

Masculinity and psychotherapy: a qualitative study of clinical psychologists' experiences working with men

Nicola Holt

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know you would have loved talking to me about this work.

A complicated, troubled, and problematic man, and at the same time one of the best men

I've known:

This is for you.

Abstract

Introduction: Generally, men are less likely to seek psychotherapy than women, despite suffering similar rates of mental health difficulties. Theorists often link men's mental health difficulties and their reluctance to seek help to societal models of masculinity, which emphasise restrictive emotionality and toughness. Therapy, with its emphasis on emotional vulnerability, has been described as the antithesis of masculinity. However, if men are well engaged they can achieve similar rates of positive outcomes as women. Evidence suggests that therapists are reluctant to admit to making assumptions based on gender about their male clients, but do make use of gender stereotypes in their talk about clients anyway. This study aimed to examine how discourses of masculinity influenced and were used within therapists' talk about their male clients, and what the implications of this might be.

Method: Semi-structured interviews were conducted with 9 UK Clinical Psychologists working in adult secondary mental health care about their experiences working with male clients in therapy. Responses were analysed using Foucauldian Discourse Analysis.

Analysis: Participants' responses to their male clients were informed by wider discourses of masculinity, and aspects of masculinity were constructed as posing specific difficulties in therapy with men by all participants. Participants were more likely to rely on discourses of masculinity, as opposed to psychological discourses of mental health, when talking about clients who had evoked strong negative feelings, such as fear or revulsion, or with whom therapy had not been successful. It was possible to overcome this tendency; however, achieving this required deliberate, on-going effort and self-reflection on the part of the therapist.

Discussion: This study highlighted the importance of therapists reflecting on and processing their own assumptions about and responses to aspects of masculinity in their work with male clients, so that they do not become barriers to effective therapeutic engagement.

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List of Abbreviations

ACT	Acceptance and Commitment Therapy
APA	American Psychological Association
CAT	Cognitive Analytic Therapy
CBT	Cognitive Behavioural Therapy
CFT	Compassion-Focused Therapy
CMHT	Community Mental Health Team
CP	Clinical Psychologist
DA	Discourse Analysis
DBT	Dialectical Behaviour Therapy
DP	Discursive Psychology
EMDR	Eye Movement Desensitisation and Reprocessing
FDA	Foucauldian Discourse Analysis
GRRAACCEESS	Gender, Race, Religion, Age, Ability, Class, Culture, Education, Ethnicity, Spirituality, Sexuality
GRC	Gender Role Conflict
GRCS	Gender Role Conflict Scale
GRS	Gender Role Strain
GRSP	Gender Role Strain Paradigm
IAPT	Improving Access to Psychological Therapies
IPA	Interpretative Phenomenological Analysis
IRAS	NHS Integrated Research Application System
MREC	University of Leeds School of Medicine Research Ethics Committee
MRI	Masculinities Representations Inventory
MRNI	Male Role Norms Inventory
MRNS	Male Role Norms Scale
NHS	National Health Service
POTT	Person-of-the-therapist model
PPPM	Positive Psychology/Positive Masculinity framework
TA	Thematic Analysis
TMF	Traditional Masculinity-Femininity scale
UKCP	UK Council for Psychotherapy
ZPD	Zone of Proximal Development

Chapter 1. Introduction

This study will focus on how therapists' talk about their work with male clients is influenced by common discourses of masculinities, and what the effect of this might be.

Despite similar lifetime prevalence rates of mental health disorders between men and women (Wilhelm, 2014), men are less likely to seek help for their psychological difficulties (Oliver et al., 2005). Men are typically likely to access professional mental health support only at times of crisis, and more likely to engage in unhealthy coping behaviours such as binge drinking (Gough et al., 2016). A focus-group study of men from a variety of different social and occupational groups found high levels of resistance to talking about mental health difficulties, especially among young men for whom being strong and silent was a perceived requirement of traditional masculinity (O'Brien et al., 2005). Explanations for men's specific mental health difficulties and reluctance to help-seek are often rooted in theories of masculinities, and the social, emotional and coping behaviours which are allowed and encouraged in men (Pleck, 1995; Vogel et al., 2011). As such, much literature has focused on examining and reducing the ways that traditional masculinity might be a barrier for men in accessing and engaging in therapy.

However, much of this literature is focused on the masculinities of male therapy clients themselves. This left me wondering what, if any, impact there was of therapists' own relationships to discourses of masculinities in their therapy work with male clients. Within our society, messages about gender are ubiquitous and we receive suggestions about how men and women are supposed to be from the day we are born (Eckert & McConnell-Ginet, 2013). Therapists are not exempt from this, and so will hold their own ideas about gender roles and norms. However, there is little existing research into the effects of therapists' own relationships to ideas about gender and masculinities on the way they work with male clients. If therapists' responses serve to either reinforce aspects of masculinities which might

be contributing to clients' difficulties, or to unnecessarily challenge their masculinities, male clients' experiences in therapy could be negatively affected. In attempting to make therapy a more welcoming environment for men who might already be reluctant to seek help, understanding these processes is as necessary as examining male clients' own masculine behaviours.

The results of this study will have implications for how therapists might be taught to mitigate the influence of their own ideas about masculinities on their work with men, in order to work with male clients more effectively. Additionally, exploration of participants' accounts of times when therapy with men has been successful will provide insight into how therapy might be tailored to men to maximise engagement and reduce early terminations, and how therapists might be trained to recognise and respond to specific expressions of traditional masculinities in effective and supportive ways.

In this chapter, I will begin with a broad summary of current theories of gender, and of masculinities more specifically. The way that masculinities are believed to relate to men's mental health difficulties, and to their relationship to psychological therapy, will be outlined. Finally, I will examine the existing literature on psychotherapists' own relationships to masculinities and the effects these have on therapy with men. The gaps in this evidence base will also be considered, along with a rationale for the way the current study will further our understanding of these processes.

1.1 Sex and Gender

This section will briefly consider models of sex and gender development, in order to provide context for how theories of masculinities might be understood. Despite early psychological research being based on the assumption that there were only two categories of gendered people (women and men), in which men were only masculine and women were only feminine, ideas about sex and gender have developed in the past century to encompass a much more complex and

nanced understanding of the subject (Hyde et al., 2019). Reconceptualisations of male and female psychology beginning with feminist movements in the 1960s led to the (now widely accepted) distinction between sex and gender, with “sex referring to the biological attributes that result from being male or female and gender denoting the psychological and sociocultural attributes that are associated with a biological sex, such as masculinity and femininity” (Levant, 2011, p. 766).

Constructions of gender build on sex differences, but also exaggerate biological differences between males and females and infer biological difference in domains in which they are irrelevant. Examples of this might be gendered rules about clothing and cosmetics (Eckert & McConnell-Ginet, 2013). Proving a causal path between a biological attribute and an expression of gender remains difficult. There is evidence that our socialisation and experiences can affect our biological states (e.g. through altered brain activity or anatomy) as well as the converse (Eckert & McConnell-Ginet, 2013), leading to difficulties inferring which causes which. Further, Patsopolous, Tatsioni and Ioannidis’ (2007) review of 215 articles proclaiming evidence for a genetic basis for sex differences found that most claims were based on insufficient or spurious evidence. Claims which demonstrated good validity were rare, and even more rarely replicated. As well as the complicated relationship between nature and nurture in shaping people’s development, sex itself is based on a combination of anatomical, endocrinal, and chromosomal features which, in many cases, does not support easy distinction between what a culture defines as male or female. Examples of this might include chromosomally intersex individuals, those with insensitivity to certain androgens, or female children who experience late onset adrenal hyperplasia, leading to the expression of physical characteristics more commonly associated with those who are biologically male (Eckert & McConnell-Ginet, 2013). The way people are perceived and treated throughout their lives according to their gender expression (whether male, female, or outside of such a binary classification) is culture-dependent, and will further cloud any potential examination of the independent impact of biology on sex and gender expression. As such, modern models of gender development tend to include experiential as well as biological factors.

1.1.1 Models of Gender Development

The social cognitive theory of gender role development posits that gender is a product of broad social influences with which children learn and interact, leading to the construction of a cognitive model of gender which they can apply to themselves and others (Bussey & Bandura, 1999). Examples of how gender is constructed in this way might include direct messages about gender (“little girls don’t behave like that”), implicit differential treatment such as marketing of toys aimed at boys versus girls, or modelling of gender by peers, families, and others. There is some evidence that enforcement of gender roles is more intensely aimed at boys than girls, both by other boys and by adults, particularly adult males (see Eckert & McConnell-Ginet, 2013 for a review).

Eckert and McConnell-Ginet (2013) give a thorough summary of the myriad ways children are treated differently from the moment they are assigned male or female, and the near-constant presence of gender in the way we conceptualise other people. This leads, they suggest, to a common understanding in which:

“Members of any western industrial society are likely to be able to produce the following set of oppositions: men are strong, women are weak; men are brave, women are timid; men are aggressive, women are passive; men are sex-driven, women are relationship-driven; men are impassive, women are emotional; men are rational, women are irrational; men are direct, women are indirect; men are competitive, women are cooperative; men are practical, women are nurturing; men are rough, women are gentle.” (Eckert & McConnell-Ginet, 2013, p. 22)

As such, in this model masculinities are considered a set of culturally-dependent social constructs which are learned throughout our lives.

However, Hyde (2005) reviewed 46 meta-analyses of gender differences on domains of cognitive variables, communication, social or personality variables,

psychological well-being, motor behaviours, and miscellaneous constructs (such as moral behaviour). Of 128 effect sizes, 78% indicated no or small differences between male and female participants. Hyde suggests that both scientific and societal assessments of the size of gender differences have been vastly overestimated, with consequences affecting the lives of people of both genders. Despite this evidence that the genders may be more similar than they are different, social discourses about masculinities and femininities persist and continue to pervade Western society. However, many researchers are beginning to recognise that there is not one consistent version of masculinity, but many possible masculinities which represent how men “do gender” across cultures, generations, and different settings (Englar-Carlson, 2006).

This way of thinking about gender and masculinities is aligned more with social constructionism than with social cognitive approaches, because it allows for people to interact with and make use of gender in different ways in different situations, rather than assuming a relatively stable internal working model of gender for each person (Addis & Cohane, 2005). However, Waling (2018) highlighted that men and masculinities studies have still tended to rely on essentialist categories of maleness, rather than seeking to explore diversity and individuality within and beyond gender groupings. This mirrors a wider social trend in which, as a result of feminist activism, specific theories of ‘femininity’ have largely fallen out of favour; whereas masculinities have continued to be perceived as an overarching framework which must be referred back to in explaining gender relations (Waling, 2018). This has the effect of continuing to position masculinities as being done to men, rather than something men have a choice over how to engage with.

Addis, Mansfield and Syzdek (2010) advocate a move towards a “pragmatic and functional” perspective, which would consider how men learn to use masculinities in different contexts and interactions, including the consequences of such uses and non-uses and how they allow men to succeed in their social worlds.

However, much of the research literature surrounding men and masculinities continues to build on more social cognitive ideas, seeking to define and capture stable masculine traits and examine their impact. Efforts towards this, and influential models which have shaped psychological and wider thinking about men and masculinities will now be considered.

1.2 Masculinities

In this section I will outline current models of masculinities. Unless otherwise specified, references to 'men' or 'males' in this thesis will refer to cisgender ("used to describe someone who feels that they are the same gender as the physical body they were born with", Cambridge Dictionary, n.d.-a) men. This is the group upon whom the majority of research into masculinities and the effects of masculine socialisation has been conducted, and who will be the focus of the study described later in this thesis. Non-cisgender individuals would be expected to have vastly different experiences of gendered socialisation, which are worthy of study in their own right, but are not the focus of this piece of work.

As this thesis is being undertaken in the UK, it will inevitably lean towards a Westernised (i.e. relating to countries in the west part of the world, especially North America and Western Europe, Cambridge Dictionary, n.d.) view of masculinities. While it is important to consider cultural variations in conceptualisations of gender roles, and these will be covered where evidence is available and applicable, this thesis is concerned with the impact of Western masculinities on Western men's mental health and engagement with mental health services. Consequently, the implications of this work will be for health systems supporting men in the UK and wider Western world, in which specific barriers are related to Western masculinities. It is also important to note that a limitation of the literature on this type of Western masculinities is its often restrictive focus on middle-class, heterosexual, white men. While there is a small body of research exploring masculinities in more diverse groups of men, which suggests that men

from different backgrounds do interact with ideas about masculinities differently, much thinking continues to be framed in terms of the dominant paradigms of masculinities, which mainly represent the most socially dominant groups of men (Englar-Carlson, 2006).

1.2.1 Hegemonic Masculinities

The dominant masculine ideology (which refers to commonly held beliefs about the origin, nature, and importance of masculine identities) identified in a given culture and time period is referred to as 'hegemonic masculinity'. This sets out the "currently most honoured way of being a man" (Connell & Messerschmidt, 2005, p. 832), which functions to include, exclude, and organize society in gender unequal ways. This can incorporate different masculinities for different types of men, such as Connell's distinction between the physical masculinities of the working class, in which strength and physical power is a dominant marker of masculinity, and the technical masculinities of the upper-middle-class which enables men in this bracket to gain social power instead through scientific, corporate or political means (Connell, 1995). Hegemonic masculinity as an overarching framework, therefore, upholds existing power structures which privileges not only men over women, but interacts with other social hierarchies to uphold the power of certain types of men (e.g. white, heterosexual, able-bodied) over others (e.g. sexual minority men).

In the 1970s, David and Brannon (1976, cited in Thompson & Pleck, 1986) summarised Western hegemonic masculinity with four key traits (although it is not clear without access to the original text what evidence David and Brannon based their conceptualisation of masculinity on):

1. No Sissy Stuff: avoidance of associations with femininity
2. Be a Big Wheel: achieving masculinity through success and power
3. Be a Sturdy Oak: rationality, toughness, and self-reliance

4. Give 'em Hell: men must balance the 'rationality' of the sturdy oak with daring and aggression, and take risks in order to become the big wheel.

Various measures attempting to capture and measure masculinities have been developed since (e.g. the Male Role Norms Scale [MRNS]; Thompson et al., 1992 and the Male Role Norms Inventory [MRNI]; Levant et al., 1992 – the two most commonly used). In general, they have continued to conceptualise masculinities as relating to avoidance of femininity/homosexuality; achievement of status; restricted emotionality; self-reliance; and toughness/aggression. However, most scales measuring 'traditional' masculinity were developed between the 1970s and early 1990s. If, as outlined above, masculinities are to be understood as a set of rules governing the behaviour of men which are time-, culture- and context-specific, it is reasonable to expect common conceptualisations of masculinities to change over time. As Wade (2015) highlights, updated versions of measures of masculinities based on thorough qualitative examination of men's experiences of masculinities across groups and settings are lacking. This leaves research into masculinities vulnerable to a bias in which knowledge about current masculine ideologies is limited to that which outdated scales are able to measure and track.

1.2.2 Modern Masculinities

The 20th and 21st centuries have seen drastic social changes across the Western world in terms of gender, with more women in more work roles than ever before and less social investment in traditional family structures (Oláh et al., 2014; Pinsof, 2002). Young people report less rigid beliefs about gender roles than previous generations (The Atlantic, n.d.) and are even beginning to reject binary systems of gender in favour of fluid, flexible gender identities on a larger scale (Brooks, 2017). As feminism and other egalitarian movements have become more mainstream, the qualities of competitiveness, aggression and stoicism which make up traditional masculinity have been more widely questioned and criticised, such that:

“Masculinity, certainly as it has been traditionally understood, has become unfashionable and the 'crisis' has been created by a reversal in value of 'male' and 'female' traits.” (Itulua-Abumere, 2013, p. 44)

The word ‘crisis’ here refers to a regularly proclaimed ‘crisis in masculinity’ in which men have lost their status as providers, have less access to the supportive traditional family structure, and are facing increasing pressure to recognise their privilege and decry the ‘toxic’ masculinities which are associated with aggression, dominance, sexism and homophobia (e.g. Raisin, 2017). This ‘crisis’ appears to be ill-defined and largely anecdotal (and has been used at many different times historically to represent different versions of a new crisis for masculinity, Reeser, 2020), but appears to represent the idea that discourses of masculinities, and therefore men themselves, are stuck between old and new models of masculinity. In other words, as Itulua-Abumere (ibid.) suggests, men are stuck between the way they have been (and continue to be) socialised (i.e. the personal) and the way that mainstream media messages now tell them they ought to be (i.e. the public). Perhaps compounding this effect is the difficulty that ‘modern masculinity’ is itself ill-defined, and tends to be framed simply in terms of *not* embodying the traits of traditional, hegemonic masculinity or in terms of embracing more traditionally feminine traits, such as sensitivity (e.g. Schroeder, 2017). What new discourses of masculinity seem to lack is an offer of any concrete, positive traits that can be claimed as specifically masculine, for men to be able to identify with.

1.3 Masculinities and Mental Health

The most influential theory of how traditional Western masculinities relate to mental health difficulties in men is the Gender Role Strain Paradigm (GRSP, Pleck, 1995), which is based on the following assumptions:

1. Gender roles are defined by stereotypes and norms about gendered behaviour.
2. Gender role norms are contradictory and inconsistent.

3. The proportion of individuals who violate gender role norms is high.
4. Violating gender role norms leads to social condemnation.
5. Violating gender role norms leads to negative psychological consequences.
6. Actual or imagined violation of gender role norms leads individuals to overconform to them.
7. Consequences for violating gender role norms are worse for non-conforming males than females.
8. Certain characteristics prescribed by gender role norms are psychologically dysfunctional.
9. Each gender experiences gender role strain (GRS) in its paid work and family roles.
10. Historical change can cause gender role strain.

The GRSP model has spawned a wealth of research relating traditionally masculine socialisation to men's mental health difficulties (see Levant, 2011 for one summary).

Other models of the relationship between masculinities and mental health difficulties exist, although they tend to make similar arguments to those contained within the GRSP. For example, O'Neil's (1982) Masculine Mystique model posits that the process of masculine socialisation encourages men to internalise ideas which actively encourage emotional disconnection, achievement, status-seeking and interpersonal dominance, all of which inherently cause problems in living for men. Vandello, Bosson and colleagues (2008; 2013) introduced the term "precarious manhood" to describe what they saw as the "problematic and anxiety-provoking" (Vandello & Bosson, 2013, p. 103) nature of the male gender role. This model posits that 'manhood' is a specific social status which must be achieved by men (rather than being automatically granted to them) and which can be revoked at any time in the eyes of oneself or one's peers, thereby making manhood "hard won" and "easily lost". The implication of this is that both striving to maintain one's perceived manhood, and losing this status, would have consequences for men's

mental health. Heesacker and Snowden (2013, p. 121) poetically summarise this model as viewing masculinities as “a persona, a performance, a mask that men and boys often wear to shield their vulnerability and disguise their humanity”. While a model with generally promising face validity, much of the evidence in support of the ideas proposed remains confined to controlled experimental conditions, and has been conducted by the original proponents of the theory, and so the real-world applications and implications remain largely untested as yet (Isacco & Wade, 2017).

