model has been in widespread use for many years, a meta-analysis of Duluth interventions (Babcock et al. 2004) found

they had only about half the benefit of interventions based on relationship enhancement. This begs the question of why Duluth is mandated in preference to other psychological interventions, such as anger management, which have a proven track record of efficacy.

It has to be said, however, that most therapeutic or care approaches for men in the UK, USA and in many other countries are not gender-specific at all, whether male-friendly or male-unfriendly. The culture of therapy and counselling within the UK, for example, remains relatively *gender neutral* in the sense that outcome research is rarely conducted with a view to gender differences in therapy preferences or responses, and services are rarely designed with gender in mind at all. Where services are a little more gender-specific, this tends to be mainly in relation to women's issues and problems, for example eating disorders, self-harm, sexual abuse, women's refuges and postnatal services. There is additional evidence, however, that even our supposedly gender-neutral counselling and therapy services are inherently 'feminised' in that they offer a 'talk-based' approach based on direct face-to-face emotional exploration which is more congruent with evolved female patterns of communication than it is with male styles of emotional processing and functioning (Morison et al. 2014). The findings of Holloway et al. (2018) support this view: interviews with 20 experienced clinical psychologists, psychotherapists and counsellors found that, on average, male clients want a practical "fix" for their problems, whereas women want to explore their feelings.

It should therefore be acknowledged that the surface problem of men not talking or seeking help can also be seen as rooted in a deeper problem of therapy services, and society as a whole, not being receptive or empathic to the male gender. It's perhaps not so much that men won't talk, but that society isn't listening. In this regard, Seager et al. (2014b) refer to the concept of 'male gender blindness' when describing how men's needs are often implicitly overlooked, which also helps to explain why the question of whether men have specific needs from therapy is one that is seldom even asked (Golden 2013; Kingerlee et al. 2014).

In general, it is hardly surprising that client dropout from therapy is reduced when the preferences of clients are catered for (Swift et al. 2011), but in terms of gender, there is evidence that the professional help typically on offer is routinely blind to the needs and preferences of men, despite the increasing recognition within the general public of male suicide and other male problems. However, our response to male distress reverts back to urging men to use the services that they are already avoiding rather than thinking of ways to design approaches that will connect better with men. The resulting situation is a 'stand-off' whereby men's distress is plain enough through their actions, but the response is to repeat the same verbal and

emotional messages to them. This situation is reflected in the findings of Liddon et al. (2017) who found that men were more likely than women to report systemic barriers to help-seeking (e.g. a lack of male-friendly options).

The lack of male-friendly services therefore deserves more attention in order to address the issue of improving uptake of mental health services by men. This chapter will focus on whether therapy can be made more appealing to men. In doing so, it will take a person-centred approach, which perhaps due to male gender blindness is an approach often overlooked when it comes to men. If, as many people claim (see chapter on masculinity by Seager and Barry) masculinity is susceptible to cultural influences, then it is the culture of therapy that needs to be adapted and tailored to optimise its impact on men, as would be the case with any client demographic. In this chapter, the 'positive masculinity' model will be applied (Kiselica and Englar-Carlson 2010), which approaches masculinity in a way that emphasises and builds on its strengths and positive attributes, and sees these strengths as an advantage in therapy, rather than focusing on deficits and pathologies which are seen as barriers to progress.

Based on the evidence presented in the rest of this chapter, Table 1 offers a summary of recommendations outlining key factors that make a therapy male-friendly. It is hoped that this list, along with other evidence provided in this volume, will assist policy makers, healthcare leaders, clinicians and therapists who want to design and provide services that are more suited to the needs of men and are consequently more effective in changing their lives for the better.

What Is the Evidence That Men Benefit from a Gender Sensitive Approach?

A recent research programme undertaken by the Male Psychology Network, an organisation founded by Barry and Seager to promote the well-being of men and boys, highlights the importance of considering gender. The research programme included evidence from 46 therapists in three interview studies (Russ et al. 2015; Lemkey et al. 2016; Holloway et al. 2018) and evidence from 364 men and women in the general population, half of whom had been in therapy before (Liddon et al. 2017). In interviews with a range of experienced psychological therapists, it was found that most of them described gender differences in various aspects of therapy. Those differences can be summarised simply as 'men seek a practical solution, whereas women want to talk about their feelings'.

