# 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).

L. Liddon
Male Psychology Network (MPN), England, UK
e-mail: louise@malepsychology.org.uk

R. Kingerlee
Norfolk and Suffolk NHS Foundation Trust, Wymondham, UK
e-mail: Roger.Kingerlee@nsft.nhs.uk

M. Seager
Change, Grow, Live, Dagenham/Southend, Essex, UK
e-mail: mjfjseager@btinternet.com

J. A. Barry (✉)
University College London, London, UK
e-mail: john.barry@ucl.ac.uk


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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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