Three types of specific GRS have been proposed in the context of masculine ideologies (Levant, 2011). First, discrepancy strain refers to failure to live up to one’s own internalised ideal of manhood. Second, dysfunction strain results when one fulfils the requirements of masculine norms, because many of the dominant masculine ideologies can have negative side effects (e.g. poor social support or high levels of aggression). Third, trauma strain relates to groups of men whose experiences with GRS are thought to be particularly harsh, such as veterans or survivors of child abuse. Men whose other identities lead to experiences of discrimination and abuse – thereby denying them the status and self-esteem which is supposed to be afforded through masculinities – also fall under this category, such as men of colour and non-heterosexual men (Levant, 2011).

Taking this work further, O’Neil introduced the concept of Gender Role Conflict (GRC) which refers to the observable negative outcomes of GRS, and occurs when rigid, sexist or restrictive gender roles “result in the restriction, devaluation, or violation of others or self” (O’Neil, 2008, p. 362). Examples might include experiencing conflict between work and family relations, or feeling unable to express how one is feeling. O’Neil reviewed 232 published papers which had used the Gender Role Conflict Scale (GRCS, O’Neil et al., 1986) since its development, including both published and unpublished qualitative and quantitative research across 20 countries. He found that male GRC positively related to measures of depression, stress, anxiety and self-esteem across various categories of male diversity (e.g. race, sexuality, age), as well as to various

problems in men's relationships with others and negative attitudes towards women, homosexual men and, in one study, racial minorities. In a therapeutic context, there was evidence that GRC related significantly to male clients' psychological distress and problems, but convincing evidence was lacking on any successful interventions specifically targeting GRC.

The psychological literature on masculinities and male mental health, then, primarily focuses on the ways in which traditional, hegemonic, masculinity can inadvertently cause harm to the men who subscribe to or deviate from it. However, not all men who are socialised into masculine norms experience mental health difficulties. Despite the evidence linking male GRC to poorer mental health outcomes, little is yet known about the mechanisms determining these associations. Further research is also required to understand which other factors might moderate or mediate these relationships, and help to explain why some men experience higher rates of GRC than others (O'Neil, 2008).

1.4 Masculinities and Psychotherapy

The UK Council for Psychotherapy (UKCP) defines psychotherapy and psychotherapeutic counselling as "talking therapies [that] are used to treat emotional problems and mental health issues" (UKCP, n.d.). Modern psychotherapy originated with the work of Sigmund Freud in the late nineteenth century (Bowen, 1976). Nowadays, there are more than 400 different schools of psychotherapy from which to choose; some more well-known than others, but none of which has offered convincing evidence of its superiority over others in the treatment of all different kinds of complex psychological problems (Norcross, 2003). Since the 1930s, scholars have highlighted the common factors which appear present in most, if not all, psychotherapies, and which account for much of the observed variance in therapeutic outcomes (Wampold, 2015). These factors include a therapeutic alliance between client and therapist, a safe and healing setting in which the therapy can take place, an explanation for the client's

difficulties which is culturally and personally acceptable to them, and an opportunity to practice or enact new behaviours in the service of achieving positive change (Murray & Rucklidge, 2017; Norcross, 2003).

Psychotherapy has been described as the antithesis of masculinity (Meth et al., 1990), with its foci on relationship formation, openness to one's vulnerabilities, awareness and acceptance of emotions, and so on. Englar-Carlson (2006, p. 13) stated that,

“being a man matters to the extent that masculinity is a focal organizing principle for all aspects of a man's life ... Masculinity, therefore, can be an influential contributor to not only why (or why not) a man is in psychotherapy but also how therapy is ultimately enacted.”

Male GRC has been found to negatively relate to attitudes to seeking psychological help (O'Neil, 2008). There is some evidence that men hold specific fears about seeking help through talking therapies (Englar-Carlson, 2006). These may relate to both concern about damage to their social or self-image by being seen to enter therapy, and to concern about being coerced or pushed to think, do, or say things they are not comfortable with within therapy. Scher (1990) summarised the difficulty that men may have in seeking and engaging in therapy as follows:

“Psychotherapy is traditionally viewed as the refuge of the weak—those who cannot handle their own situations and therefore must submit to the help of another. Therefore, the man who comes for therapy feels at a disadvantage and must compensate for that. He feels powerless and exposed. These feelings cause him to behave less than ideally as a client because he struggles to stay hidden and have control over the situation. This behavior is compounded by the typical qualities of men that are contrary to the qualities necessary for therapy. These necessary qualities include openness and willingness to examine oneself in the presence of and with the aid of another person. Accepting one's vulnerability is also a great asset in the therapeutic endeavor.” (Scher, 1990, p. 323)

However, although men seek therapy less often than women (Briffault et al., 2008), if they are well-engaged they can achieve similar rates of positive outcomes (Bedi & Richards, 2011). An analysis of therapy cases in Swiss outpatient clinics found that neither gender of the client or therapist, nor whether their gender matched, had a significant influence on improvement in symptoms or functioning by the end of therapy (Staczan et al., 2017). Clients' gender was also unrelated to how well they rated the therapeutic alliance, suggesting that male and female clients did not differ in how well they were able to engage in therapeutic relationships. This study was large, with data from 237 therapy cases undertaken by 68 different clinicians, and included work from 10 therapeutic models (although did not include several commonly-practised models, such as cognitive therapy or systemic approaches). Outcomes and ratings of therapeutic alliance were collected by independent clinicians, reducing the effects of clinician bias in interpretations of alliance or clients' improvement. However, this analysis was only conducted on cases of therapy for which full outcome data was available, including a one-year follow-up. One hundred and forty-two cases were excluded due to having incomplete data, representing around a third of the original sample. These findings, then, may be understood to represent more successful instances of therapy (regardless of outcome scores) than ones in which men chose not to continue or to provide outcome data.

Much recent literature has focused on how men may be better engaged in therapy in order to achieve the best possible outcomes. Bunnell (2016) highlights some of the difficulties which may inhibit effective therapeutic alliances with male clients, including failure to notice countertransference because men's emotional responses may be unexpected or atypical (such as irritability or alexithymia rather than overt sadness, Branney & White, 2008).

In an attempt to build a taxonomy of helpful and harmful practices for working with male clients, Mahalik, Good, Tager, Levant and Mackowiak (2012) surveyed 475 practising psychologists from the membership of the American Psychiatric

Association (APA) for their experiences and perspectives. The ten areas their results identified were:

- being aware of and avoiding stereotypes, biases, and discomfort with male clients
- holding awareness of therapists' own gendered socialisation
- accounting for the effects of gender socialisation in assessments, including being aware of male presentations of distress
- being aware of male gender socialisation and incorporating this into therapy in a person-centred way
- addressing emotions appropriately
- making male-friendly adjustments to therapy such as using humour, self-disclosure and problem-solving or being more active in sessions
- being aware of and responding sensitively to male responses to trauma and abuse
- positively addressing sexuality and sexual behaviour
- maintaining awareness and avoiding discrimination relating to intersections with other sociocultural identities
- addressing intimate relationships.

These recommendations were developed based on psychologists' responses to questions about specific, real-life clinical scenarios (e.g. "describe incidents where a therapist provided care demonstrating special sensitivity to a male client (boy or man) in psychotherapy") as well as more general questions about what the psychologists thought would be beneficial in therapy with male clients.

Classification of responses into themes was thorough, being completed by two independent teams, one of whom developed the categories and the other who re-coded the full dataset into those categories, to monitor reliability over several iterations. However, this study was limited by its inclusion of only psychologists who were members of the APA, thereby excluding many other types of therapists as well as psychologists who chose not to join the APA, and so may represent a

narrow view of therapy with men. The findings are also limited to therapists' views of what is helpful and harmful in working with men, and were not cross-checked with the views of male therapy clients. So, while they may appear to hold some face validity for therapists, it might be the case that the recommendations fail to match up to what male clients say they find most helpful in therapy.

A qualitative systematic review of 44 published texts which included recommendations for making therapy more male-friendly identified 4 themes (Beel et al., 2018):

- Therapists having knowledge about men, masculinities, and masculine socialisation, including knowledge of intersections with other identities, and not assuming all men ascribe to Western traditional hegemonic masculinities.
- Therapists being aware of their own gendered socialisation, including any biases against men, and having a commitment to self-care, professionalism, and activism in relation to these.
- Making masculinity-informed treatment adaptations, including drawing on existing strengths and positive aspects of masculinities. Consideration of the environment, such as therapy office décor or magazines on offer in waiting rooms, was also mentioned. Reframing therapy in a way that reduces stigma, such as framing it as a place for winners, not losers, was also suggested to help overcome men's potential reluctance to accept help and reduce shame. Therapists were also warned to be prepared to accept 'difficult' behaviours, such as aggression or prejudicial attitudes.
- Finally, the review recommended that tasks and goals be masculinity-informed, including bringing the client's attention to the impact of masculine socialisation on his difficulties and introducing emotion-expressive interventions in a timely and sensitive manner.

The themes across these two studies, which could be applied to therapy of any modality, appear to be broadly similar, reflecting a number of ways in which

therapists might try to “[draw] attention to features, strengths, vulnerabilities, and impacts of masculinity in the lives of men in clinical assessment, alliance formation, and treatment design” (Beel et al., 2018, p. 600). Englar-Carlson (2006) notes that it is rare for masculine socialisation to be openly discussed in men’s lives, and so therapists inviting it into the conversation in a way which both normalises it and draws attention to how it might relate to problems may represent a unique opportunity for male clients. However, Beel et al.’s (2018) review was based on themes from non-empirical sources (mostly book chapters), and Mahalik et al.’s taxonomy was based on psychologists’ perceptions of what was helpful with male clients. While expert opinion has its merits, as Beel et al. acknowledge, there is a noticeable lack of evidence from therapy outcome studies regarding whether these or any modifications to therapeutic approaches do actually make a worthwhile difference to male clients’ experiences and outcomes.

Qualitative studies involving men who have experienced therapy do broadly support the themes outlined above as being important for engagement. Doherty, Conway, Clark and Merritt’s (2017) narrative interviews with seven young men who had attended counselling found that feeling that entering therapy was their decision – that it was within their control – was important to their participants. One who felt he had been pushed into agreeing to the therapy had reacted by dropping out. This need to retain control over their attendance and what and how they shared things with the therapist continued throughout therapy for the men in this sample. Seidler et al. (2018) interviewed 20 Australian men who had received psychotherapy for depressive symptoms about what they found engaging (or not) in their therapeutic experiences, and analysed their responses using interpretive descriptive methodologies. The men reported finding it helpful to be oriented to therapy (e.g. by contracting, describing treatment and providing psychoeducation), for therapists to establish trust and share control by being transparent and individualising therapy, and to be enabled towards actions which empowered them in achieving their goals (which, for this sample, favoured structured and activity-based therapy rather than what they had experienced as “basically a talkfest”).

Englar-Carlson (2006) also reminds therapists that, despite a tendency for talk about masculinities to focus on their drawbacks, it also offers a potential source of strengths for male clients which can be harnessed in therapy, such as problem-solving skills, a willingness to carry their own and others' burdens, or a reframing of emotional inexpressiveness as an ability to remain calm in times of crisis. The positive psychology/positive masculinity (PPPM) framework offers an alternative approach to reconciling masculinity and psychotherapy (Kiselica & Englar-Carlson, 2010). Rather than framing masculinity as a problem which needs to be worked around, these authors recommend starting therapy with the view that certain aspects of clients' masculinities are strengths which can be tapped into. The framework identifies male strengths including male relational styles; male ways of caring; generative fatherhood; male self-reliance; the worker-provider tradition of men; male courage, daring and risk-taking; the group orientation of boys and men; fraternal humanitarian service; male forms of humour; and male heroism. The authors acknowledge that these strengths are neither male-specific nor biologically-determined, but do represent the qualities that boys and men are socialised to develop and demonstrate. The model is suggested as a way to refocus male clients' attention onto the positive parts of themselves, and help them understand their areas of growth. The authors give a case example, in which application of the PPPM framework is contrasted with the client's previous experience with a therapist who was experienced as adopting a deficit model of masculinities, pointing out everything the client was doing wrong. By using the PPPM framework to emphasise the client's strengths and benevolent motivations, the therapist in the case study was able to build the client's trust and create a foundation of mutual respect from which the client felt more able to explore ways he could make changes in his life. However, others have argued that focusing on positive masculinities rather than general positive human traits might reinforce unhelpful binaries and uphold existing structures of male privilege (Addis, 2010). Empirical support for this model is not yet available, and so it is not possible to know whether focusing specifically on positive masculinity would improve experiences in therapy for men (Cole et al., 2020).

It seems to be the case that the 'common factors' of therapy (such as empathy, alliance and shared expectations, Wampold, 2015) continue to be important. However, specific acknowledgements of masculinity may be required, such as recognising that men may have preferences for some aspects of therapy (such as more task-focused approaches), remaining vigilant to not pushing men too far out of their comfort zone, or identifying particular strengths that male clients might bring to the therapeutic process. A multilevel modelling analysis of 222 therapy cases found that while there was no difference in post-therapy change in psychological well-being for male and female clients overall, examining the work of individual therapists indicated that some were more likely to produce positive outcomes (i.e. were more effective) for men and vice versa for women (Owen et al., 2009). This was not predicted by therapist's gender. The authors suggest that this supports the existence of a 'gender competence' in which some therapists may be already (naturally or consciously) working in a way which favours men or women's success in therapy. They did not, however, assess the components of therapists' work and so cannot say why these differences were found in their sample or what this 'competence' might look like. Although this study relied on retrospective responses from former therapy clients, comparison with sessional measures suggested that clients' estimates of their pre-therapy emotional states were generally reliable. Still, a prospective cohort analysis which collected measures throughout a course of therapy and beyond, while also including some measure of therapy processes (such as recordings of sessions or analysis of sessional notes) would add weight and depth to these findings.

1.5 Psychotherapists and Masculinities

As was identified in the guidance for therapists working with men outlined above (Beel et al., 2018; Mahalik et al., 2012), therapists, as well as clients, will enter therapeutic work with their own set of relationships to gender roles. All of the issues which may make therapy difficult for male clients will also relate in some

way to how male therapists have experienced gendered socialisation, and both male and female therapists will hold their own beliefs about gender roles. Proctor (2008) suggests that male therapists may share an understanding of the unique gendered pressures faced by men by virtue of their own experiences. However, therapeutic relationships between males may also be made more difficult by, for example, limitations on how nurturing men are encouraged to be towards one another, or uneasiness with expressing vulnerability (and therefore surrendering dominance) with another male. When female therapists work with male clients issues may arise relating to sexualised or oedipal transference (Deering & Gannon, 2005). Female therapists are also cautioned to be mindful of their countertransference when working with men. For example, assuming that a male client's dominance-asserting behaviours relate to the therapist's female gender, rather than to his anxiety and unfamiliarity with the therapeutic setting, may lead to defensive or shaming responses from the therapist (Deering & Gannon, 2005). While these recommendations are based on clinical experience rather than empirical study of relationships between therapists and their male clients, there is some face validity to the notion that therapists' own gendered socialisation will impact how they interpret and respond to clients' actions.

1.5.1 Literature Search

To understand the scope of the currently available literature on how therapists' own relationships to masculinities might affect their therapeutic work with men, a literature search was conducted, details of which are given in Appendix A. This search was initially completed in May 2018, with an email alert in place for new papers identified by the search terms throughout the duration of this study. Papers were selected for further reading if their title and abstract suggested that they contained evidence pertaining to therapist's own relationships to masculinities (such as attitudes to masculinities; endorsement of gender norms; therapist ratings of male clients' masculinities, etc.), rather than those of clients. Any further papers identified from wider reading during the course of this study

were also included. Eleven key papers were identified, the main findings of which will be considered next.

1.5.2 Experimental Studies

Most (8) of these studies involved therapists describing or responding to fictional clients whose characteristics were manipulated, for example, by making vignette clients seem more or less in line with masculine stereotypes and then measuring therapists' responses to them. The designs of these studies are summarised in Table 1. Findings indicated that non-traditional male clients were, predictably, rated as less masculine (Harris et al., 2001). Robertson and Fitzgerald (1990) found that therapists were more likely to ask questions about and attribute problems to non-traditional domestic situations for male clients (e.g. the client was a homemaker and his wife the breadwinner). Marwit (1981) found that psychologists did use gendered stereotypes in their constructions of healthy adults of different genders, with a slight positive bias towards more masculine traits. However, more recent studies have found more problematising responses to more traditional male clients (e.g. raising issues of gender and power more often in couples therapy where the gender roles were more traditional, Harris et al., 2001; and rating non-traditional fathers as better parents, Miller & Spengler, 2018). Wisch and Mahalik (1999) found that male therapists with higher GRC were less empathetic and comfortable with homosexual male clients; however, gay fathers were rated more positively than heterosexual fathers by therapists of both genders in a more recent study (Miller & Spengler, 2018). Richley-Suttles & Remer (1997) found that participants who scored higher on traditional attitudes towards men were more likely to blame a male victim for his sexual abuse, and less likely to describe the incident as definitely sexual abuse. Overall, Bowers and Bieschke (2005) found that female clients were rated as stronger and more powerful than male clients, while Artkoski and Saarnio (2013) found that female therapists generally had a more positive attitude towards their clients than male therapists did, regardless of their gender role scores.

Taken together, these studies provide evidence that therapists' responses to their male clients may indeed be influenced by a number of factors such as their traditional attitudes towards men, their own gender role conflict, or how they feel about client attributes such as sexuality. However, these studies provide only a snapshot of possible interactions between therapists and clients depending on which variables the researchers have chosen to manipulate and measure at the time. In three studies, participants were blinded to the gendered focus of the study (Harris et al., 2001; Miller & Spengler, 2018; Wisch & Mahalik, 1999), meaning that therapists' gender-based responses are likely to have arisen more naturally. However, it was scarcely reported whether the researchers coding participants' responses were blinded to which experimental condition they were in, and so interpretations of responses might have been open to experimenter bias. Several studies presented participants with traditional and non-traditional male clients, perhaps creating a false dichotomy which is unlikely to represent the complexity of genuine clients and masculine presentations. Additionally, given that these findings are based solely on therapists' responses to hypothetical individuals, their scope for generalisability is limited. What therapists say about a client they have read about on paper might be markedly different from how they respond to a client within a real, dynamic therapeutic interaction.