Table 1 Elements which help to make a therapy male-friendly

Approach	Factor	Male-friendly application
Features of therapist	*Empathy*	Be aware of men's issues and the available literature that is supportive of men's mental health, e.g. positive masculinity
	Client-centred	If a man experiences stress from interpersonal relationships and conflict (including domestic violence or divorce), try to resist the implicit cultural pressure to assume the man may be "the perpetrator". Connect with his experience and point of view as the starting point for therapy as with any other client
	See client's strengths	There are many positive masculine attributes that can help therapy, including self-reliance, group orientation, humour, courage and strength, as outlined by Seager and Barry in this volume (Chapter 6). There are more processes that aid therapeutic development than the traditional feminine capacity to introspect or explore feelings and male-typical attributes such as risk-taking can also be "utilised" (see below). This all comes under the general heading of positive masculinity
	Know the demographic	Age, social background, education level, ethnic group, sexuality, disability etc are all important interacting factors for men as with other client groups
	Utilisation	Draw upon specifics of the client (attitudes, interests, behaviours, etc.) to help therapy, e.g. if they talk only about football, use football as a metaphor (e.g. working as a team to achieve goals) rather than trying to steer them away too quickly onto an introspective theme
	Respect masculine norms	Don't presume that being a 'typical man' is a problem. Take a positive attitude to masculinity as part of the human condition and avoid a "corrective" attitude. The need for respect and positive regard for any client's individual identity is a general principle within the values and ethics of therapy

(continued)

Table 1 (continued)

Approach	Factor	Male-friendly application
	Sex of therapist	Find out whether male clients prefer a male or female therapist, as would often be the practice with female clients
Psychological approaches	*Port of entry/indirect approaches*	Listen to see if the client prefers a solution-focused approach rather than discussing their feelings. Only explore feelings when the client appears comfortable or ready to do so. Be aware of the comfort level by using eye contact and other indicators. Allow for banter and humour to serve as a bridge that can lead to talk of feelings
	Solution focused	A male client may be more likely to prefer a solution-focused approach, at least to begin with (see 'port of entry' above)
	Group setting	All-male groups can work well for many male clients. There is considerable evidence that male spaces can create supportive, therapeutic environments where men feel permission from other men as a peer group to feel the way they do. Communication in male groups might fluctuate from banter to core emotional issues and this punctuation and rhythm in the group process is positive and helpful
Techniques	*Language*	It may help to avoid traditional therapy and mental health language. For example, it might help to call an intervention 'strategies for living' rather than 'therapy'
	Communication style/banter	Humour is often used by men to deal with stress, build rapport and communicate meaningful information. Humour and banter can be part of an indirect approach with men that can be therapeutic in itself but also serve as a bridge to deeper feelings when these are available
	Non-verbal communication	Shoulder to shoulder styles of communication, where interaction takes place in a dynamic situation rather than requiring eye contact in a static face to face situation, are more likely to be preferred by men

Before we get to the heart of this chapter, a caveat about generalisations is needed. Most importantly, it should be noted that in identifying sex differences, we are not suggesting that '*all* women prefer approach A, and *all* men prefer approach B'. Although there are general differences *on average*, there are of course individual differences to be taken into account. Also, in some cases, the sex differences are relative. In the research by Liddon et al. (2017) preferences for therapy were identified as relative differences, not absolute levels of preference. For example, although men liked group therapy significantly more than women did, both men and women liked individual therapy more than group therapy. Thus, an appreciation of the complexities of providing a male-friendly service is needed when applying these findings.

Male Gender Blindness

'Male gender blindness' is the tendency to overlook issues facing men and boys (Seager et al. 2014b). A key finding of Russ et al. (2015) and Holloway et al. (2018) was that most therapists appear to experience *cognitive dissonance* when describing gender differences in their clients. This was shown in their reluctance to discuss gender differences without some sort of caveat or apology, e.g. '*I hate generalising for lots of reasons, but women are more inclined to blame themselves*' (Russ et al. 2015, p. 87). This reluctance to identify gender differences (beta bias—see chapter on cognitive distortions by Seager and Barry) was interpreted by the authors as evidence of male gender blindness. For these therapists, acknowledging that men were different and had specific needs in therapy created dissonance because it meant considering something that goes against the mainstream cultural assumption they had internalised, that men and women are pretty much the same. Overcoming this type of gender blindness and recognising the gendered needs of clients is therefore a key issue facing therapists today.