Table 1 Design and key findings of experimental studies

Study	Participants	Fictional Clients/People	Measures*	Key Findings
Artkoski and Saarnio (2013)	246 Finnish substance abuse therapists	Vignettes of male and female clients with substance use disorders, varied for sexual orientation	Participants' own gender roles (Bem Sex Role Inventory, BSRI, Bem, 1981). Responses to clients (by choosing 6 out of 50 possible adjectives).	Therapists' own gender role scores were not related to their appraisals of clients; but their actual gender was. Female therapists had a more positive attitude than males towards all cases. This difference was most marked in relation to a homosexual male client.
Bowers and Bieschke (2005)	303 practising psychologists from the APA	Male and female client vignettes, varied for sexual orientation	Attitudes towards client (semantic differential measure). Attributions of responsibility for problems (Self-Attribution Scale, Karuza et al., 1990).	Female clients were rated as stronger and more powerful than male clients for all participants. Male therapists rated clients as more responsible for their own actions than female therapists. Female therapists rated bisexual clients as more likely to improve than heterosexual clients; while male therapists rated homosexual and bisexual clients as more likely to harm another person during the course of therapy. Male and female therapists also rated clients differently on a

			Clinical evaluation (Global Assessment of Functioning, GAF, APA, 1994). Treatment expectations for client (8 items developed for this study).	number of non-gendered outcomes (e.g. likelihood of becoming suicidal; likelihood of requiring hospitalisation).
Harris, Moret, Gale and Kampmeyer (2001)	99 USA Family therapists	A heterosexual couple in couples therapy, in which one person was more expressive and the other more instrumental during the session	Clients' gender roles (BSRI). Gender and power measures (single-items generated for this study).	When speaking the same expressive text, female actors were rated as more expressive than male actors, and vice versa for the instrumental text. Therapists considered issues of gender and power less often when clients were in a gender non-traditional relationship (instrumental female and expressive male).
Marwit (1981)	163 USA Psychologist Practitioners	Participants described a healthy adult male, female, and person of unspecified gender using the Bem Sex Role Inventory	Hypothetical person's gender roles (BSRI)	Healthy adult males and people of unspecified gender were ascribed greater masculinity than femininity scores. Healthy adult women were rated as more androgynous than healthy adult men or unspecified gender. Masculine traits were rated as

				more universally desirable than feminine traits by all therapists of both sexes.
Miller and Spengler (2018)	133 Counselling Psychologists within the APA	Vignette of a man who had recently adopted a son with a partner presenting for therapy, manipulated for sexual orientation and gender role expression	Client's overall adjustment (five Likert-scale items). Parenting Self-Agency Measure (Dumka et al., 1996). Therapist Personal Reaction Questionnaire (Davis et al., 1977). Concern for Appropriateness Scale (Lennox & Wolfe, 1984). Male Role Norms Scale (MRNS, Thompson & Pleck, 1986).	Therapists had more positive personal reactions to gay fathers than heterosexual fathers. Non-traditionally masculine fathers were rated as better parents, but as more poorly adjusted overall, than traditional fathers.

Richey-Suttles and Remer (1997)	154 USA Psychologists	Vignette of male childhood sexual abuse victim, manipulated for gender of the perpetrator, whether the abuse involved contact or not, and how the boy responded	Attitudes towards men (MRNS). Attribution of blame for the abuse (Jackson Incest Blame Scale, Jackson & Ferguson, 1983). Vignette Response Sheet (6 Likert-scale items developed for this study).	Therapists who scored higher on male role norms were more likely to blame both the victim and society for the sexual abuse, but less likely to define the incidents as abuse. Perpetrators were blamed more when therapists had treated more sexual abuse survivors in their careers, and when the victim's response was not passive. Male therapists overall blamed society less than females. Incidents were more likely to be labelled as abuse when there was physical contact, when the victim was not acceding, and when the therapist had treated more victims of abuse.
Robertson and Fitzgerald (1990)	47 USA Counsellors and Therapists	Video vignette of a male client who was presented as gender-traditional or non-traditional in terms of their occupation and family roles	Participants' simulated responses to the client in therapy (coded using the Counselor Verbal Response Category System, Hill, 1978).	Therapists who viewed the non-traditional client were more likely to ask about their marriage agreement, but this was not significant. Non-traditional men were more likely to be diagnosed with a severe mood disorder, but overall severity ratings did not differ between clients. Therapists were more likely to attribute the client's problems

			Diagnostic Questionnaire (developed for this study using DSM-III criteria). Client's gender roles (BSRI).	to his marital situation and children when he was in the non-traditional role. Non-traditional clients were rated as less masculine, but not more feminine, than traditional clients.
Wisch and Mahalik (1999)	196 male Psychologists within the Division of Psychotherapy in the APA	Male therapy clients manipulated for sexual orientation and type of emotional expression observed in a session with him (angry, sad, or restricted emotion)	Participants' own gender role conflict (Gender Role Conflict Scale, O'Neil et al., 1986). Responses to the client (6 Likert-scale items taken from Hayes, 1984).	Male therapists who were more rigid about being successful, powerful and competitive and about emotional expression and expressing affection to men tended to like the client less, have less empathy towards him and comfort with him, and to be less willing to see the client when he was homosexual or expressing anger but not sadness. Male therapists with less rigidity about expressing affection to other men saw the homosexual client's prognosis as better and felt more comfortable with him.

* Citations are as given in the included studies. Full references for measures are not provided here as they have not been independently verified as part of this review. Please see the original papers for further information about measures.

1.5.3 Qualitative Studies

The remaining three identified papers reported on qualitative studies with participants who delivered therapy to male clients. Werrbach and Gilbert (1987) interviewed 5 male and 5 female psychologists working in mental health services about their experiences with male clients. Participants were given a brief summary of prevalent views about male expressivity and its relation to gender role socialisation, and then asked questions relating to how the therapists perceived their male clients as being affected by male gender roles. Their aim was to better understand the influences of male gender role socialisation and the concerns which bring male clients to therapy. The published article contained no information on how the therapists were recruited, their personal characteristics beyond gender and work role, the summary information provided at the start of the interview, or how responses were analysed, and so the methodological quality of this study cannot be evaluated. The therapists in this study perceived their male clients as more cognitively-oriented and wanting to engage in problem-solving, rather than in the “murkiness” of emotion-related work. The male clients were described as avoidant and withholding, and as frightened of emotional dependency and vulnerability. The therapists felt this was particularly pertinent in male-male therapy dyads, due to men’s socialisation not to be as emotionally vulnerable with other men as they are with women. With female therapists, some male clients were described as controlling and dominating in sessions, as a way to reduce their vulnerability.

This study provides insight into how therapists might think about their male clients, although it must be noted that it was published more than 30 years ago, and so is unlikely to fully represent contemporary views. However, the authors stopped short of exploring how the therapists’ responses about their male clients might have been influenced by their own gendered socialisations and ideas. Instead, the therapists’ accounts in this study were taken to represent truths about how men present in therapy. Indeed, the findings were offered in straightforward support of the idea that men do present in traditionally masculine ways, and so

therapists need to adjust therapy to manage this. The findings of this study, then, are limited in their ability to inform our understanding of how therapists' thinking and talk about their male clients is shaped by their own relationships to ideas about masculinities.

Bailey, Eisikovits and Buchbinder (2012) interviewed 15 male social workers about their experiences of delivering therapy with men who perpetrate intimate partner violence in Israel. Their aim was to better understand the dynamics between male therapists and their clients within the field of partner violence. The authors report that participants were recruited from a list of 'most' of such practitioners within the country, that 'most' agreed to take part, and that the sample represented between 50-65% of the nationwide cohort of male social workers working in partner violence. Interviewees were asked about their professional background, the role of masculinity in treatment, their own models of masculinity, and how they constructed their work in the context of their personal, interpersonal, and professional lives. Interviews were analysed using Content Analysis, using multiple separate analysts who agreed findings through a clear and rigorous three-stage process.

In this study, the therapists talked about drawing distinctions between themselves as men and their male clients who had been perpetrators of aggression. This included significant self-examination of their own masculinities and questioning of their roles as men in relationships, suggesting that therapy with men can influence as well as be influenced by the therapist's own relationship to ideas about masculinities. Participants talked about initially experiencing a lot of fear and revulsion in relation to their clients, but that with time, experience, and reflection this had diminished. By understanding the clients' complexities and vulnerabilities, the therapists had become more able to empathise with them. When the discourse about their male clients moved away from violence, participants were able to acknowledge similarities between themselves and clients that they found it harder to claim when thinking of the men only as batterers.

Interviewees reflected on the judgemental and paternalistic approaches they had taken towards their clients in earlier years when they felt less comfortable with them.

This study provides an in-depth analysis of how these male therapists had experienced relating to a specific group of male clients, particularly in the context of a type of violence which is perceived as explicitly gendered in many circles. However, the specificity of the client group, and the study being undertaken in Israel means that it is difficult to relate the findings to how therapists from other cultures might relate to more typical male clients. Additionally, only male therapists were included in this study, and so we cannot draw any conclusions about how female therapists might relate to clients and their masculinities.

Based in the UK, Russ et al. (2015) conducted a grounded theory analysis of interviews with 5 male and 15 female life coaches about differences in their work with female and male clients. The aim of this study was to understand the degree to which coaches believed that men and women differed in both their inclination to seek coaching and their preferences for different approaches within coaching. Participants were recruited from the professional network of one of the authors, meaning the sample may have represented a limited range of coaches. No information is provided on how many potential participants were contacted or how many declined to participate.

Participants in this study stated an ambivalence towards acknowledging gender differences between male and female clients. There was a perception that acknowledging differences based on gender perpetuated inequality and reduced respect for the client as a person. However, the coaches still made gender-based distinctions between male and female clients despite expressing their dislike for making generalisations (the paper is called "I hate generalising, but...", based on one participant's quote). These gender-based distinctions included suggestions that

men and women seek help differently, and that they have different needs within coaching.

As this study was not specifically focused on eliciting the coaches' experiences in their work with male clients, it was not possible to determine what, if any, impact these differential expectations might have. Additionally, life coaching differs from psychotherapy in focusing more on the achievement of goals than on addressing the past. It is likely that those presenting to coaching services have significantly different needs than those in mainstream psychological therapy services. The findings have limited application, then, to understanding such gendered dynamics within psychotherapy.

1.6 Summary

Despite experimental evidence that therapists' own views and perspectives might influence the ways they respond to different male clients, research into how this might affect real-world therapeutic interactions remains limited. Qualitative research has indicated that therapists and coaches might hold gendered views about their male clients, but has stopped short of fully examining the impact of this. There is also a lack of contemporary study of the influence of therapists' relationships to masculinities which can be applied to men utilising mainstream psychology services in the UK. There is, therefore, a need for further study into how therapists relate to the masculine gender, and how this affects their work with male therapy clients.

1.7 Discourses of Masculinities

The study presented in this thesis used Discourse Analysis (DA) to explore therapists' accounts of working with male clients. When using DA methods, researchers are concerned with how participants construct the objects of study using language, how these constructions are influenced by wider societal

discourses, and what the effect of these constructions might be (Willig, 2008). Therefore, in this study, I was interested in how the discourses relating to masculinities which are available to therapists might influence the ways they construct their talk about their work with male clients. This includes the way that different ways of responding to male clients might be permitted, justified, or foreclosed by the way that clients are constructed. Discourse analysis methods have been applied to the study of male clients' talk within therapy (e.g. S. Martin, 2016; Sutherland et al., 2016; Zverina et al., 2011); however, these studies did not involve analysis of the therapists' contributions, and I was not able to identify any existing studies of therapists' talk with or about their male clients and the potential impact of this.

As has been explored in this chapter, this study was conducted at a time in which competing discourses of masculinities are prevalent in Western Society. Notably, constructions of traditional, hegemonic masculinity remain ubiquitous and continue to be used to socialise children into gendered ideas, and as standards to judge men and boys against (Eckert & McConnell-Ginet, 2013). However, there is a competing discourse which stands in direct opposition to this, and suggests that men should eschew traditional Western masculinity in favour of more modern, cooperative, sensitive styles (Itulua-Abumere, 2013). As my participants were all adults, living and working within the UK, it is likely that they will have been exposed to both of these discourses in their personal and professional lives.

Further, as practising psychologists, it is likely that my participants will have been exposed to the prevailing models of masculinities and mental health, which posit that traditional Western masculinity is problematic for men. The literature outlined in Section 1.4 relating to masculinities and psychotherapy further contributes to a discourse that traditional masculinity is problematic within therapy. The efforts which have been made to suggest ways to improve therapy with men – although offered with the noble intention of improving services for

male clients – serve to position therapy with men as something unusual, different, and which presents challenges to therapists.

Bunnell (2016) warns from clinical experience that the perception that men are less emotionally sophisticated and need ‘fixing’ may leak into the clinical process. It is possible that these ideas – that masculinity is a problem for men – might be present in participants’ talk about their male clients. Conversely, the ideas contained within traditional masculinity, such as that men should not talk about their feelings or that they should be able to provide for others, might also influence how therapists think and talk about their male clients. This study will explore how the tensions between competing discourses of masculinities are negotiated and made use of within participants’ talk.

1.8 Aims and Research Questions

In this thesis I will aim to elicit therapists’ narratives about their work with men with a focus on the impact of various aspects of masculinities on therapy. Exploration of participants’ talk about their understanding of male clients’ presentations and behaviours, and the way they describe their subsequent responses, will provide insight into how discourses of masculinities influence their perception of the barriers and facilitators to effectively working with men in therapy. The following two research questions will be explored:

1. How is therapists’ talk about their experiences with male clients constructed in relation to masculinities?
2. What is the effect of the way therapists make use of discourses of masculinities in their talk about their work with male therapy clients?

Chapter 2. Method

2.1 Introduction

In this chapter I will outline the methodological position of this study, and the methods by which it was conducted. The study was originally designed around the principles of Interpretative Phenomenological Analysis (IPA), in which researchers examine themes in people's descriptions of their own specific experiences.

However, it became clear after the first few interviews were completed that using this method would mean having to discount large portions of participants' accounts, which were filled with clinical descriptions, amalgamated experiences, and abstract ideas on the topic of men and masculinities. The method of analysis was changed to accommodate this variety of data, and Foucauldian Discourse Analysis (FDA) was selected instead. This process is described in more detail in section 2.2.2.

2.2 Methodology

2.2.1 Research Paradigm

Mason (2018) recommends that researchers begin the planning of their research by considering the essence of their enquiry, and the assumptions about the nature of the world and our ability to know it that informs it. This means positioning oneself within both an ontological and epistemological perspective, in which "epistemology concerns what it is possible to know whereas ontology concerns what there is to know in the world 'out there'" (Harper, 2012, p. 84). Simply put, then, ontology relates to what we might be able to know of the world, and epistemology to how we might come to know about it. At one end of this spectrum of ideas are positivism and realism, both based on the idea that there is an objective reality and we are able to experience and understand it through inductive scientific observation (Tebes, 2005). Most researchers now agree that purely objective scientific observation and description are impossible, because what we choose to investigate and how we choose to interpret it are naturally

selective. Therefore modern sciences tend to adopt a critical realist approach, in which we assume that data can tell us about reality, but is not a direct mirror, meaning that we have to consider wider contexts in our interpretations (Harper, 2012). The other end of the spectrum from realism, relativism, assumes an entirely contextual view of truth and reality, in that what we claim to know about the world is always dependent on our unique circumstances and interpretations (Tebes, 2005). Proponents of this idea reject traditional scientific methods in favour of narrative hermeneutic and linguistic approaches to understanding human experience, always acknowledging that there are many valid interpretations of the same observation (Harper, 2012). Qualitative research can be positioned anywhere along this spectrum of ideas, while quantitative research is rooted in broadly positivist assumptions. Qualitative researchers tend to be interested in the quality of people's experiences, rather than exploring causal relationships (Willig, 2008). As this study was interested in therapists' accounts of working with men, a qualitative methodology was chosen as the best way to meet the research aims.

Towards the relativist end of the epistemological spectrum lies social constructionism, which posits that human experience and perception are unavoidably informed by history, culture, and language. As Willig (2008) explains,

“what we perceive and experience is never a direct reflection of environmental conditions but must be understood as a specific reading of these conditions. This does not mean that we can never really know anything; rather, it suggests that there are ‘knowledges’ rather than ‘knowledge’” (Willig, 2008, p. 7).

Research from this perspective is concerned with identifying the ways of constructing a social reality that are available in a given culture and understanding their implications for human experience and social practice. Within this school of thought, critical realist social constructionists argue that,

“alongside an awareness of the importance of studying qualitative data in detail, it is also important to go beyond the text in order to add a further layer

of interpretation – by setting what is said in a broader historical, cultural and social context” (Harper, 2012, p. 92).

This approach is ontologically realist, as it acknowledges the existence of practices and structures which can influence how things are talked about, but epistemologically relativist as it takes the position that we can only access these effects through people’s subjective accounts of them (Harper, 2012). It also recognises that discourses themselves can exert power and influence over our social world:

“A realist social constructionism, in other words, would see language, discourse and culture as products of interacting causal powers and also, potentially, as causal forces themselves.” (Elder-Vass, 2012, p. 12).

This position is the one which aligns most closely with my personal and professional stance as a clinical psychologist in training, and so will be the paradigm from within which the research is conducted. In relation to the research questions, I believe that the way people talk about masculinities and male mental health will inevitably be influenced by the cultural and social forces they have been exposed to throughout their lives. The effect that these ways of talking have on the possibilities for how people might act are of particular importance for the second research question, and relate to the clinical implications of this piece of work; i.e. how therapists might respond to their male clients as a result of the way they construct masculinities.

2.2.2 Research methodology

Planned Analysis Method. Several methodological approaches to qualitative data analysis were considered for this study. As stated in section 2.1, I originally considered Interpretative Phenomenological Analysis (IPA) a good fit for the aim of exploring participants’ narratives of their experiences with male clients. However, while the interview schedule was designed to elicit extended accounts of experience, the data generated represented a more varied and less experience-

intensive set of accounts (see Pages 38-39 for a full description), which meant that alternative methods had to be considered. Thematic Analysis (TA) and Discourse Analysis (DA) both fit with the overall research paradigm outlined in section 2.2.1, and would have been suitable to apply to the dataset. However, given my overall interest in understanding how therapists' own relationships to ideas about masculinities might influence their work with male clients, I felt that using DA offered a specific opportunity to explore this in the context of how common discourses about masculinities were used within participants' talk about their work with men. I revised the research aims and questions in line with the new analytic method (see Pages 43-44). A more thorough description of the change from IPA to DA methods is given below. Grounded Theory (Strauss & Corbin, 1967) was ruled out early in considerations as theory generation was not the aim of the research.