What causes male gender blindness? Russ et al. (2015) and Holloway et al. (2018) argue that male gender blindness is due, in part, to the present culture of 'beta-bias' or ignoring sex differences (Hare-Mustin and Marecek 1988) and an overly enthusiastic embracing of the 'gender similarities hypothesis' (Hyde 2005). Thus, the notion that 'there are more similarities than differences' between men and women has perhaps become more a creed than a fully evidenced and completely understood scientific proposition.

There may also be evolutionary roots to male gender blindness, stemming from 'male disposability' in which attitudes to men reflect an acceptance that they have throughout evolution (and still do) take more risks, undertake more dangerous and laborious roles and lose their lives more often both in

military and civilian situations than women do. This also relates to the fact that in terms of sexual reproduction and the repopulation of human societies, the survival of females is more critical (see Baumeister 2010; Barry and Seager 2019 in this volume).

Male-Typical Presentation of Mental Health Issues

Another key aspect in overcoming male gender blindness is recognising that mental health problems sometimes present differently in men and women. One important example is *male depression*, the pattern often seen when men are depressed: they might sleep less, become irritable, abuse drink and drugs, play video games, use sex or pornography more, become aggressive or fight (Brownhill et al. 2005). Health professionals, and male patients too, who are trained to look for more "classic" symptoms of depression may not recognise when men are depressed. This probably reduces the level of sympathy felt for depressed men and the amount of help offered. It is also likely to reduce the amount of help sought by men whilst also increasing the likelihood that any help offered will be rejected. Given that depression is such a common mental health disorder, better awareness amongst health professionals and the general public is badly needed on this issue.

It is possible that our blindness to male-typical presentation and needs could result from generalising findings from predominantly female groups to men, thus masking gender differences. This is likely to be an issue with research into self-harm, for example, where studies may consist of as few as 5% males (Wilkinson 2018).

Outcomes in Therapy

It is possible that therapists don't think there are gendered needs in therapy because assessments of therapy outcome usually aren't analysed by gender (Parker et al. 2011). However, when such analyses are performed, significant differences can emerge. For example, a longitudinal study of 2300 participants assessed the effectiveness of brief therapy as offered by Employee Assistance Programmes (EAPs) in the UK (Wright and McLeod 2016). Although both men and women showed significant benefits immediately following therapy, at 6-month follow-up the male participants had fallen back to baseline levels of mental health, whereas the female clients had maintained their gains. This study demonstrates the importance, for therapists and researchers, of testing for sex differences in psychological outcomes, and the dangers arising from beta-bias.

Creating a Male-Friendly Therapy: Features of the Therapist

Empathic Attitude

Probably, the key component in the success of any therapy is the therapist's empathy for the client. This will facilitate rapport and help the client to feel listened to. Although therapists might presume that being client-centred is an automatic part of their work, it is possible that most people experience an implicit cognitive bias or barrier to empathising with men, called the 'gender empathy gap' (see Seager 2019 in this volume). In brief, this means that people also don't instinctively sympathise with men who are depressed or in a vulnerable state because men are expected archetypally to give protection, not receive it (see chapter by Seager).

Liddon et al. (2017) found no gender difference in preference for therapy by phone, but a project called 'Man Talk' (see Seager 2019 in this volume) was able to demonstrate an improvement in the duration of phone calls with male callers to the helpline of the Central London branch of Samaritans. 'Man Talk' consisted of a series of workshops aimed at training and educating volunteers about a variety of issues relating to masculinity, manhood and the male experience. These included a workshop on blues music, with an emphasis on how lyrics can be interpreted as being about male longing for secure attachment, and another workshop involving female actors from the Royal Shakespeare Company playing male parts in excerpts from 'Julius Caesar' and discussing the impact of this with volunteers. The project ran for a whole year between 2014 and 2015. An analysis of samples of over 1000 calls pre- and post- the project revealed that the percentage of short phone calls (less than 5 minutes) with male callers had reduced from 32% to 25% whilst the percentage of such calls with females remained the same (17%). This difference was significant both statistically ($p < .05$) and clinically. In a qualitative survey undertaken after the project, many of the volunteers (80% female) reported feeling much greater empathy with the male experience. This demonstrates that it is not necessary to change men to help men achieve better outcomes from talking therapies; changing the level of empathy of the listener improved how well male callers felt listened to. It can be inferred that, given callers to Samaritans are frequently at risk of suicide, even a simple intervention like this can potentially save lives.