Researchers using IPA are concerned with trying to understand what a person feels and thinks about the subject under consideration, with the assumption that people are actively engaged in interpreting and making sense of the experiences they have throughout their lives. Analysts attempt to examine this process and investigate the meanings people have made from their experiences (Pietkiewicz & Smith, 2012), while recognising that researchers will engage in their own interpretative process to try to best translate their understanding of the participant's experience. IPA is said to be particularly useful "where the topic under investigation is novel or under-researched, where the issues are complex or ambiguous and where one is concerned to understand something about process and change" (Smith & Osborn, 2004, p. 231). As research on masculinities and therapy is relatively scarce, participants' constructions of issues relating to masculinities were expected to be subtle and complex, and this study focussed on the process of how therapists consider and respond to ideas about masculinities in therapy, an IPA approach was initially considered to offer a good fit.

Change in Analysis Method. Undertaking analysis using IPA methods requires participants to provide rich, detailed descriptions of their first-hand

experiences as well as their reactions to and interpretations of these experiences. Although the interview schedule was designed to elicit these experiences in therapy with male clients, it became clear upon reading the first few transcripts that participants had responded to the interview prompts and questions in a number of ways which would not be suitable for IPA. This included describing clients' experiences rather than their own; offering formulations of clients' difficulties; and generalising from several male clients rather than discussing one experience in detail. This trend was noticed from the first interview, and efforts were made in subsequent interviews to more closely capture participants' personal experiences in therapy. These included explaining at the start of the interview that this was what the study was interested in, and ensuring that prompts asked participants for specific rather than general or second-hand experiences (e.g. asking "is there a specific client this brings to mind for you?" instead of "are there any clients this brings to mind for you?", and prompting participants to talk about their own thoughts and feelings in the therapy.) However, by the time four interviews had been completed, it was clear that participants were reluctant to talk at length about their own experiences as therapists, and tended to move quickly back into talking about clients' histories and formulations. The reasons why participants might have found it difficult to describe their own, personal experiences in detail were discussed in research supervision. It is possible that participants found it less exposing to talk about the content of therapy rather than the process and what they personally thought and felt about it. Further, because participants were free to talk about any male client brought to mind in the interview, some of the cases were from some time ago. As a result, much of the specific detail of participants' experiences of and reactions to clients within sessions was not easily recalled. In addition, the interview schedule involved the use of statements about masculinities (see section 2.5.2) to prompt reflections on participants' wider conceptualisations of men and masculinities. While these were originally intended to open up discussion in relation to specific experiences with clients, participants' responses to these statements provided rich data about their wider worldview, and about generalised rather than specific experiences with male clients, which it would not have been possible to analyse using IPA.

Having recognised that there was a mismatch between the nature of the data generated and the proposed use of IPA, and wanting to be able to make best use of the data already provided by the participants, other methods which fit with the overall research paradigm were re-considered. DA was selected as the most appropriate, and ethical approval was obtained to refocus the analysis in line with DA principles and methods (see Section 2.7).

Within DA, language is examined in terms of both its construction (how is this being said?) and its function (what does this utterance achieve?) (Georgaca & Avdi, 2012). Language is considered a form of social action through which people achieve interpersonal goals, such as to disclaim, excuse, justify, persuade, and so on (Willig, 2008). There are numerous approaches to DA. Discursive Psychology (DP) research is concerned with discourse practices, or studies of what people do with language. However, DP researchers are not concerned with subjectivity (that is, our sense of ourselves) or attempting to explain why people choose the discursive practices and objectives they do. Because the focus of this research is on the wider implications of therapists' uses of discourses of masculinities in relation to their clients, Foucauldian Discourse Analysis (FDA) was selected as a more appropriate method.

Foucauldian Discourse Analysis. Power is a key concern within FDA research, particularly how the construction of subjects and objects through our use of language can serve to create, maintain and uphold power structures in society (Graham, 2005; Willig, 2008). Foucault himself applied these considerations to subjects such as madness, discipline within prison systems, and the regulation of sexuality (Arribas-Ayllon & Walkerdine, 2017). FDA concerns itself with how objects of study are made noticeable by how they are constructed as problematic, and the social technologies used to govern human conduct within these problematisations (Arribas-Ayllon & Walkerdine, 2017). Put simply, FDA is concerned both with how

language is used to construct subjects and objects within available discourses, and also the ways of being that these constructions make available to people:

“Foucauldian discourse analysis asks questions about the relationship between discourse and how people think or feel (subjectivity), what they may do (practices) and the material conditions within which such experiences may take place” (Willig, 2008, p. 113).

FDA can be conducted “wherever there is meaning” (Parker & Bolton Discourse Network., 1999, p. 1) and is commonly applied to the analysis of interview data (although acknowledgement of the influence of the interview set-up and interviewer themselves is essential in interpreting the data, Potter & Hepburn, 2005, and see Section 2.10.2). There are several key concepts within FDA:

Discourses. Discourses are sets of statements which construct the object of a communication, and offer an array of positions which might be available within that construction (Willig, 2008). Discourses are societal, and dominant discourses can become so entrenched they become thought of as objective truths, which are often taken for granted and can be difficult to challenge. Given their societal nature and the power structures underlying them, “discourses are related to the interactional and wider sociocultural context and operate regardless of the speaker’s intentions” (Georgaca & Avdi, 2012, p. 147). An example may be the use of an evolutionary discourse to explain one’s beliefs about the roles of men and women in relation to work and home-making.

Language as Functional. FDA assumes that people in an interaction will use language (i.e. use discourses to construct certain objects) in a way which achieves specific goals. Examination of the context within which certain constructions are employed – and especially the use of different constructions at different times – may give insight into the person’s aims within the interaction and how they are using language to achieve them (Willig, 2008).

Subject Positions. When using language, speakers take up subject positions which have consequences for the sense of self and experience of the speakers (Georgaca & Avdi, 2012). Making use of a certain discourse involves positioning oneself within the set of rights and duties it makes available to a speaker, thereby offering the vantage point of a version of reality and a moral location from which to act (Arribas-Ayllon & Walkerdine, 2017). Taking up a subject position has direct implications for the speaker's sense of themselves – unlike discursive constructions which can be employed without identification. For example, a therapist using a medical discourse of mental illness may position themselves as a healer and an expert, who possesses the power and knowledge with which to resolve clients' problems. Clients in this example are constructed as passive victims of disease, powerless to know how to help themselves.

Power and Action. Discourses are inevitably linked to power because “they make available certain versions of reality and personhood, whilst marginalising alternative knowledges and associated practices” (Georgaca & Avdi, 2012, p. 148). A researcher might ask whether a discourse identified within a dataset serves to uphold or challenge dominant institutions or practices. The employment of a given discourse contains within it a set of possibilities for action, also delineating what is acceptable and what is not (Graham, 2005).

Consideration of the ways in which discourses uphold or challenge systems of power is of particular note for this study. On one hand, we might consider gender-based systems of power, such as notions of patriarchy and male privilege. The very nature of 'hegemonic' masculinity involves the imposition of authority of some men over others, and of men over women and other groups (Connell & Messerschmidt, 2005). However, as noted in Chapter 1, there is a competing discourse which has gained its own power in recent years, and challenges the authority of Western hegemonic masculinity. At the time of writing, the hegemonic power of traditional masculinity is in direct competition with the cultural power of

modern masculinity (Itulua-Abumere, 2013), such that alignment with either discourse could be considered both a dominant and subversive position.

Secondly, relevant to this study will also be the system of authority contained within psychology, and mental health systems more widely. My participants, as Clinical Psychologists, are inevitably affiliated to health-related institutions which hold power in our society, and which have historically been used to wield this power against those constructed as 'mentally ill'. Foucault himself wrote at length on the topic of how 'madness' has been constructed and responded to by societies throughout history (Foucault, 2006). There is power, then, simply in being a psychologist talking about one's clients in relation to existing mental health systems. Given the construction of masculinity as 'the antithesis of therapy' (Meth et al., 1990), there are those who claim that psychological services actively exclude men from their practice (e.g. Barry, 2018). This suggests that even if men are considered a socially dominant group, the authority of traditional masculinity may be outweighed by the authority of healthcare systems which constructs it as problematic. The way that the participants negotiate, use, and position themselves in relation to these complex power dynamics will be particularly relevant to my second research question.

Subjectivity. Taking up a particular subject position will have implications for the participant's subjective experience – in other words, what it means to be a person located in a particular discourse. The analysis of subjectivity is concerned with what can be felt, thought and experienced from within a subject position, and how the person views themselves as a subject of a moral code (Arribas-Ayllon & Walkerdine, 2017; Willig, 2008). In this way, the adoption of a subject position might serve to absolve guilt, to justify an action, or to disclaim responsibility for an outcome, offering possible positive outcomes for the speaker such as preserved self-esteem or reduction of distress.

Research Questions. Following the change in analysis method, the research questions that this study sought to answer were reviewed and refined. Previously, the research questions had been strongly focused on the nature of participants' experiences and the ways they made sense of them. With the limitations of the dataset in relation to answering these questions, however, and the change to a FDA approach, the research questions were refined into two questions (as presented in Chapter 1) with a focus on participants' talk and use of discourses, instead of their experiences:

1. How is therapists' talk about their experiences with male clients constructed in relation to masculinities?
2. What is the effect of the way therapists make use of discourses of masculinities in their talk about their work with male therapy clients?

2.2.3 Summary

Foucauldian Discourse Analysis examines the ways discourses permeate our data, and the effect they have on how we experience ourselves and relate to each other (Georgaca & Avdi, 2012). Using FDA for this research project, then, enabled analysis of which discourses therapists drew on in their descriptions of working with male clients. Examination of the use of these discourses also offered a chance to explore what their constructions meant for how they might think and feel about themselves and their clients, and the possibilities for action made available or unavailable within the therapeutic dyad. I will now outline the methods used to investigate the research questions within this approach.

2.3 Design

This study adopted a qualitative research design, using face-to-face semi-structured interviews to gather data. The specific details of the research design are outlined in the remainder of this chapter.

2.4 Participants and Recruitment

A sample of UK clinical psychologists was recruited to participate in the study, as provision of individual therapy across a range of presentations is a core part of the work of UK clinical psychologists. The decision to focus on clinical psychologists rather than other psychotherapists reflected the fact that clinical psychology training requires students to be taught more than one model of therapy, with many courses offering teaching on a variety of models, thereby limiting the risk that the results would be too heavily influenced by one therapeutic model's conceptualisation of gender and psychotherapy processes. In addition, clinical psychologists are typically allowed more freedom around the type and length of therapy they deliver, as opposed to those working in target-driven services such as IAPT in which therapy is more likely to be manualised.

Inclusion and exclusion criteria were as follows:

Inclusion criteria:

- Qualified clinical psychologist
- Has undertaken regular individual therapy work with male clients
- Currently working in mental health services for working age or older adults

Exclusion criteria:

- Currently working in one of the following clinical areas:
 - Forensic services
 - Learning disability services
 - Gender identity services
 - Child and adolescent services
 - Neuropsychology assessment services

Restrictions were placed on potential participants' current area of work for two reasons. Firstly, it was expected that provision of 1:1 psychotherapy – the focus of the interviews – would be limited in some services (e.g. neuropsychological assessment), and so potential participants may not have had sufficient recent experiences to draw upon. Secondly, this study aimed to understand clinical psychologists' experiences with typical presentations of masculinities in therapy for common mental health problems. Within some of the services excluded, perceptions of masculinities are likely to be skewed (e.g. strong links with aggression in forensic services; perceived limited expression of personhood, including gender, in learning disability services). Gender identity services work with people considered gender dysphoric, and child and adolescent services work with people at an earlier stage of developing their gender identity. Although it would not be possible to control for participants having ever worked in any of these services before, the criterion of current employment in Community Adult Mental Health services was intended to reduce the likelihood of participants' current view of masculinity being too strongly shaped by a particular client group.

Participants were recruited from adult and older adult mental health teams within three NHS Trusts in West Yorkshire. I circulated information about the study to all clinical psychologists working in these services both by email and, where possible, in person at team meetings. After receiving information about the study, potential participants were directed to an online survey where they could read the full information sheet and give their consent to take part.

2.5 Materials

2.5.1 Online Survey

Background information about participants was collected using the Online Surveys (formerly Bristol Online Surveys) platform (See Appendix B) This

information was captured to give a sense of the participants' own context in terms of gender, other identities, and professional practice. At the end of this survey, participants provided their contact details to enable me to begin the process of arranging interviews.

2.5.2 Interview Schedule

The interview schedule was developed in collaboration with my two research supervisors through a series of drafts and re-drafts. It was further refined through review by an expert-by-experience service user group representative and trial interviews with trainee clinical psychologists. The full interview schedule is presented in Appendix C.

Social desirability was a key concern in developing the interview schedule. As Russ, et al. (2015) found in their study with life coaches, professionals can be reluctant to disclose any prejudices or biases they hold, despite evidence that they do think in these ways. I wanted the interview schedule to facilitate a space in which participants felt safe to talk through their thoughts about masculinities and male clients without fear of judgement. This was achieved in two ways: firstly, by asking participants to focus on describing their experiences with male clients rather than their opinions about or attitudes towards them. In this way, the ideas they drew on to describe their experiences with male clients would be revealed through the way they spoke about the examples they chose to highlight. Secondly, stimulus materials were included in the interview in the form of short statements to offer participants ideas about masculinities which they were encouraged to discuss. The development of these statements is described in the next section. The aim of including them was to introduce and normalise topics into the discussion which participants might censor themselves from voicing otherwise.

Interviews began by asking participants what drew them to taking part in the study, as a way to get to know the participant and ease them into the interview

process. The main body of the interview consisted of showing participants three separate pages, each with three statements about men and/or masculinities printed on them (see Figure 1). The pages were presented one at a time, and participants were first asked to reflect on whatever the statements brought to mind for them, with probing questions designed to elicit participants' personal reactions to the topics on the cards. I then asked participants to tell me about a client for whom the issues in the statements felt relevant. Probes were included in the interview schedule to encourage participants to give more detail and reflect on different aspects of the work (e.g. the effect of their own gender). The interview ended with two closing questions: whether there was anything participants wanted to say that we had not yet covered, and how they had found the experience of the interview. Most participants commented they had enjoyed the interview and felt it had given them a chance to think about their clients in a different way.

Although the change in analysis methods occurred part-way through data collection for the study, I decided not to seek to change the interview schedule in response to the switch to FDA. Possible changes might have included more specific probing questions about the language participants were using, the ways they constructed their experiences with clients, and how they were positioning themselves in their talk. I decided not to make such a change, and made efforts within later interviews to continue to seek experiential data from participants where possible, in order to maintain consistency across the dataset. This meant that participants' responses could all be interpreted within the same context (i.e. the original interview schedule). The implications and limitations of this are considered in the Discussion.

2.5.3 Development of Statements about Masculinities

The aim of including the statements was to introduce ideas into the interview which opened up discussion about participants' thoughts and feelings about masculinities. The statements, then, were intended to give participants permission to reflect on ideas about masculinities, by offering suggestions of things people

might say about masculinities with which they could agree or disagree. They were then invited to reflect on how these ideas related (or did not) to their clients.

I began by looking at published instruments designed to measure attitudes towards masculinities. Eighteen scales were identified from a comprehensive review of 16 measures of masculine ideologies and people's internalised beliefs about them which had been psychometrically assessed and used in published, peer-reviewed research since 1995 (Thompson & Bennett, 2015) and a forward citation-search from the review (Kachel et al., 2016; Luyt, 2018). Of those reviewed, 4 were designed exclusively for adolescents; 3 were worded in such a way that they were not usable with female respondents; 5 were validated only for specific ethnic and cultural groups (e.g. Latino or Russian men); and 1 was a measure of respondents' conformity to gender norms rather than attitudes towards masculinities. One scale offered the opportunity to compare differences in cultural representations of masculinities; however, this was designed to be used to compare groups in a research context rather than to provide intra-individual information, and so was also excluded. The remaining 4 self-report questionnaires were examined more closely. However, on examination of the items, the measures seemed to be heavily skewed towards traditional ideas about gender and masculinity, which did not seem to fully reflect current discourses. For example, items such as "most men marry to obtain sexual and domestic service" from the Attitudes Towards Men Scale (Iazzo, 1983; Maltby & Day, 2001) and "in an emergency a man should always take charge" from The Brannon Masculinity Scale (Thompson et al., 1985). Given that psychologists tend to lean more liberally in their socio-political alignment (Inbar & Lammers, 2012), I expected that participants would be unlikely to endorse the ideas contained within such items, and might simply reject them outright. As part of the purpose of including the statements was to reduce the influence of social desirability on responses, I felt the statements I used needed to be more acceptable to my participants as a way to open up rather than close down conversation.

One of the main authors of literature on the Gender (or Sex) Role Strain Paradigm (GRSP), Joseph Pleck, included in his 1981 book “The Myth of Masculinity” (Pleck, 1981) two quizzes on attitudes to gender roles, the second of which he claims “tests the degree to which your interpretation of sex roles is in agreement with the [GRSP]” (ibid., p. 133). He did not describe the development of this 11-item quiz, nor its psychometric properties. It would, therefore, not be appropriate for use as a validated measure of attitudes to gender roles. However, as my purpose in seeking a set of statements about masculinities was to promote conversation rather than gain a numerical measure of participants’ attitudes, the items in this quiz appeared appropriate for adaptation. Some items were immediately excluded due to out-dated language or because they related too closely to another item, and the wording of others was changed to be appropriate for a contemporary sample. The original items included references to both men and women, but these were modified to only relate to men. Items were grouped together according to three themes: sheet 1: societal expectations about masculinity; sheet 2: types and quality of masculine traits; sheet 3: difficulties living up to societal expectations. Figure 1 depicts the changes made, leading to the final set of statements used in the interviews.

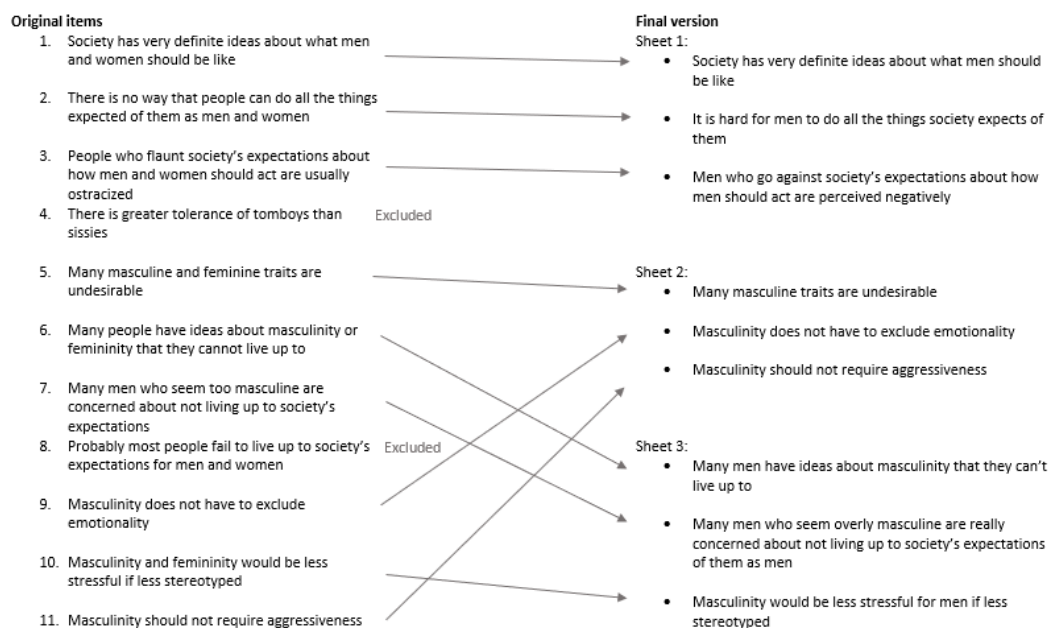


Figure 1 Changes from Pleck's (1981) original items to the statements about masculinities used in interviews

2.5.4 Piloting and Expert by Experience Review

The interview schedule was trialled with three trainee clinical psychologists. One provided informal feedback on the questions, suggesting ways that he might answer the questions and any changes to the wording that might make them easier to understand, which were incorporated into the interview schedule. The other two trainees (one male, one female) engaged in a full pilot interview, answering the questions as a participant would. The aim of the pilot interviews was to gain feedback on the interview schedule, questions, and process of the interview, as well as to have a clearer idea of how long the interviews might take and refine the questions and structure.

Feedback from all three trainees was positive, with consensus that the topic was interesting and thought-provoking, and the questions asked were clear and appropriate. The first full trial interview was very long, and had to be cut short after around 2.5 hours due to other scheduling commitments. This led to a change in the structure of the interview, from an earlier draft in which participants were asked to reflect on their clinical work and then were shown the statements, to the version described above in which the two tasks were combined. During the second trial interview, the trainee reported finding the wording of some of the statements ambiguous (e.g. “many men who seem overly masculine are really concerned about not living up to society’s expectations of them as men”) and questioned whether it might be possible to provide the statements ahead of the interview, to give participants time to think about their responses and which clients they might talk about. However, from my (researcher) perspective, the parts of the interview in which she had been ‘thinking out loud’ to work through competing ideas or understandings about masculinities had been some of the most interesting. These moments provided rich data about the implications of the ideas about masculinities and how people negotiate their positions and responses in relation to them. Because of this, following discussion with my supervisors, I decided not to change the wording of the statements and to allow any natural ambiguity to stimulate

participants' own understandings and interpretations. The trial interviews both provided rich experiential data of the trainees' experiences with male clients, and so the trend away from this in the research interviews was not yet evident. This perhaps reflected a difference between trainees, who are immersed in a process of reflecting on and learning from their experiences (and sharing these with supervisors and tutors), and qualified psychologists for whom clinical work may have become more routine. It perhaps also related to a difference in the amount of experiences available to draw on, such that trainees might have a smaller pool of clearer and more recent experiences of therapeutic work compared to qualified psychologists, and so were able to give more specific detail.

A male service user representative ('M') from the group Everybody's Voice volunteered to provide feedback on the study. I sent him copies of the study protocol and interview schedule, and asked for feedback on the documents and study design. I was particularly interested in whether he would feel comfortable if he knew his former therapist was answering the questions about him, as I would be unable to obtain direct client consent to be described in the interviews and so wanted to make sure the questions were appropriate and did not breach client confidentiality. M commented that he felt it was important to conduct research to better understand men's experiences in therapy, as men and women have different needs, and ideas about masculinity have changed so much in recent years that he felt it was important to ensure we know how to relate to and support modern men. He was satisfied with the arrangements to protect client confidentiality and felt the questions asked in the interview schedule were appropriate and that he would not feel that they infringed on his rights as a therapy client.

2.6 Procedure

At the start of the online survey, participants were provided with an information sheet about the study and a consent form (See Appendix D). Once they

had consented to take part in the study, participants completed the short online survey about themselves, providing their contact details at the end. I contacted all participants by email to arrange interviews at a time of mutual convenience. Interviews were conducted in private rooms at participants' workplaces.

On the day of the interviews, I explained the structure of the interview schedule to all participants and invited and answered any questions they had about the process. Once they were happy to proceed, the interviews began and were audio-recorded using an encrypted Dictaphone. Unfortunately the recording quality of one interview, which had to be conducted over the phone, proved too poor to be able to transcribe, and so this participant was excluded from the analysis. Interviews lasted between 67 and 122 minutes, averaging 93.5 minutes across all participants.

Interview recordings were transcribed verbatim either by myself or by transcribers internal to the Leeds Institute of Health Sciences, who had signed a confidentiality statement. Transcriptions included significant non-verbal occurrences in the interviews such as pauses, filler words (um, ah, uh), changes in tone, volume or pace of voice, laughter, interruptions and unfinished words and sentences. Although no formal transcription convention was used, I reviewed all transcriptions before analysis to ensure that important verbal and non-verbal factors were consistently included.

2.7 Ethical Considerations

Ethical approval for the study was granted by the University of Leeds School of Medicine Research Ethics Committee (MREC reference 18-085; see Appendix E). The study was also reviewed and approved to recruit within NHS Trusts in England by the Health Research Authority (IRAS reference 258747; also in Appendix E). Informed consent was sought from and given by all participants prior to taking part

in the study. There was a concern that talking about case materials may raise uncomfortable feelings for participants, particularly if they began to feel they had not responded to a client as they would have wished (for example if their assumptions about masculinity had affected their response). However, no participants reported any negative outcomes following their interviews. Ethical approval was sought and obtained from MREC for the change in analytic method from IPA to FDA (see Appendix E).

2.7.1 Informed Consent

Participants were given informal information about the study and given an opportunity to ask questions at the time of recruitment. Once they opened the link to the online survey, they were presented with a full information sheet about the study, along with my contact details for if they had any further questions. They were then asked to sign a consent form to take part in the study. Without providing they could not progress any further, ensuring that no data was collected without consent. When we met to complete the interview, I provided the participants with another copy of the same information sheet and invited any further questions. They were asked to sign a consent form specific to the interview, without which the interview would not have taken place. All information and consent documents are presented in Appendix D.

2.7.2 Data Storage and Security

All identifiable electronic data was stored on a secure University of Leeds drive, which was only accessible by myself. Anonymised electronic data, such as interview transcripts and research notes, was stored in a secure University of Leeds OneDrive folder. Participants' paper consent forms, as signed on the day of the interviews, were held in a locked cabinet in a locked office at the University of Leeds. All data storage arrangements adhered to the University of Leeds Information Protection Policy and the DClInPsychol Policy on Safeguarding Sensitive Data.

2.7.3 Participant and client confidentiality

Confidentiality was a particular concern for this study because it used a sample of working clinical psychologists talking about their therapy work. Protecting the confidentiality of the participants themselves was important, especially as their colleagues (and clients) may read the study and be able to identify them if their identities were not adequately concealed. Participants were all assigned a pseudonym, and specific details provided in their online surveys (such as age and place of work) were generalised or obscured in the write-up of the study.

Also of importance was maintaining the privacy and confidentiality of the clients that participants talked about in their interviews. Participants' spontaneous responses to the interview questions were the main source of data for the study, and so it was not possible to ask them to think of or choose clients to talk about ahead of time. This meant that it was not possible to consider including a mechanism for gaining client consent to be described in the study design. To compensate for this, the confidentiality of therapy clients was protected in the following ways:

- Participants were asked at the start of the interview to be mindful of clients' privacy and to not reveal any more detail than was necessary to give context to their responses to the work.
- Participants were also asked to identify any instances in which they felt they had given too much detail, so that this could be removed during transcription.
- Any other potentially identifying information that I noticed while listening to the interview recordings was also removed before analysis.
- Care was taken when selecting material from the interviews to be described or directly quoted in the write-up of the results that as little description of clients was included as possible.

2.8 Analysis

While Foucault's approach to discourse analysis by its nature resists systematisation into a formal research method (Graham, 2005), there are guides available which offer a structure to thinking about data from a Foucauldian perspective. For this study, analysis followed the six-step approach to FDA outlined in Willig's (2008) chapter on the subject. I also drew on the 20-step guide summarised in Landridge and Hagger-Johnson (2013) and the 28 'tools for doing discourse analysis' contained within Gee (2014) for closer inspection of sections of data which proved challenging to interpret, as both offer specific, concrete foci and questions to ask of the text in order to aid analysis. Prior to analysis, transcripts and audio recordings were read and listened to several times, while I made notes on my initial impressions. Transcripts were then prepared for analysis by highlighting all sections of text which were relevant to the research questions for further inspection – in other words, those in which participants were talking about their work with men and/or relating these experiences to masculinities. The un-selected sections of text were not discarded, but were summarised in terms of the discourses they made use of to give context to the analysis. Each participant's transcript was analysed fully before moving on to the next. For the analysis, the six stages contained within Willig's approach were as follows:

1. Discursive constructions:

Analysis begins by identifying the ways in which discursive objects are constructed within the text, by highlighting all instances of reference to them (both explicit and implicit). For the purposes of this analysis, the discursive objects I was most interested in were male mental health and experiences of therapy with male clients. I also noted the ways in which participants constructed masculinities, mental health, and their work as therapists more generally, to give context to the analysis.

2. Discourses:

Next, attention is given to the differences between constructions of the

same discursive object, and the location of these constructions within wider discourses.

3. Action orientation:

This stage involves looking at the functional aspects of participants' use of language. For example, which contexts were different constructions deployed within and what the functions of this might be.

4. Positionings:

Having identified the various ways of constructing the discursive objects and located these within wider discourses, the analyst then considers the subject positions made available to participants and the repertoire of rights and duties offered within them.

5. Practice:

This stage involves a systematic exploration of the ways in which the discursive constructions and subject positions contained within them open up or close down opportunities for action, allowing for a mapping of the possibilities for action contained within the various discursive constructions identified in the text.

6. Subjectivity:

The final stage of analysis requires consideration of the consequences of taking up various subject positions for the participant's subjective experience – i.e. what could be felt, thought, and experienced from within various subject positions.

One area which is important within FDA research, but is lacking in the six stages outlined by Willig, is a consideration of power in relation to participants' talk. To ensure that this was accounted for in the analysis, I included a specific consideration of the location of power in the analysis of the subject positions participants took up in relation to their clients and their masculinities.

Analysis was conducted using Microsoft Word to enable sharing of documents with my supervision team remotely. Appendix F gives examples of how each stage of the analysis was undertaken. Analysis of each participant's transcript and the dataset as a whole were discussed regularly in research supervision.

Analysis was refined through the use of written summaries of each participant's unique talk about the subject, and by then re-examining the original data to look for supporting or contradicting information.

Available guides for conducting FDA research, such as Willig's, do not tend to specify how data from multiple sources (in this case, multiple interviews) should be synthesised. I made use of generic tools of systematisation, such as tables and mind maps, as a way to ensure methods were applied consistently across the dataset (see Appendix G). I kept notes throughout the entire analytic process on topics such as common themes in participants' talk, similarities and differences in their constructions of the same problems, and emerging similarities in the positions they took up in their talk in relation to their male clients. These notes were used as a starting point to consider how the findings might be synthesised. Analysis across the dataset took an inductive approach, being led by emerging patterns in the data. As with all FDA research, I acknowledge that the resulting analysis is only one of many possible versions which might have emerged from the data.

2.9 Methodological Quality

I was aware of a number of different guidelines to conducting high-quality qualitative research, which were held in mind throughout the course of this study (e.g. Potter & Hepburn, 2005; Yardley, 2000). To operationalise a method for accountability in this respect, Elliott, Fischer and Rennie's (1999) seven specific guidelines for publishable qualitative research were followed throughout the process of analysis and writing up the results. Table 2 outlines how each was achieved within this study.

Table 2 Application of Elliott, Fischer and Rennie's (1999) guidelines for publishable qualitative research

Guideline	Evidence in this study
1. Owning one's perspective	See Section 2.10.1
2. Situating the sample	I have provided participant characteristics in Section 3.1.
3. Grounding in examples	Appendices F and G gives examples of how data was analysed, and quotations from participants are used throughout the results chapter to evidence interpretations.
4. Providing credibility checks	Two research supervisors had access to all transcripts, and provided feedback and discussion at all stages of the analysis. Three clinical psychologists also read an anonymised draft of the results to check for coherence and credibility between the interpretations and participants' own words.
5. Coherence	Refinement of the overall narrative of the findings was discussed at length in research supervision, and care as taken to ensure representation of all participants' approaches to the topic. Where this was particularly relevant was in consideration of the subject positions that participants took up in relation to the main discourses of masculinities, and the effects these positionings had on the interactions.
6. Accomplishing general vs specific research tasks	In this case, the sample was selected to achieve a high degree of homogeneity (clinical psychologists working within adult or older adult mental health services in West Yorkshire). Therefore, the study cannot claim to generalise to other types of therapists or mental health professionals, or to how male clients may be discussed in other services. This research adds to the body of available knowledges on how therapists' own relationships to ideas about masculinities might affect the therapeutic process, but does not claim to provide definitive answers on the topic.

7. Resonating with readers	This criterion is difficult to establish prior to publication. However, the research team consisted of two qualified and one trainee clinical psychologists, and the results were reviewed by three other clinical psychologists, for whom the findings were relatable. Given that therapeutic work is naturally emotive, and that all therapists will find some pieces of work more challenging than others, I hope that the findings of my exploration of these experiences will be familiar to other psychologists and therapists reading this analysis.
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Because of the lack of specificity of analytic methods (Graham, 2005), FDA research can be particularly vulnerable to analytic shortcomings. Antaki, Billig and Edwards (2003) offer six examples of ways that discursive researchers might under-analyse their qualitative data: (1) under-analysis through summary; (2) under-analysis through taking sides; (3) under-analysis through over-quotation or through isolated quotation; (4) the circular identification of discourses and mental constructs; (5) false survey; and (6) analysis that consists in simply spotting features. These examples, and the suggested ways to avoid them, were used in conjunction with Willig's analysis stages to strive for analytic rigour throughout, for example, by reading and re-reading quotations and the interpretations of them to check how they supported and expanded on one another.

In relation to the specific methods of this study, I also acknowledge criticism that critical discourse analysis (CDA) approaches (with which FDA is affiliated) can be vaguely defined and susceptible to interpretation in line with the biases and political leanings of the researcher (Breeze, 2011). This relates specifically to CDA's focus on the operation of systems of power through language, which means that analysis can involve the task of judging and prescribing "not only ... how society is, but also ... how it could and should be" (Breeze, 2011, p. 496). This is a departure from other qualitative approaches, which seek mainly to comment on the data they are examining within the analysis. In order to counteract the effects of this within my analysis, I used reflexive tools to note my own leanings and made efforts to

question them when they arose during any stage of the research, as will be described more fully in the next section.

2.10 Reflexivity

Researcher reflexivity is an important part of any qualitative analysis, especially so in social constructionist research. Throughout the entire course of a piece of research, from first conceptualisation to write-up and publication, the researcher makes choices and selects courses of action which shape the questions asked and the knowledge produced and shared. As Willig explains,

“Reflexivity requires an awareness of the researcher’s contribution to the construction of meanings throughout the research process, and an acknowledgement of the impossibility of remaining ‘outside of’ one’s subject matter while conducting research” (Willig, 2008, p. 10).

Harper (2003) conceptualises reflexivity as a process through which researchers can be made accountable for their analyses, through explanation of their interests and context. Throughout the process of this study, I kept a reflexive journal in which I recorded my emerging thoughts, feelings, and expectations about the research. This was done in both an ad-hoc (for example, when I found a topic in the literature particularly resonant) and a planned manner (for example, recording my thoughts before and after each research interview). An example from this journal is given in Appendix H. At various stages of the process, I specifically recorded my current thinking on the wider topic of the study and what I expected would emerge from the analysis. The contents of this journal were used throughout the analysis to keep myself accountable to the data and challenge my own assumptions and biases, continuously asking myself whether there were ways of constructing the topic that differed from or challenged my own. I will summarise below the main themes from my reflections.

2.10.1 Owning my position

I came to this research having been interested in feminism and gender politics for a long time. Exploring these topics had introduced me to ideas around power, systemic oppression, and intersectionality. I believe that our society privileges certain identities over others, and that those who inhabit less privileged identities are discriminated against systematically, if not always directly. Most of those privileged identities are ones I benefit from, such as being white, middle-class, able-bodied, heterosexual and cisgender. It is my belief that being male is another identity which is privileged in our society, particularly when combined with other axes of privilege. There are those who understand feminism to mean blaming or even hating men for society's problems. I do not subscribe to this view. The version of feminism I subscribe to views gender disparity as a systemic issue, perpetuated by social and institutional structures rather than specific individuals (although direct sexism does still exist) and which is upheld by both men and women. I also believe that patriarchal norms which privilege certain forms of masculinity such as toughness and anti-femininity (as outlined in Chapter 1) are as prohibitive and damaging to men as they are to women. I have found it challenging at times to verbalise what I would consider 'positive' masculinities, because the narratives I have been exposed to about masculinities have been overwhelmingly problem-laden. In relating this to male mental health, I tend to agree with the ideas behind the gender role strain paradigm, in that I believe holding any expectations of oneself too tightly will inevitably prove disappointing. I believe that people are more complex and diverse than simple gender roles account for, and so trying to live up to them will always end in failure. I note that my view of male mental health relating to gender role strain relates to discourses within psychotherapy that increased psychological flexibility is a positive outcome for clients (Avdi & Georgaca, 2007) which I also needed to be mindful not to take as self-evident. By making note of the ways that therapists were constructing themselves as therapists more widely (e.g. the models they used, use of ideas such as zone of proximal development, etc.), I was able to hold in mind their own particular view of what a successful therapy and therapist might look like, rather than imposing my own.