A Positive, Client-Centred Approach: Seeing the Client's Strengths

There is much to be gained from adopting a positive psychology approach to men's mental health, rather than following a deficit model (Levant and Pollack 1995) which focuses mainly on the ways in which masculinity might be harmful. The positive psychology/positive masculinity (PPPM) approach (e.g. Kiselica et al. 2006; Kiselica and Englar-Carlson 2010) suggests that better outcomes will be achieved by building upon the positives about men and masculinity rather than focusing on the negatives. Positive masculinity represents a shift away from the negative view of masculinity in the 1990s, towards greater acceptance and integration of strength-based approaches. Krumm et al. (2017) found that some men coped successfully with depression by using their masculinity in a positive way, for example, by chopping wood, or reframing help-seeking as an active and rational course of action. Other researchers are starting to find positive links between traditional masculinity and health status (Levant et al. 2019). The evidence to date suggests that projects that use PPPM-like approaches are successful in building rapport with hard-to-reach men and boys, for example adolescent fathers (Kiselica 2008).

Know the Demographic

Although in this chapter we tend to speak of men in general, it is an important part of being client-centred to recognise the individual man and all the personal factors that place him at a unique point within the spectrum of male clients (Robertson et al. 2015). For example, a young middle-class man might feel more comfortable talking about his feelings than an older working-class man. Some guidance is already available on the specific needs of some demographics, e.g. *Pink Therapy* for gay men (Davies 1996).

Utilisation

A practical application and extension of being client-centred called *utilisation* was developed by Erickson (1954), who suggested that therapy could be facilitated by harnessing and connecting with a wide variety of characteristics of the client, even if those characteristics might not appear to be useful to therapy. This approach might be helpfully adapted for use with men. For example, banter is a male-typical style of communication and, rather than being seen as an avoidance of emotional contact, could be construed as way

of connecting with the therapist (thus facilitating rapport) and also built upon in ways that are authentic to the client's character and the personality of the therapist. Utilisation has become part of many solution-focused, narrative and constructivist therapies (Kiselica and Englar-Carlson 2010).

Respecting Masculine Norms

It is likely that most men have a core sense of the centrality of their masculinity to their being, even if this is not discussed or expressed consciously. Respect for traditional notions of masculinity is therefore important. An example of the importance of core masculinity is the male gender script of *provider and protector* (Seager et al. 2014a; see Seager 2019 in this volume). The strongest predictor of well-being in a survey of 2000 men in the British Isles (Barry and Daubney 2017) and 5000 men in the US (Barry 2018) was job satisfaction, a finding which is clearly relevant to the provider role, and seems unlikely to be the product of socialisation alone, without any deeper influence. Therapists should therefore be aware of significant threats to a client's sense of masculinity, and if their client experiences problems in such areas (e.g. unemployment), then a key goal of therapy should be to address this issue (e.g. support in finding work with good job satisfaction), perhaps referring to other experts and agencies who can help with meaningful employment.

The importance of respecting a man's sense of masculinity is highlighted in the chapter in this volume by Ashfield and Houwes. They suggest that men's disinclination to help-seeking should not be dismissed as simply a question of stubbornness, ego or pride, but rather should be seen as a reasonable need felt by men to preserve the integrity of their masculine identity, which should not be dismissed lightly or judgmentally. Strategies to improve male help-seeking need to go with the grain of masculinity (e.g. Krumm et al. 2017), not treat it as a barrier. Seeing masculinity as a barrier leads to unimaginative strategies such as the Childline 'Tough to Talk' campaign, which attempted to get boys to overcome their reluctance to talk by simply *urging* boys to talk.

Attitudes to Avoid: Victim Blaming

The current mainstream narrative around male help-seeking is that men and masculinity need to change in order to adapt to existing talking therapy models. This can be seen as a variety of victim blaming. Common examples are:

- *If men don't seek help, it's their own fault.*
- *If men don't want to talk about their feelings, it's their own fault.*

- *'Patriarchy' 'and 'male privilege'and 'male privilege' cause men's mental health problems* (see chapters by Seager and Barry, and by Powney and Graham-Kevan). Ideas like this are surprisingly common in psychology and sociology (e.g. the APA's 2018 guidelines on therapy with men and boys) but demonstrate a failure of empathy for distressed men that is likely to create a barrier to seeking therapy for many.
- *Some of men's problems result from 'toxic masculinity'.* Some people use this concept in a well-intentioned way, perhaps not realising that the idea itself is fundamentally toxic (see Chapter 6 on masculinity by Seager and Barry).
- *Some demographics or sub-groups of men are more acceptable or deserving than others*, for example minority groups such as gay men, disabled or BAME men. This attitude reinforces the negative assumption that masculinity itself cannot incorporate victimhood. Ironically, this is exactly the 'traditional' attitude to masculinity that men themselves are blamed for having.
- *He's a criminal—he needs prison not sympathy.* It is all too easy to become judgmental towards men who are accused of being perpetrators of abuse. It is with such individuals that negative attitudes towards masculinity, and towards criminality, may interact to a prejudicial level, making it hard to connect with the damaged and vulnerable parts of these men's personalities that are most in need of therapeutic change. A non-judgemental approach is vital (Robertson et al. 2015). Although some men might accept full responsibility for their actions at the outset of therapy, unless they are a captive audience (e.g. already in prison), if they expect no empathy from their therapist, it might be more difficult for them to seek or accept therapeutic help.

Sex of the Therapist

The question of preference for therapist is an important one, because even if only a small number of potential clients have a specific preference, it could be that they will not properly engage in therapy, or even refuse to seek help, if their preference is not taken account of.

It has been suggested that there is a 'female effect' in therapy, in which female clients enjoy a more positive alliance with a female therapist (Bhati 2014). However, much of the research evidence is less clear on this; for example, Behn et al. (2018) found that the therapeutic alliance between a male client with a female therapist deteriorates in the first three sessions, but improves after this point. Although some studies (e.g. Bernstein et al. 1987) found preferences amongst male clients for male therapists, most research finds either no strong preference at all amongst male clients or a preference for female therapists (Pikus and Heavey 1996; Landes et al. 2013;

Liddon et al. 2017). Some clients prefer a same-sex therapist and others an opposite-sex therapist. This lack of agreement in the literature suggests that the sex of the therapist is not the only or even the main factor determining preference in choosing or bonding with a therapist, and it is more likely that the type of presenting problem (e.g. relationship issues) impacts preferences regarding the sex of the therapist (Duncan and Johnson 2007).

Psychological Approaches

Apart from the attitudes and characteristics of the therapist, how else can we make therapy more male-friendly? The next section will outline various approaches and techniques that can be used, regardless of theoretical orientation in many cases.

Indirect Approach

Although men might ultimately benefit as much from discussing their emotions as women do, men tend to prefer to solve or fix a problem than discuss their feelings about it (Holloway et al. 2018). Therefore, creating the context in which a man will share his feelings is likely to require a mix of the therapist's attitude (e.g. empathy) and an indirect approach to introducing a focus on feelings. There are two basic ways of using an indirect approach: (a) starting therapy with a more solution-focused approach, e.g. coaching and (b) starting treatment by talking about less difficult topics (e.g. sport) or engaging in banter, to create a male-friendly space in which more core issues can emerge.

Finding the appropriate *port of entry* (Holloway et al. 2018) or 'hook' (Robertson et al. 2015) to working with feelings is an important and often subtle task. On the other hand, sometimes life stressors force their own 'port of entry'; some men come to see a therapist only when they experience a crisis and/or are referred by a female relative (Russ et al. 2015).