During the interviews, I was aware of being drawn to agree with participants who expressed similar views to those outlined above. When a discourse fits with one's own worldview, it can be more difficult to hold in mind that it is only one way of seeing the world and is not a self-evident truth. During my listening to the tapes after each interview, I made note of the moments I found myself agreeing with participants to highlight areas which I might need to be reminded to fully scrutinise. Where participants expressed views different to my own, I found it easier to adopt a curious and questioning stance. No participant responded in a way which shocked or offended me, although one did make use of ideas that I find generally disagreeable due to having seen them used as vehicles to attack and discredit prominent women. I found this interview fascinating, and the analyst role enabled me to engage with those ideas in a more open-minded way than I have previously. During the analysis, I made particular effort to consider the positive possibilities offered by these discourses, as my inclination was to treat them as inherently negative and oppressive.

2.10.2 Influence of the Interview and Interviewer

Research interviews are, by their nature, interactions, and so it is important to acknowledge what the interviewer contributes, as well as the interviewee (Potter & Hepburn, 2005). Firstly, I had to consider my own position in relation to the topic and the participants, and how this might have affected the interviewing process. I conducted this research as part of my Doctorate in Clinical Psychology studies. This means that I was professionally aligned with the participants, who had all completed the same training. Several participants expressed that part of the reason they signed up was that they liked to help doctoral researchers where they could, having been through the process themselves. I believe this helped me to establish trust and rapport with the participants, although it might also have introduced an element of them wanting to give me 'useful' answers. Where this became apparent (e.g. some did ask "is this OK?") I consistently reassured them that anything they said would be useful data, and emphasised that the topic was so wide-ranging that any perspective was interesting for my analysis.

I also needed to acknowledge my own gender in relation to the process of interviewing. As a woman, I did not have a direct personal stake in participants' talk about men and masculinities, which is likely to have helped them feel able to speak more openly. However, any discussion of gender-related topics has implications for both genders, and so my being female was not irrelevant to the process. In particular, it is likely that being interviewed by a woman might mean that participants feel less able to express views which support male superiority over women in any or all domains. As a female psychologist in particular, participants may have assumed certain things about me, such as that I would hold more liberal and feminist views, and so may have censored perspectives which challenged this to avoid potential confrontation or judgement. I was particularly aware of this in James' interview, as he expressed the views which most strongly differed from my own, and there were noticeable times at which he stopped himself from talking about certain topics. He mentioned having been negatively judged by his colleagues in the past for talking about the same things, and so I do not believe this self-censorship was entirely down to his perception of my responses. However, despite my efforts to encourage him to talk openly, this discomfort was evident throughout the interview.

Finally, the content of the interview schedule must be acknowledged. Having developed it with a different analytic method in mind, full consideration had not been given to the specific discourses and positions that the questions and statements made available or unavailable to participants. Reflecting on the statements in particular, I acknowledge that my efforts to present items which would be palatable to participants who I had assumed would be liberally-minded meant that more traditional gender discourses were not represented. Having taken the statements from Pleck (1981), they noticeably reflect the discourse within the literature which suggests that traditional masculinity is a problem for men and for others around them. I was pleased to note that the participants did feel able to disagree with the statements, and so introduce different perspectives. For

example, the statement “Many masculine traits are undesirable” was generally met with disagreement or qualification, and all participants identified aspects of masculinities that they considered to be positive. However, responses were certainly skewed towards a more modern and liberal understanding of masculinity, and one which is in line with the view that traditional masculinity contributes to men’s specific mental health difficulties. It is not possible to know to what extent this relates to the framing of the statements, or to psychologists’ more general ideological leanings, but it must be recognised as a factor in how the findings are interpreted.

2.10.3 Personal discursive repertoires

Willig (2008) recommends that analysts have an awareness of the problematic status of their own knowledge claims, and of the discourses used to construct them. To make this explicit, I used a piece from my reflections (the time before conducting my interviews, when I talked about what I would expect to hear in participants’ responses) which was recorded and transcribed, to examine the ways I was constructing my ideas about the research topic. As part of the exercise, I had asked myself again what drew me to the topic, what I hoped would come out of the research, and both how I would answer the interview questions and how I expected participants might answer them. I noted on the transcript where I used different constructions of the topics of interest, and grouped these together under common discourses. This exercise helped me to notice which discourses I made use of in conversation, again to enable me to be aware of their use in participants’ accounts rather than taking them for granted as truths or common sense. They were as follows:

- A strong use of the discourse that gender is a social construct, something imposed on people from outside. This included references to gender (and masculinities) as offering many options to choose from, but at the same time being restrictive and impossible to achieve. I talked about gender roles as a problem which never seems to be solvable, as they are so intangible

and there are negative consequences for both adhering to and challenging them.

- Overall my use of discourses of masculinities was negatively framed. This included masculinity as involving aggressiveness, insensitivity, and not being able to talk about your feelings or problems. This was often linked to extreme consequences, such as male suicide or men in forensic psychiatric settings. I tended to talk about positive traits as either belonging to femininity or as gender-neutral – this may be so that I (as a woman) am not excluded from accessing them. It also might be that I find it more challenging to ascribe positive traits to a socially dominant group: in this case men, but I would find it similarly difficult to say what the strengths of, for example, white or able-bodied people were as a group. In my speech, positive masculine traits were often talked about with the qualifier that either gender could achieve them or that striving for them too hard would also cause problems.
- I also referred to discourses of masculinities as changing, and this was overwhelmingly framed in a positive way – as a good thing. At times this meant aligning myself against certain groups (such as older generations). The change was constructed as one towards flexibility and increased acceptance of human variability, the consequences of which were posited to be good for everybody.

I also noticed a tendency to distance myself from judgemental statements, and to position my own view as that of the majority (“I imagine other people [the participants] will say quite similar things”). Undertaking this exercise was illuminating for me in recognising my own biases, but also served as a reminder for me to look at participants’ accounts with a more empathetic eye. Looking closely for the ways people are using language felt, for me, at times like trying to catch them out using different discursive strategies to achieve their own aims. Having scrutinised myself in a similar way reminded me that the use of these strategies is common across all people and to look for benevolent interpretations of participants’ use of language as well as more critical ones.

2.11 Summary

In this chapter, I have outlined the processes through which this study was conceptualised, designed, conducted, and analysed. The contents of this chapter should serve to contextualise the findings of the next chapter by giving a clear sense of how the data was generated and analysed, and the factors which have influenced it throughout the course of the study.

Chapter 3. Analysis

In this chapter I will present the sample characteristics and the Foucauldian Discourse Analysis of participants' interviews. First, in seeking to answer the first research question (how is therapists' talk about their experiences with male clients constructed using discourses of masculinities?), I will outline the ways participants constructed their clients in relation to masculinities, and consider the wider discourses they drew on to underpin these constructions (stages 1 and 2 of the analysis).

Next, in seeking to answer the second research question (what is the effect of the way therapists make use of discourses of masculinities in their talk about their work with male therapy clients?) and in line with Willig's (2008) third stage of analysis, I will outline the Action Orientation of participants' constructions of their male clients. That is, an exploration of the function of the different constructions. Finally, I will describe the Subject Positions taken up by participants within their talk (stage 4). This will include consideration of how clients and therapists were both positioned within participants' talk, how power was negotiated, and the possibilities for practice and subjective experience made available within each subject position (Willig's final two stages).

3.1 Sample

To minimise the risk of identifiability, participants' demographic and professional details will not be given individually, except where these are necessary to contextualise the analysis of their responses. Nine transcripts were available for analysis, based on interviews with six female and three male psychologists. Participant characteristics, as provided in the online survey prior to interviews, are provided in Table 3.

Table 3 Sample characteristics

Average Age (range)	46.44 (32 - 65)
Ethnicity	7 <i>White British</i> 2 <i>White Other</i>
Sexual Orientation	8 <i>Heterosexual</i> 1 <i>Bisexual</i>
Average Years Since Qualification (range)	12.83 (3 - 23)
Therapy models used ^{1, 2}	7 <i>CBT</i> 3 <i>Schema Therapy</i> 3 <i>EMDR</i> 3 <i>CAT</i> 3 <i>Trauma-focused</i> 2 <i>CFT</i> 2 <i>Narrative Therapy</i> 2 <i>Psychodynamic</i> 2 <i>Relational</i> 1 <i>ACT</i> 1 <i>DBT-informed</i> 1 <i>Systemic</i> 1 <i>Developmental</i>
Percentage of caseload typically male (participant estimate)	6 26-50% 3 51-75%
¹ Therapy model names are as given by participants	
² All participants responded with more than one model	

3.2 Discursive Constructions

Participants constructed two broad categories of masculinities within their talk about male clients: traditional masculinity and modern masculinity. Traditional masculinity was by far the most common construction, and related to the ideas espoused in models of Western hegemonic masculinity, as outlined in Chapter 1 (e.g. Thompson & Pleck, 1986). Within this construction, participants also differentiated types of toxic traditional masculinity, and positive traditional masculinity. These could be thought to represent different ends of a spectrum from helpfulness to harmfulness in terms of their effects on men. Modern masculinity was less clearly defined than traditional masculinity, but was generally constructed as permissive in that it allows and encourages men to be whoever they choose, in comparison to traditional masculinity which sets out specific ways of being. This trend in participants' talk mirrored wider constructions of modern masculinity, which tends to be defined simply as something different – a rejection of the old way, but which lacks any identifiable rules or roles of its own (e.g. Schroeder, 2017). I will now outline how each version of masculinity was constructed in relation to participants' therapy clients.

3.2.1 Traditional Masculinity

Protect and Provide. Participants talked about several of their male clients feeling a need to protect and provide for other people, particularly their partners and families, as well as women more generally: *“this person was very protective, very manly in many ways, like, both that protective, supportive ... and trying to be a provider as well.”* (Melissa). This drive to protect and provide was constructed as highly important for some men; for example, Susan described one client feeling *“an overriding sense of responsibility as a man to be the provider for everyone”*, and David talked about a client feeling *“worthless”* when he wasn't able to be the breadwinner in his house. This construction gave a sense that men's value could be tied up in their ability to protect and provide for others. In some instances, this was constructed as an internal pressure that men place on themselves:

“some of the men I've seen as clients have been much more badly hit by unemployment [...] other than, you know, the poverty, the inconvenience, the humiliation of it in general, it's more bothered them about who they are.” (Laura)

Elsewhere, it was also constructed as an external pressure exerted by others: *“one of the things that society really does expect of men, and that is, is that they work” (James).*

Success and Achievement. Similarly to feeling a need to protect and provide, some male clients were constructed as having a strong need to succeed professionally: *“he used to say things like, you know, 'if you don't sort of earn a hundred grand a year, like what's the point of working?’” (Laura).* This, again, was constructed as both an internal motivation for clients, such as the one in the above quote which Laura described in terms of a *“very, very self-critical boom and bust kind of, 'I must be incredibly successful' sort of pattern”*, and as one which could be externally driven, such as for one of Michelle’s clients who she described as *“trying to be someone who was a big deal, important, [...] a reputation, if you like”*. Both talked about working with their clients to change their expectations around success and introduce more acceptance of other parts of themselves.

Don’t be weak. One of the most prominent constructions of traditional masculinity was a need to avoid vulnerability and weakness (real or perceived) at any cost. Within this construction, many male clients were said to believe that experiencing and expressing most emotions was not permitted for men. Anger in particular was consistently singled out as an acceptable emotional state for men, while others were constructed as being forbidden:

“A lot of the men I see have quite a narrow range of emotions that they think are acceptable. So, you know, anger is acceptable, jealousy might be acceptable in certain contexts, erm, pride might be acceptable in certain contexts, but, you know, getting really upset over some kind of loss might

not be acceptable, or not moving on after your girlfriend leaves you or something like that might be not seen as acceptable.” (Laura)

The experience of difficult emotions was linked to vulnerability in participants’ talk, and both were linked to shame: *“he has, sort of a sense of a shame of like over emotional vulnerability that’s like sometimes actually quite hard to access or quite raw, and very defended against it in different ways” (Joshua)*. As they were talking about therapy clients, participants identified psychological underpinnings to men’s avoidance of vulnerability, such as having experienced abuse (a position of extreme vulnerability) in their childhoods. This was, again, constructed as interacting with ideas about masculinity in the way that male clients responded to their traumatic experiences, for example, *“I think it’s particularly difficult when men have been abused by women, because again that kind of goes against societal rules in terms of strength and whatever, what it means to be male” (Michelle)*.

As well as being discouraged from being emotionally vulnerable, participants suggested that men were also discouraged from talking about emotions:

“maybe not opening up in intimate relationships, not, not being very open with friends, you know kind of trying to maintain a very kind of jolly persona when inside he was experiencing a lot of emotional pain. Yeah so I guess, yeah, and I guess a lot of that would be about his ideas about how a man should be, so kind of the fun down the pub, but not, not, revealing vulnerability” (Amy)

When talking about this, Michelle did say that it was a *“huge generalisation cause some of the clients I think I work best with have been men because they have been very open and willing to talk and work on things”*, but that *“they will tend to be harder to get information out of, if you like” (Michelle)*. This suggests that such ‘generalisations’ about male clients might continue to be applied despite accessible exceptions.

Be strong. Linked to the imperative to not be weak was the complementary imperative that men must be strong. As well as being emotionally strong by avoiding or not showing their feelings, participants constructed a need within their clients to be physically strong, which was associated frequently with aggression and violence: *“you still hear that that saying, you know to be a man you’ve got to stand up for yourself, which gets translated as you’ve got to have that fight”* (Susan). The majority of participants constructed masculine anger and aggression as a response to difficult feelings, such as shame and vulnerability:

“actually I think the more masculine and aggressive they are the less in touch they are going to be with emotion, cause usually anger is a defence against sadness and worthlessness” (David).

Toxic and positive traditional masculinities. Participants constructed the effects of traditional masculinity differently in relation to how helpful or harmful they felt the traits to be for their clients. For example, the imperative to protect and provide was generally talked about in sympathetic terms, and at times constructed as a kind of positive masculinity, as in the following case of a client who had told two troublemakers to leave the shop he worked in:

“So, you know, and he just kind of [stood up to them], and I was actually like really proud of him. Erm ... and I think that's kind of ... I dunno, is that quite a masculine -? It's quite a nice - it's a sort of protective, nice thing to do, isn't it?” (Laura)

Where the expectation to protect and provide was constructed as a negative aspect of masculinity was when it became too rigid an expectation to live up to. Similarly, taking the expectation to succeed to extreme levels was constructed as a toxic aspect of masculinity, but where they served a function, traits such as being *“dynamic”* and having a *“fire in your belly”* (both Laura) were constructed as positives.

In the examples above, the toxicity of certain elements of traditional masculinity was related to their impact on men themselves. However, participants also constructed toxic masculinity in relation to male aggression and violence, thereby locating the toxicity in the effect it has on others, as well as for men themselves.

“you’d see that in the devastation, the wake of devastation of domestic abuse, that women would bring into services, you know, so I’ve got quite a negative idea of sort of traditional masculine traits I think because of that, I’ve seen the sort of the worst excesses of it, yeah.” (Joshua)

As Joshua says here, toxic masculinity was located in the “worst excesses” of traditional masculinity, suggesting that traditional masculinity is not toxic in itself, but can become so when taken to extremes. By contrast, Amy talked about one client she found “quite incredible” and spoke about him in reverent language. This person was constructed as having “a very masculine presence, and a posture and... yeah in a... in a strong [way] but was very respectful, and considerate and thoughtful” (Amy). This description seems to speak to an inner masculine strength rather than an externalised show of strength such as aggression, which Amy constructed in positive terms, and therefore was better able to relate to and admire.

3.2.2 Modern Masculinity

Acceptance. The primary construction of modern masculinity was acceptance of men of all kinds, whether they fit the rules of traditional masculinity or not.

“you get different ideas of what it is to be a man, I’m a man but I’m also, I’m a man but I’m also gay, I’m a man but I’m also a goth, I’m a man but I’m also, I’m a man, and I’m a football player, you know what I’m saying, you wouldn’t say ‘but’ I’m a football player [laughs] but you know what I mean, it’s like, so I think there are different things available, and I think that does equip men to be, to find it a bit less stressful” (Joshua)

As well as acceptance of different identities, participants talked about acceptance of emotional sensitivity as a key component of modern masculinity:

“He’s quite okay with being emotional and with being, with crying and he’s welled up a couple of times with me and that’s- he’s said that’s okay and it seems to be okay. Umm, and he sort of has a, a good enough sense of himself that, that’s sort of who he is.” (Sarah)

Sarah’s reference to her client’s *“sense of himself”* here also speaks to a construction of modern masculinity involving self-acceptance, in contrast to traditional masculinity which was constructed as involving not accepting certain parts of the self, such as emotions.

Femininity. The elements of men’s experiences which were allowed under the discourse of modern masculinity were often constructed in terms of femininity, and engaging in activities which had previously been considered feminine. Examples included shared parenting (*“men aren’t being flacked off so much in public if they’re out pushing a pram” (Susan)*), dressing more colourfully (*“the colourful outfit is like a cardigan knitted by his partner, which he is very proud of [...] So, it’s like a masculine man who’s dressed with his feminine side” (Melissa)*) and being more sensitive (*“many more influences now that are suggesting that men should also be really sensitive and caring and considerate” (David)*). In this way, modern masculinity was constructed in more androgynous terms, suggesting that men could take on whichever roles and traits they wanted to, rather than having to choose only masculine ones.

Confusion and disempowerment. Most participants made reference to a sense of confusion for men as a result of the shift between traditional and modern masculinity: *“I’ve got to be a sort of a tough guy one minute and then like.. you know, modern metro sexual man, on the other, you know it’s like, bit of a balancing act I guess, maybe that’s quite tricky” (Joshua)*. Michelle talked about a *“double bind”* for men in that *“the stereotype [traditional masculinity] is still there and people are kind of invalidated for not being it but equally they’re judged negatively*

for being it” (Michelle). This construction created a sense of a crossover period between the two discourses of masculinities, in which men are not sure which they should be aspiring towards, and face a lose-lose situation in trying to live up to both. David likened this to the discourse of the pressure for women to ‘have it all’:

“so traditionally that would be the, for women, you know, should be a successful career woman and a mother and you know and this and that but I think men are being asked to be a lot more things than what they used to be, and are getting lots of mixed messages about it, and it’s evolving all the time.” (David)

Despite this, none of the participants identified any clients they had seen for therapy whose difficulties originated in this double-bind, and so its use was illustrative of perceived wider societal problems than clinical ones:

“N: Have you had any clients who have maybe struggled with those changes of how things are shifting?

D: [long pause]... I, there’s different people going through my mind and I can’t think of anyone where that was clearly a problem” (David)

3.3 Discourses

3.3.1 Socio-Cultural

Participants constructed masculinity as a socio-cultural phenomenon. This construction suggests that masculinities are not static or inevitable; rather, they develop under a certain set of circumstances and may be subject to change. Most participants talked about such a change occurring in recent years, illustrating the shift from traditional to modern masculinities:

“we’ve changed [our attitudes towards masculinities] exponentially in society, in the last three, four decades, five decades, and so there’s a big chunk of society, historically who are older but also I think probably still within lots of communities this is still the thing” (Michelle)

In this way, traditional masculinity as a cultural phenomenon was often constructed as something which was outdated, and which was changing for the better. Modern masculinity, by contrast was constructed as a recent societal shift away from restrictive models of masculinity (which Melissa referred to as a “*straitjacket*”) and towards men having more freedom in their self-expression.