Therapeutic Orientation: Emotion Focused vs Solution Focused

The traditional style of therapy—where problems are resolved by talking about feelings—may be less appealing to men than to women (Kingerlee et al. 2014; Holloway et al. 2018). In support of this, Liddon et al. (2017) found that psychotherapy appeals more to women than men, and

information-orientated group therapy appeals more to men than to women. Note that both men and women rated CBT as their most liked therapy, perhaps because it combines elements of problem-solving and talking about feelings, or perhaps because it is a widely known type of therapy.

Group Versus One-to-One

Kiselica and Englar-Carlson (2010) note that men show a greater 'group orientation' than women do and that women often prefer to communicate in dyads. Liddon et al. (2017) found that although on average individual therapy appeals more than group therapy to both men and women, groups appealed significantly more to men than women. The informal nature of some groups may have more appeal for men, as seen in the popularity of *Men's Sheds*.

Techniques That Can Be Applied to Therapy with Men

Language

Many studies (e.g. Holloway et al. 2018; Seidler et al. 2018) state that the type of language used in therapy is crucial for men. For example, the term 'therapy' itself is said to be off-putting to many men, and alternatives derived from masculine norms are suggested, e.g. 'strategies for living'. This use of language can be seen as part of an indirect approach to therapy. Another example of male-friendly language is talking about 'regaining control' rather than 'help-seeking' (Robertson et al. 2015).

The review by Seidler et al. (2018) suggests that therapy with men should employ language and communication conforming to traditional masculine norms (where appropriate). These should be: 'action-oriented, future-focused, and progress-driven (e.g. offering symptoms as distinct problems requiring solving; "getting hard work done" through education, upskilling, and repairing)', i.e. *doing* rather than *talking* (Seidler et al. 2018).

Banter and Humour

One of the variables that made the 'Man Talk' intervention (see above) successful was the acceptance of banter as a legitimate form of communication in therapy (Seager 2019 in this volume). An example of how banter can be useful

was given by comedian Mo Gilligan: 'If I'm feeling depressed and someone says to me 'open up', I just say 'I'm fine' and shut down. But if my friends challenge me about my mood with a bit of banter, I open up' (Barry 2017). Seidler et al. (2018) suggest that earthy language, humour and use of metaphors around male-typical themes (e.g. sport, computers) can facilitate communication. Liddon et al. (2017) found the coping strategy most liked by men and women was talking with friends, but it is likely that men and women tend to communicate in slightly different ways, with men making more use of banter as an indirect way of processing feelings (Roper and Barry 2016).

Non-verbal Communication

A key and recurring phrase in the Men's Shed movement is 'Men don't talk face to face. They talk shoulder to shoulder'. Seidler et al. (2018) cite two studies that emphasise the relevance of body language, and also silence, to connect with male clients.

Recommendations for a Male-Friendly Therapy

Table 1 (above) provides a summary of factors, based on the material discussed in this chapter, that make therapy more male-friendly.

Existing Examples of Approaches That Capitalise on One or More Male-Friendly Elements

So far in this chapter, we can see consensus emerging that men and women may often have different preferences for psychological help, and non-traditional routes to getting help should be developed to improve male help-seeking. Kingerlee et al. (2014) suggest various interventions and services which have elements—in terms of content and style—that make them more male-friendly. Some of these are summarised below:

Integrated Exercise and CBT (Indirect Approach)

Football (soccer)-based interventions can combine a sport appealing to men with exposure to therapy (CBT) in an accessible and engaging way. Men learn psychological techniques as they play, including goal-setting, problem-solving and resilience. For example, a randomised controlled trial

(RCT) resulted in a significant reduction (approximately 45%) in depressive symptoms (McGale et al. 2011). In such interventions, which are becoming more widespread, the emphasis on engagement and participation, versus direct self-disclosure, is demonstrably acceptable to many men. In this way, potential barriers to help-seeking can be overcome by taking an indirect approach.

Male-Specific Therapies (Direct Approach)

Therapies are being developed internationally that target male issues specifically. One such is Alexithymia Reduction Treatment (ART) in the USA (see also the 'reconnection' chapter by Kingerlee et al.). ART is a short-term therapy that aims to help men further develop their emotional repertoire and skills, in a group format (Levant et al. 2009).

Electronic and Online Interventions and Services

There has been an explosion in the development and use of electronic and online services, many of which await high-quality research (Bakker et al. 2016). Various options aimed primarily at and/or effective for boys and men have been launched internationally over recent years. One prominent example here is the Big White Wall (BWW; www.bigwhitewall.com; see also the 'reconnection' chapter by Kingerlee et al.). Originating in the UK in 2007, BWW now operates also in the USA and New Zealand and offers an online space for individuals to seek support anonymously, guided by professionally trained 'Wall Guides'. Liddon et al. (2017) found that anonymity was the most important factor for men in seeking help (and one of the most important for women too).

Numerous apps have also emerged with men in mind. One of these is the CBT-I Coach, free to download on all major operating systems. Developed in the USA jointly by Stanford University and the Veterans' Administration (VA), CBT-I Coach aims to offer veterans (predominantly but of course not exclusively a male population), information and psychological tools relevant to their experiences. The app includes information about insomnia and sleep hygiene. There is valuable information about PTSD, and how it can be experienced. There is an array of excellent tools that can be used in the 'Quiet your Mind' section. These tools, narrated by a female voice, include progressive muscle relaxation, body scan, guided imagery and observing

your thoughts among a total of 9 options. Day-to-day clinical experience suggests that CBT-I Coach is easy to access, is useful and directly contributes to positive clinical outcomes for both male veterans and civilians. In our experience, in fact, CBT-I Coach has been the central factor in the recovery of some men, who have been engaged by applying the tools on offer, independently. All of which underlines the potential benefits of utilising the Internet and smartphones for helping men.

Crisis Services Targeting Men

As discussed in the 'reconnection' chapter by Kingerlee et al., the UK-based organisation CALM has been a major innovator in reaching men at risk of suicide over the last 15 years or so (www.thecalmzone.net). CALM was set up in the North West of England with the express intention of addressing male depression and in particular male suicide. On the basis that, as noted above, many males find it difficult to access help through traditional routes, CALM has offered men a different path. Currently, CALM offers men various ways of accessing help, in what amounts to a multimodal package.

By virtue of its consciously proactive, positive, multimodal model (Robertson et al. 2015), CALM reaches out to men at risk of suicide. Moreover, it may be that by offering a free, anonymised service to callers the potential social threats felt by men, that often push them into abandoning help-seeking and/or psychological reflection, are by-passed.

Alternatives (or Different 'Ports of Entry') to Traditional Therapy

Table 1 describes approaches specifically intended primarily for professional psychological therapists. However, the fact is that mental health can be improved without seeing a psychological therapist, and such 'DIY' approaches have been used by people for stress relief throughout history. 'Behavioural activation therapy' (like 'social prescribing' and 'community referral') capitalises on this fact and encourages people to improve their mental health by engaging in everyday activities that they enjoy. Such everyday therapies are generally more easily recognised as such in women (e.g. shopping, spa treatments, hairdresser), and Kingerlee et al. (2014) suggest that men might be more likely to seek relief for mental health problems outside of the mental health system.

Robertson et al. (2015) suggest that grounding mental health in community interventions is useful, thus it should be no surprise that many everyday 'therapies' exist in the community. Some of these may be regarded as potential 'ports of entry' to therapy, e.g. CALM leaves beer mats in pubs with their contact details, creating a potential link between the pub and the helpline, which might then signpost to formal therapy. In terms of Table 1, all of the below have the advantage of not being a formal therapy and so less direct and less potentially off-putting for men.

Barbershops

It is well established that women enjoy going to the hairdresser, and it is part of African American culture for men to enjoy going to the barber. Roper and Barry (2016) found that Black participants reported having significantly greater well-being benefits of visiting the barber than White men. Grass-roots organisations, notably the 'Lions Barber Collective' in the UK, are capitalising on this phenomenon and have utilised the barbershop as a friendly community 'port of entry' for mental health support. The barbershop approach uses various elements of Table 1, including being a place where banter is acceptable (Roper and Barry 2016).

Sheds

The Men's Sheds movement has become a benchmark for how everyday activities can promote men's mental health. It is also the epitome of the shoulder-to-shoulder approach (Table 1), where men can socialise and, at their own pace, gradually begin conversations about their personal issues.