“he doesn’t feel, I don’t, too tied down by umm social- society’s idea about men in the social expression context yeah. Mm, yeah, he’s kind of relatively freed” (Sarah)

The terms “*straitjacket*” and “*freed*” evoke ideas of constraint and liberation, suggesting that the move towards modern masculinity serves to release men from the restrictive and oppressive effects of traditional masculinity.

Similarly to Michelle (above), several participants expressed the idea that traditional masculinity continued to be more strongly held in certain sub-cultures, particularly among lower- or working-class groups. This was linked to ideas about people from lower classes being more “*rough, aggressive, less sensitive*” (Melissa), as compared with people from middle classes:

“there’s something about trying to just open up a discussion that there are lots of ways to be a man, in that kind of nice, middle class where you’ve got all those opportunities and choices, he probably didn’t feel he had”

Although participants were not asked to self-identify their own class, talk such as this tended to locate them in alignment with the middle classes, and their clients with lower or working classes. This served to create a sense of distance between the participants, who advocated for the more refined notion of modern masculinity, and their clients who were mostly associated with the less sophisticated tenets of traditional masculinity. Participants who mentioned class differences tended to do so very briefly and did not openly reflect on potential power imbalances between themselves and their clients in this regard. This was perhaps indicative of a kind of middle-class discomfort making such topics feel too difficult to discuss in depth, despite their positioning in relation to the discourse clearly demarcating themselves as knowing better than their clients. One notable

exception to this was James, who seemed to align himself more with working class ideals of masculinity, stating that middle class men would *“ape a kind of femininity ... a false niceness”*.

Most participants constructed a social transmission of ideas about masculinities: *“what does society tell us, what did our parents tell us, what did society, what messages do you get from media etc?”* (David). Within this construction, other people became both the bearers and the upholders of traditional masculinity, as participants talked about masculine ideals being enforced by other people: *“he didn't really get on with this kind of laddy banter kind of environment, he didn't partake of that. He was excluded, he was bullied.”* (Laura). Participants typically used this construction to demonstrate that traditional masculinity could be questioned and challenged. By framing it as something we have been taught, rather than as a truth, one can question the expertise and motivations of the teller(s), and so undermine the message. Modern masculinity, by contrast, was held as more self-evident, and so was not scrutinised in the same way. This perhaps related to the alignment between the constructed ideals of modern masculinity and those of therapy: self-acceptance, flexibility, and so on.

“I can think of lots of people where they thought that how they were didn't really fit with being masculine, and therapy has helped them to feel comfortable enough in who they are and to think well I'm still a worthwhile person, it hasn't explicitly focussed on, you know, I'm still a good enough man, it's been more well actually you're just a good enough, worthwhile person because I haven't been trying to get them to feel like a good enough man cause that's the society stereotype that, um, you know there's not a predetermined destiny of where therapy is supposed to be going, it's more about their sort of psychological and emotional, [...] actualisation.” (David)

3.3.2 Psychological

Participants' talk about masculinities drew on psychological discourses of identity development, suggesting that ideas from traditional masculinity could become part of some people's sense of self: *"I think that men particularly struggle when they're not working because their identity has to a very great degree been bound up in their productivity"* (James). Typically, men who were constructed as very traditionally masculine were talked about in terms of having restricted identities, and being disconnected from parts of themselves, particularly in relation to their emotions: *"as you process trauma they realise they can get in touch more with their feelings and manage slowly to make a more integrated self than the fragmented one."* (Melissa). This, again, aligns therapeutic aims with modern masculinity and against traditional masculinity.

In relation to their clients' mental health, all participants constructed an interaction between psychology and masculinities: *"there's something around chicken and egg really in terms of underlying psychological formulation and the, the, the discourses that men might draw upon"* (Joshua). This interaction involved the experience of difficult childhood experiences leading to psychological distress, and men having access to a limited range of prescribed coping strategies to deal with this, which were rooted in traditional masculinity (such as not talking about it, or becoming angry and aggressive).

"he's somebody who grew up with a very abusive step-father who was incredibly controlling and very, very nasty and abusive, and who was a very old school man, [...] so he's quite clearly able to identify that, yeah I've got some of that, I learnt that that's how you do things, and you know that's all wrapped up in this traditional idea of masculinity I think, yeah." (Joshua)

For some clients, the problem was constructed as being that they did not live up to these masculine ideals in the face of adversity, and therefore they experienced shame. For others, the masculine coping strategies were themselves constructed as problematic and as perpetuating men's difficulties.

3.3.3 Evolutionary

Despite primarily constructing traditional masculinity as a sociocultural phenomenon, participants' talk did include references to natural sex differences: *"but actually I do think people have a temperament and I do think fundamentally the temperament of men and women has been very different, I'm sure that has some sort of evolutionary basis"* (Michelle). This included references to men being more naturally aggressive and dominant, as well as physically stronger, and women being more nurturing. Generally where these ideas were talked about, they were constructed as something to overcome – positioning modern masculinity as a more evolved way to be than traditional masculinity. However, James framed such natural differences as being useful and meaningful, as in the following extract.

"if you're overly masculine then [...] what that might look like is being an alpha male or being more socially dominant [...] that, sometimes is a reaction to an environment where if you don't do that you expect to be predated upon, so that's one, that's one of the reasons, I don't think that's anything to do with living up to society's expectations of men but that is one of, that's an adaptive response as I would see it."

The use of the word *"predated"* here evokes an animalistic sense of survival, despite James having been talking about modern human environments. Drawing on evolutionary discourses in this way gives a sense that traditionally masculine traits are both a necessary and useful response to a world which is dangerous for men, and evokes the scientific status of evolutionary biology as a way to emphasise the credibility of the argument.

3.3.4 Hierarchical

Participants linked traditional masculinity to power in society: *"it's a hegemonic position isn't it in terms of power structures"* (Joshua). Most participants drew on feminist discourses of a patriarchy-based society, in which men are the dominant sex and exercise their power over others, as suggested in Joshua's use of

the word 'hegemonic' above. Within this construction, traditional masculinity was framed as a problem.

For other participants, though, traditional masculinity and the power associated with it were not constructed as a problem. Melissa constructed a need for some people in society to be more dominant, depending on the needs of the environment: *"you need complementarity, so there need to be, kind of like, leading roles and supportive roles"*. She drew on talk about men and women's natural differences to support these ideas, and gave examples of different situations in which each sex might be more natural leaders. As such, this construction was relatively neutral in its stance on men and power, suggesting that any male dominance in society was simply a product of their skills matching the demands of the environment, rather than a deliberate exercising of power over others. For James, men holding power in society was constructed as a positive occurrence: *"men want social status and I don't think it can be any other way, [...] and when people have social status they live longer, they have happier lives in various different ways"* (James). Here James outlined the benefits to men of holding high social status and power, and elsewhere throughout his interview he talked about men having lost their access to such social capital through a feminisation of the workforce in recent years. Both James' and Melissa's talk, then, was supportive of hierarchical discourses, in which society was necessarily stratified in terms of certain characteristics – in this case, gender and masculinities. They might also, then, be considered to be aligned with a more conservative discourse which seeks to maintain social hierarchies, whereas the rest of the sample championed more progressive discourses relating to social change and egalitarianism.

Participants also talked about power dynamics in relation to mental health and the therapeutic process. They generally constructed experiencing mental health problems and coming to therapy as disempowering for men:

"I suppose I perceive it as a response to a sort of shame and being disempowered and having to come to therapy - well they don't have to come,

you know, but you're coming to therapy to see ostensibly a middle-class female and say 'look I'm not coping very well with my emotions, that must be quite disempowering.' (Laura)

The construction here, then, is that men have lost some of their naturally higher status by virtue of joining a more marginalised group in society: those with mental health difficulties. Laura's emphasis on herself as a "*female*" therapist here serves to further the idea that this male client has been disempowered, thereby placing him in a less powerful position than a woman, who, by virtue of her sex, should be less powerful than him. Only a small minority of the participants spoke about their specific power as therapists in relation to their clients. Where any power on the part of the therapist was constructed, it was in terms of an ability to do harm to clients who were vulnerable, e.g. "*not to sort of bruise what is already quite fragile*" (Laura); "*dealing with those dynamics in a way that doesn't leave people feeling like utter shit*" (Amy).

3.4 Action Orientation

3.4.1 The need for Adaptation

Therapy with men was consistently constructed as less common than therapy with women, and as less comfortable for the clients themselves: "*I think just knowing what, what he was, what he expected to be doing in therapy, just felt really hard, so he needed that kind of hand-holding and support.*" (Sarah). This construction drew on the notion of masculinity as the antithesis of therapy (Meth et al., 1990), as participants who used it highlighted how the demands of therapy such as talking, trusting and showing vulnerability were "*foreign*" (Susan) to traditionally masculine men. The implication of this was that there needed to be adaptations in order to undertake successful therapy with some men.

Being tentative in approach was one such adaptation, and many participants talked about using humour or banter to build rapport with male

participants before attempting to engage them in the more serious tasks of therapy:

"I can think of lots of occasions where I've felt like right I need to be pretty blokey about this, there's no way I could phrase that in a, I couldn't talk about love too much with this person, it just wouldn't go down very well"
(David)

Related to this, many participants talked about needing to allow therapy more time with male clients, as they took longer to become comfortable with the process: *"I think it's a lot with the relationship and well my experience with male clients, that that relationship takes longer to build often, than it has for women"* (Susan).

Similarly, participants constructed a need to bear in mind what participants were familiar or comfortable with, and not introduce ideas which would be too far outside of their comfort zone: *"he just wasn't very psychologically minded and I think that we ended up having to work quite behaviourally"* (Amy).

3.4.2 Therapist Effort

In some cases, male clients were constructed as somewhat helpless in relation to their masculine socialisation, and so the responsibility for making adaptations was located with the therapists. Susan, for example, who used the word 'foreign' several times to describe men's lack of understanding of and language for their own emotions, said, *"maybe you kind of have to work harder as a therapist to draw out the information"* (Susan). This framing tended to draw more on evolutionary discourses, which positioned differences between the sexes as natural and so less amenable to change.

Elsewhere, however, male clients were constructed as more active in failing to engage with therapy on its usual terms. This often related to talk about clients who presented with aggression and violence, as well as those whose inability to tolerate vulnerability was constructed as frustrating the therapeutic process: *"if I tell you I'm a potential threat to you, you won't go near, you won't make me feel*

unsafe, if that makes sense” (Michelle). This talk used hierarchical discourses to frame men as powerful, which imbued the male clients with control and responsibility over their actions. Unsurprisingly, this type of male client was constructed as evoking difficult feelings for therapists:

“It’s okay when they’re able to reflect on it [toxic masculinity] really, work with it, it’s much harder when they’re happy with it, like I say, yeah, and it’s harder to manage, your own sense of frustration and crossness when they’re, when they’re, they’re happy with it as well.” (Joshua)

When men were constructed in this way, it justified a certain defensiveness in the therapists – a need to protect themselves from these feelings and from being vulnerable to the men’s exertions of power. Sometimes such constructions were used to justify taking a different approach which seemed to serve to maintain therapists’ sense of control: *“we ended up having to work quite behaviourally which isn’t, you know, a way I would usually work” (Amy).* Often in these cases, participants’ talk emphasised the limitations of the therapists’ abilities to help such men if they were not willing to adapt to therapy for themselves: *“I can’t really work with that, I can’t see, I can’t make you a more successful bastard” (Joshua).* This created a justification for the therapist to disengage from the work, and was often used as a reason the work did not go any further (such as the person Joshua described in the previous quote, who only attended for one session).

3.4.3 Addressing Masculinities in Therapy

Where clients’ masculinities were framed as impacting their mental health, therapists became justified in addressing masculinity within therapy.

“the first client I talked about definitely, we had lots of conversations about what it meant for him to be a man and to have been a man that was abused by a woman, that was a really important kind of part of the work” (Michelle)

The extent to which masculinities were constructed as problematic for different clients related to participants’ broader approaches to different types of

masculinities. For example, participants who constructed traditional masculinity as a negative force in the world (such as through using hierarchical discourses) were more likely to make a link between their client's masculinity and his difficulties if he presented as more traditionally masculine. Contrastingly, where clients were constructed in terms of modern or positive masculinity (both of which were typically held up as examples of more healthy masculinities), there was less imperative to address masculinity within therapy. For example, a client of Joshua's who was a refugee, and whose masculinity was described as being culturally different, but not harmful to the client or others in his life:

"I guess his masculinity does come in there, but there are other things, probably, well I think other things probably trump it, psychologically speaking if you like, so it's whether we get around to that" (Joshua)

In these cases, participants tended to talk about their clients using more psychological discourses than gender-based ones.

The problematisation of clients' masculinities was often linked with behaviours which might be considered generally difficult to work with in therapy, such as avoidance of difficult topics or rejection of the therapist. These interpersonal behaviours are the kind which tend to evoke difficult feelings for therapists when they arise. Therefore, the construction of them as a problematic form of masculinity would also serve the function of helping the therapist to feel more justified in their own discomfort, and in their responses which served to address the problem. For example, when Sarah talked about beginning to address masculinity with a client who she constructed as undermining her attempts to help him through passive and inconsistent engagement:

"there's maybe part of you finds that really hard, and wonders about, um what it means to be somebody who has to come to therapy! I didn't say explicitly what it means to be a man that comes to therapy ... but that's kind of where we're going." (Sarah)

Participants rarely named overtly difficult feelings in these situations, such as feeling undermined by or resentful of a client. However, clients who were talked

about in terms which suggested they had been more enjoyable to work with also tended to be constructed in terms of modern or positive masculinity, again meaning that masculinity did not need to be addressed as a problem in therapy:

“the dignity and the .. commitment to his own .. ideals and values despite what he’d experienced and managing to maintain a sense of dig-, I keep using dignity, that really came across to me, strength and dignity, and all that alongside a vulnerability and a fragility that had been caused by this torture, I thought was very moving and I, erm, I found him quite incredible actually, yeah, and he was very overtly masculine” (Amy)

3.5 Positionings

In this section, I will outline the subject positions that participants took up in their talk in relation to their clients and their masculinities. A summary of each position is provided in Table 4. The first two positions (the rescuing position and the self-protective position) represented instances in which the participant’s masculine presentation was constructed as a challenge for the therapists to deal with. Often in these cases, progress in therapy was constructed as being difficult, slow, or not possible. Experiences with these clients are likely to have challenged the therapists’ sense of competence and ability to deal with the difficulties within therapy. The adoption of either of these positions, then, could be understood as a defensive strategy to maintain their own sense of self-efficacy.

The final subject position, the therapeutic position, represented the many stories in which clients’ masculinities were not constructed as overwhelming the therapeutic process, which allowed the therapists to respond to them in ways which were more focused on their psychological needs than their masculinities. There were numerous underpinnings which supported participants achieving this positioning, which will be explained below. Importantly, it was not only with clients whose masculinity was constructed as not challenging that participants were able

to adopt this position – there were clear examples of participants experiencing but then managing their own difficult feelings within their talk about certain male clients, in a way which enabled them to still respond therapeutically. I will provide examples from participants' talk about a variety of clients to illustrate each position below.

Because the constructions of clients differed so markedly between the rescuing and self-protective positions (particularly in terms of how responsible they were held for their presentation in therapy), participants did not tend to move between these positions when talking about the same client. However, those who took up an overall therapeutic position in relation to a client often showed features of one or both of the other two positions within their talk. This was because the therapeutic position involved drawing on elements of both of the other two positions (e.g. recognition of clients' vulnerabilities, in common with the rescuing position, and enforcement of therapeutic boundaries, similarly to the self-protective position) in a balanced way rather than leaning too far into one or the other.

Table 4 Subject Positions

Therapist positioning	Client positioning	Negotiation of Power	Possibilities for Practice	Subjectivity
Rescuing	Helpless in therapy	<p>It is the therapist, not the client, who holds the power to effect change.</p> <p>Maintains the conservative hierarchical discourse that men cannot be any other way.</p> <p>Therapist and client are aligned against a perceived powerful culture which does not support men.</p>	<p>Try harder and offer more as a therapist; find an external reason for failure.</p>	<p>Feel like you are helping, and that only you can help this person; experience clients' gratitude; feel superior to others who have failed the client.</p> <p>Avoid feeling frustrated, angry, or self-critical in the face of therapeutic failure</p>
Self-Protective	Blocking therapeutic progress	<p>The client is constructed as having the power to prevent the therapy's success; sometimes related to direct expression of client's power (e.g. aggression).</p> <p>The power of therapist in reacting to the client is not acknowledged. This upholds therapy's institutional power, which serves</p>	<p>Emphasise client's choice in making changes; be more directive; detach from the process if it is not succeeding.</p>	<p>Feel frustrated, angry, and victimised by the client. Believe that anger is righteous and justified. Might feel morally superior to the client, or that you know better. Feelings of relief when therapy ends.</p>

		to exclude certain types of clients who cannot adapt. For some, the therapist is positioned in resistance to a powerful and oppressive patriarchal society.		Avoid feeling undermined, controlled, vulnerable or unsafe by reacting against the client.
Therapeutic	In alliance; an active participant	Power and responsibility is shared in therapy, and equally acknowledged on both sides by the therapist. External power structures are considered only in as far as they affect the therapeutic dyad.	Work together; compromise; learn from each other	Feel connected; empathise with client. Think of self as an effective therapist. Experience client's gratitude. Accept shared credit for successful outcomes.

There was not one unifying reason why a client's masculine presentation might be constructed as challenging for a therapist to work with or not. The participants all expressed different relationships to constructions of masculinities, and this was represented in how they recounted their experiences with clients. Even for the same therapist, there could be both subtle and stark differences between the ways they described different clients' masculinities which resulted in different responses. In total, the participants talked about their experiences with 51 different clients, albeit some in more detail than others. It would not be possible to describe the analysis of all of these accounts within the constraints of this piece of work, and so selected examples were chosen which were able to most fully illustrate the different ways the participants positioned themselves and their clients in relation to discourses of masculinities. A summary table of participants' stories, with brief notes on how each client was constructed and the position the participant took up in relation to them is given in Appendix I. Participants did talk about 6 female clients. However, these stories tended to be shorter and less well-developed than their talk about male clients, and they have less relevant implications for how therapists might work with male clients. Therefore, I elected to focus only on stories about male clients in the presentation of this analysis.