Social Drinking in the Pub

There is some evidence that moderate social drinking has mental/emotional health benefits. Dunbar et al. (2017) found that social drinkers tend to have a better support network and feel more connected with their community. Men may find the pub a useful place where it is acceptable to talk about their feelings (Emslie et al. 2013). The pub ticks many of the boxes in Table 1 and in fact includes an unofficial medication (alcohol) that in moderation facilitates talking about feelings. Drinking too much, of course, does not help mental health.

Sex and Video Games

Liddon et al. (2017) found that independent of age and other variables, as a way of coping with stress men use video/Internet games significantly more than women do (29% vs 18%), and also that men use sex or pornography significantly more than women do (27% vs 11%). Probably, sex and gaming are used primarily as a distraction from stress, and distraction is a coping strategy generally used more by men (Tamres et al. 2002).

Sport and Exercise

Seidler et al. (2018) suggest that walking outside or kicking a ball can be good ways to facilitate communication. Independent of being combined with therapy (discussed above) watching or playing sport can improve well-being (e.g. Football Foundation 2017). Increasingly popular since it began in 2011, w*alking football*, a slow-paced version of football aimed at participants over 50, has improved the mental health of many male participants through the social and physical benefits of participation (Walking Football United 2017). A potential downside is negative feelings when the team loses, though of course this may be an opportunity to learn about resilience. Team sports often offer a high-empathy group setting (Table 1). Solo exercise is inevitably less social but may still have benefits through mind–body connections.

Writing

Expressive writing, with emphasis on the client's need to tell their story, has been found to be an effective treatment of PTSD and other traumas, especially for men who otherwise feel they can only normally express themselves through the use of aggressive or violent behaviour (Smyth 1998). This form of communication can be a useful indirect approach (Table 1).

Future Research

It is essential to understand the safety and efficacy of male-friendly therapies before fully endorsing their implementation. Interventions that prove inadequate (e.g. the Duluth model—see chapter by Powney and Graham-Kevan)

should be improved or replaced. The present chapter demonstrates that enough is now known to start large-scale testing of not only the variables in Table 1, but existing community programmes for men and boys. The latter might be assessed using the *Wellbeing Benefits of Everyday Activities* scale (Barry and Roper 2016), a validated measure that can be adapted to a wide range of activities and interventions, allowing for comparison across interventions. Tests of safety (e.g. case studies, case series) and basic efficacy (e.g. pre-post, minimum 13-week follow-up) will offer a solid base for further research. As part of safety assessments, we need to measure negative outcomes. Based on these findings, we should then move on to RCTs comparing first waiting list controls, then treatment-as-usual (TAU), with longer follow-up. Randomised control trials of male-friendly therapies focusing on all aspects should be undertaken to assess preliminary evidence of the benefits of the intervention. The relative costs of interventions should be assessed too. Crucially, we need to assess the longer term benefits of therapy (Wright and McLeod 2016), and how existing health services and the social environment may help or hinder mental health. Importantly, we also need to work out how to engage better with men who are 'hard-to-reach', as these may be the very individuals who will potentially derive most benefit from male-friendly interventions.

Conclusions

We are in the early days of understanding the neglected area of male-friendly approaches to therapy. For suicidal feelings, serious mental health conditions and deep-rooted issues, seeking professional help is always indicated, but formal therapies are not the only way of helping people. There are many ways of processing and coping with distress. For men, existing models of talking therapy may be off-putting because they do not align with more masculine styles of relating. There is a need also to change our public services and the ways in which they are delivered, both in the UK and internationally in order to reach more men. Training and reflective practice in relation male gender issues need to be improved. The ongoing focus on trying to change men rather than on changing the ways we respond to men has, if anything, been inhibiting progress and failing to improve male help-seeking. Prioritising the most vulnerable groups—e.g. middle-aged men—is also important.

This chapter has offered several new and potentially beneficial avenues for exploration and intervention. If we are to advise men to seek help, then we have a duty to ensure that the help provided is relevant, empathic, effective,

tested and safe for the target client group. Male-friendly programmes hold considerable potential and look like being the best way forward.

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