3.5.1 The Rescuing Position

The rescuing position relied on the construction that traditional masculinity makes men ill-equipped to deal with the demands of therapy, such as expressing vulnerability and talking about emotions. Therefore, it related to clients with whom therapy was difficult because of their masculinity, but unlike the self-protective position, the problem here was not located in the client, meaning that he was not blamed for any effect of his masculinity on the therapy. Instead, participants drew on evolutionary and conservative hierarchical discourses in a way which made the men seem almost helpless victims of their masculine identities within the therapeutic environment. This justified a need for the therapist to adapt and scaffold for their clients within therapy, with little sense of reciprocal effort from the clients. Any negative feelings relating to the difficulties in therapy were

directed outwards, towards a society which neither equips men to cope with their feelings nor supports them when they struggle.

Client 1. Susan described one client, who had been referred for private therapy by his concerned parents, in terms which constructed him as child-like, through her focus on his young age, his schooling, and his parents, as well through as using words such as 'kids' and 'meltdown'. Although he was an adult, these terms created an image of someone adolescent:

"I suppose with him because of heavy drug use and the fact he came in his PJs for the first session, it's like the first session, I don't know, there's something appealing about these young kids, well young, [early 20s], um .. I question how motivated he would be at being engaged in, you know, because in private practice, you know, and I'm in [city] which is kind of posh I would say, a lot of them are you know just fronting up with mum or dad's credit card, and you know I could just see the scenario for this young boy that, you know, cause he'd had, you know, really serious drug use before and got kicked out of uni for dealing, got back in, blah de blah blah, had a huge meltdown at a festival because he'd taken everything really, that mum's trying to rescue him, as you would as a mum"

Her depiction of him *"just fronting up with mum or dad's credit card"* and the *"blah de blah blah"* after the description of him being kicked out of university for dealing drugs constructed this client as both not being held responsible and not taking responsibility for his own actions. This was a client with whom she described herself as *"puzzled as to why he is here"* because he could not seem to acknowledge which feelings he was struggling with:

"he hasn't spoken about the real issues, kind of like comes near it, but then he pulls back from it, so he'll kind of skirt round on other stuff, had a lot of drug use, so he would talk about his drug use, still smoking weed, and how yeah he'd have to give that up, but at the same time he's got intrusive thoughts that are really disturbing to him [...] so I was talking to him about more of an

anxious presentation, that was totally foreign, he said no, I've never been an anxious person, so again it's kind of the labelling of, for him"

This extract presents a more active construction of the client avoiding *"the real issues"* in therapy, including an understanding of his own emotional life. However, Susan also used the word *"foreign"* (here and several other times) in relation to men's relationships to their emotions, suggesting a total lack of understanding or language for them. She said she was taking this case to supervision next, indicating a sense of feeling stuck with the case. Experiencing such 'stuckness' in therapy might lead a therapist to have a number of difficult feelings, such as frustration, anger, self-criticism, or feelings of failure. Susan said that she tended *"to connect quite well with my clients, too much probably, self-survival is always an issue,"* thereby constructing herself as somebody who may put her clients' needs before her own. In this case, the construction of this client within an infantilised version of masculinity in which he did not know how to understand or help himself created a justification for Susan again going above and beyond to try to help him. She repeatedly said that *"he keeps coming back"* in a way which suggested that he wanted something from the therapy, but neither she nor he was sure what. Susan questioned:

"even what he's getting out of therapy actually because, yeah, we've been trying out a few like relaxation stuff, things he wants to try it out, and he goes yeah that didn't work, no that doesn't work, I've explained that you know relaxation is an iffy thing, you have to find the right stuff for the right person, so he's willing to try it, but yeah, anyway, that's supervision, I need to try and figure out how to get to the deeper issue which, yeah, he has no understanding of."

In this extract there was a sense of Susan trying to figure out what the client wanted from therapy on his behalf, and of her offering him a lot of different interventions to try to find one which worked. She said *"I need to try and figure out"* how to progress in therapy, claiming sole responsibility for making sense of the situation for herself, and mirroring her construction of his mother trying to rescue him. The client's own power and responsibility in the therapeutic dyad is not

acknowledged, paralleling her passive construction of him in the wider world. Working harder and continuing to search for the elusive 'right' intervention could serve to mitigate against the difficult feelings brought up by a therapy which is not progressing.

Client 2. James described a client with whom his attempt at therapy had been unsuccessful. This person was described as someone very intelligent but with no qualifications, as feeling completely alienated by society and as being inclined to read around a lot on the internet and believe in conspiracy theories. James said of these beliefs that *"some of the things that he's saying about society are actually true"* and,

"he sees this, so he, and this is the one where the madness and the normal are a bit mixed up, because some of the madness that he presents with is actually very, very sane, it's more sane than most of us".

As a result, James' construction of this client was of somebody who was rejected by society for being able to see its faults. He elsewhere talked about the client being *"hostile"*, *"narcissistic"* and that he would present as *"a pain in the arse"*, but did not offer a psychological formulation of this. It seemed that his personal identification with the client's beliefs, coupled with his overall construction of men as an oppressed group, led to a construction of the client as a victim of circumstances. This construction suggested the client was someone who lacked agency or responsibility. In describing his therapeutic offer to the client, James said he had:

"acknowledge[d] that, that he's doing what he's doing and that there's some good reasons why he's doing what he's doing, but think with him about are there any unwanted effects of this on your life, is, is, where's, granted that this is what you do, is there any way in which this is going off the rails for you, where, where is this a problem for you, how can I help you, [...] how can we together identify what you regard to be a problem and I'll be honest with you if there was, about, if there's anything that we could do together that could be

helpful with that, so again there was non-judgement, I didn't judge him, I liked him, frankly"

Throughout his interview, James talked about good therapy requiring a combination of *"compassion and challenge"*. However, for this client, the 'challenge' side of this dialectic appeared to be absent. By only focusing on what the client perceived to be a problem for him (which was that society itself was wrong and the client was right) James did not appear to offer any reframing of the problem in more balanced or psychological terms, even in the interview. The construction that the client could *"identify what [he] regard[ed] to be a problem"* and James would *"help"* him further placed the responsibility for improving the client's situation with James, rather than as a collaborative endeavour. By aligning with the client against an unjust world, a therapist in this position might experience gratitude from the client (and avoid the potential hostility he might demonstrate towards others who were perceived as less helpful), as well as a sense that they were helping somebody that nobody else would help.

This position was also evident in James' description of the outcome of the work, which was that the client had stopped attending appointments and had not responded to an opt-in letter after an initial assessment. Having constructed their initial therapeutic relationship as positive, an abrupt disengagement such as this might be expected to bring up difficult feelings for a therapist, such as feeling rejected or abandoned. However, what James said was that it *"ended well"* and that *"there's something positive to be said about this too, which is what didn't happen was there wasn't any hostile ruptures which is what had been happening before"*. This suggested that James had framed the outcome of the work as a success despite the client's inability to engage in therapy, and as being beyond the client's (or his own) control. This reframing would offer James a way to protect his own self-esteem after having offered the client so much and had his offer rejected.

3.5.2 The Self-protective Position

When taking up this position, participants positioned their clients as resisting or blocking the therapy in some way which was related to their masculinities. By constructing clients in this way, the therapists positioned themselves as victims of the clients' masculinities, and so justified attempts to resist this influence within therapy. These acts of resistance, and the power contained within them, were seldom consciously acknowledged by participants. Instead, it was the client who was constructed as powerful, and as exerting this power over the therapeutic process. Unlike participants in the rescuing position, emotions such as anger and frustration towards clients were much more evident here. Many participants drew on progressive hierarchical discourses to associate their male clients with oppressive and 'toxic' forms of traditional masculinity. Thus, resistance against these discourses became enacted and justified within the therapeutic dyad.

Client 3. The first example of this position relates to a client who attended for one session, who Joshua described as *"malicious and malignant"* and *"unpleasant"*, which gave an indication of the high level of negative feelings which were expressed about this client. From the start, Joshua constructed this client as having *"no intention"* of going along with therapy and that what he *"probably wanted was somebody to say they'd seen him so that they could continue to claim benefits"*. When asked why the client had come to therapy, he said:

"something around PTSD really, he'd been assaulted under dubious circumstances, so, and he was obviously he had a lot of hyper arousal associated with that, he was constantly ringing up the ambulance services for panic attacks that he was having, demanding, what was he demanding? Oxygen or gas and air or something like this, he wanted some sort of, he wanted paramedics to come round every time he had a panic attack and treat him essentially, you know, costing vast amounts to the national health service and he wanted for that to keep on happening, essentially, and you know I wanted to present a formulation where I thought what was happening is that

you are having fight or flight symptoms probably in response to you know intrusive memories that you're having, but also he was like he was watching like Sky news and no doubt looking at horrible memes on Facebook and getting apoplectic with rage, banging on to me about you know if we stay in the EU there'll, Sharia Law will be here [laughs] in a couple of years, you know, go red in the face, you know, he was just getting himself into a state all the time, you know, but, I don't know, difficult to emphasise with him, he wasn't a very nice bloke."

In this extract and the text surrounding it, the client was constructed as someone who was exerting his power over others through demands that they attend to his needs, but as someone who did not actually need or want the help that Joshua was offering. The suggestion that he *"wanted for that to keep on happening"* implied that the client was not interested in engaging in therapy, and the implications that the client's assault had been *"under dubious circumstances"* and that his health service use was based on *"demanding"* care created a sense that the client was responsible for many of his own difficulties.

While Joshua offered a basic formulation of the client's symptoms, he later said that if the client did not want to engage in therapy then he did not feel *"particularly compelled"* to deliver it, and did not reflect any further on where the client's difficulties might have originated. The language used to describe this client strongly suggested that Joshua experienced a negative reaction to him, although he minimised the effect the session had had on him:

"N: How did you feel after that session?"

J: I kind of, well, you know, cross but alright"

The reaction suggested by Joshua's construction of the client might have included feeling threatened, undermined, or rejected, as the person had not taken up the therapeutic offer and had embodied the 'toxic' masculinity that Joshua disavowed elsewhere. The construction that the person did not want to build a therapeutic relationship or work on his difficulties – i.e. that the client was acting in bad faith – would have been protective against these feelings. While constructed as a fairly

passive position, in which the client is in control of the decision of whether or not to continue with therapy, this may in fact represent a more active strategy of disengagement from a client who was experienced as particularly aversive and threatening to Joshua's sense of himself. It is not possible to know what happened in the therapy room, but it would not be unreasonable to question whether such a strong emotional reaction might have led to unintentionally dismissive or defensive responses in the room with the client. I had a sense that Joshua's strong reaction to traditionally masculine men such as this one related to a perceived threat to his own sense of masculinity, although he described himself as feeling very comfortable with this. This seemed to be because the version of masculinity that this client was constructed as holding was one which externalised its power over others, including him, while Joshua's preferred version of masculinity involved finding empowerment in accepting oneself and letting go of the expectations placed on men – a much more internalised version of power and strength. By constructing the client as someone who was exerting his power over others in a negative way, Joshua would be in a position to feel righteous in his own anger and opposition to him, as someone who is aligned with an oppressive system (toxic masculinity).

Client 4. While the self-protective position was mostly adopted in relation to clients constructed as embodying traditional masculinity, Melissa took up this position in relation to a client who was avoiding this kind of masculinity. The client in question was initially described as *“not somebody as traditionally masculine”* as other clients Melissa had talked about, and as avoiding taking responsibility for himself as a man:

“M: I don't see there will be any change for him unless he manages to shift his personality, his way - his way of actually seeing himself and relating to others, because he comes in as very, very weak and begging

N: Has he been like that with you?

M: Yes, and he's either very avoidant, or when you try to put him in a position of having control and kind of like, maybe boost him up, or say that you're doing that, he won't become angry and he won't become motivated. He will just become guilty and start saying [whingey tone of voice] 'I'm sorry. I'm sorry. I'm sorry. I'm sorry.' and that's it. So he doesn't shift really."

After this section, Melissa described working with this client as “*very annoying*” and said he was one of the most “*repulsive*” clients she worked with because of his presentation. She talked about him as not being somebody that women would want a sexual relationship with (“*I believe they didn't see him as much of a man*”), drawing on evolutionary discourses of sexual selection, and described his appearance as “*very adolescent*”, making a link to childishness in his emasculation. This client was conceptualised as “*somebody who doesn't know who they are and they try to come across as somebody who they're not*”. What this seemed to mean was that he was not behaving like a man should behave, and so was avoiding his own true identity. In the extract above, Melissa expressed frustration that her client would not become “*angry*” or “*motivated*”, again drawing on the discourse that aggression and dominance were key aspects of masculinities. Taken together, this all created a representation of a client who was avoiding his real – meaning his masculine – self, in a way which was deeply unappealing to Melissa as an outside observer.

The description of this client as avoiding his emotions within therapy suggested that the therapy felt stuck, and was not progressing as she would have hoped. Despite her assertion that she “*think[s] as a psychologist*” and would not let her personal views influence her clinical judgements, there did seem to be a lot of strong feelings about the way a man was supposed to be (such as finding him annoying and repulsive) in the way she talked about this client. He was constructed as almost obtuse in his passivity, and her description of his refusal to take up the role she felt he should suggested a deliberateness in the way he was preventing the therapy from progressing. In response to this passivity, Melissa talked about giving this client more direction than she did with her other clients, such as asking him to

try wearing different clothes. This suggested that she adopted a more didactic position, which could be understood as an enactment of power in trying to shape him to who she thought he should be as a man. Her own power in the therapeutic relationship was not overtly reflected on; instead, it was the client who was constructed as having the power over whether or not he chose to change. That he refused to be more assertive, and in return Melissa became more so herself, suggested an interpersonal process in which she was trying to maintain a sense of control with a client who she perceived was defying her help. Her statement (in the above extract) that she did not think there would be much change for this client suggested a view that if a person was not willing or able to accept their assigned gender role (in this case, his responsibility as a man to be stronger) then therapy could not help them. This position would justify losing hope in a therapy, and possibly blaming the client for its failure, if the client was not able to do what was constructed as necessary. Being able to place the responsibility for therapeutic failure with the client would protect Melissa from any difficult thoughts or feelings associated with the idea that she herself had failed as a therapist, and would enable her to feel justified in her frustration towards the client.

Client 5. Sarah recalled one client who she had said would “pretend” not to remember things which had been talked about in therapy, and would “play dumb” and pretend not to understand psychological concepts. Sarah also said this client would call her pet names such as “babe” and “hon” in a way she described as “a bit demeaning” and related to another story about “sleazy” men, although she said that was not the right word for this client. There was a sense of a struggle for power and control in therapy with this client, in which he was constructed as deliberately dominating and obfuscating the process and she as trying to prevent this and keep the therapy going in a useful direction:

“At first I used to be really wound up by him. Mm, used to be wound up by his like almost obvious kind of umm .. denial or this playing dumb thing or umm, not being, not being honest. This is what I had to kind of think about, not being honest. Not in a, yeah, just, what is the function of his claiming to

have certain experiences or pre-pretending that things don't .. bother him or that things are, exist and they don't – or not pretending but unconsciously-. I think this is where the conscious / unconscious thing came about.

Unconsciously . . . umm . . . sort of not, er . . . yeah, not putting in effort. [...]

Umm it was really hard to engage him in like his conversations and I really warmed to him in the middle and we got on, we started getting on better umm, found sessions quite easy; it wasn't something I really had to plan for. Things would evolve and come out. He would often, there were times when I would feel like more annoyed with myself. He'd kind of dominate and change direction quite a lot and I think it was quite clever and protected but umm, it stopped us going in the direction I wanted us to kinda go in so yeah, elements of frustration with kinda warmth and connection umm, I'm glad to discharge him, but, and I like him at the same time"

This section of text contained a number of contradictions which suggested that Sarah had struggled with her feelings towards this client. After saying she found sessions “quite easy” and “didn't have to plan for them”, she contradicted herself by describing a process where the client would “dominate and change direction” in a way which constructed his actions as deliberate. That Sarah here says she would get annoyed with herself was also contrasted with a statement a few lines earlier that “I used to be really wound up by him”. This gave a sense of passive resistance, in which Sarah had moved from feeling wound up by the client to accepting that the therapy would not progress as she wanted but being more frustrated with herself for not spotting when she had been tricked by his changing directions. This construction still places blame for the barriers to the therapy with the client and his actions, despite the annoyance being directed at herself.

In this example, Sarah reported that her strategy of naming the client's unconscious avoidance behaviours in order to work through them had not worked, as he continued to engage in them. This barrier to full therapeutic engagement evoked feelings of annoyance for Sarah, as stated by her, and, in the context that the client was described as being overtly dominating as well, may have also raised

feelings of powerlessness or victimisation, which are supported by her descriptions of his actions as deliberate. Her construction that his language towards her was demeaning also added the sense of a gendered dynamic to the struggle for control, as the client is constructed as attempting to undermine her as a woman.

The more ambivalent and detached position Sarah adopted later in the description of the therapy (*“elements of frustration with kinda warmth and connection umm, I’m glad to discharge him, but, and I like him at the same time”*) would serve to minimise the impact of the difficult feelings brought up by this client, such as anger and rejection, or feeling controlled or undermined. An earlier description of his avoidance being *“hard wired”* may also have helped to reduce feelings of inadequacy for not having been able to work through the avoidant behaviours, as it suggested that they were somewhat inevitable. That she used words such as *“playing dumb”*, *“not being honest”* and *“pretending”*, with only a brief allusion to the possibility that these occurrences might have been unconscious suggested that her construction of him was more informed by the discourse of a dominant man than by the psychological theories she made use of elsewhere.

3.5.3 The Therapeutic Position

The key feature of the therapeutic position was that clients’ masculinities were not treated as an insurmountable problem – sometimes not even as a factor – in how the participants talked about them and their therapies. This meant that when participants adopted the therapeutic position, their talk was more likely to be characterised by psychological language than by masculinities-based language, and their responses to the clients came across as more reasoned and measured. In this sample, there were several different types of clients constructed with whom the participants had taken up this position.

Where clients' masculinities were not constructed as problematic, participants were able to easily take up the therapeutic position in relation to them. This construction depended on a participant's general stance on different kinds of masculinities. For example, James was broadly supportive of the ideas contained within traditional masculinity, and so was able to talk about traditionally masculine clients in a more therapeutic way than other participants who constructed it as a problem. The first example given here, though, relates to a client who was constructed in terms of modern masculinity, which was consistently framed in positive terms and supported the adoption of the therapeutic position through its alignment with broader therapeutic goals.

Client 6. Sarah described this client as a *"square peg in a round hole"* and a *"different kettle of fish"* compared to other men, and particularly compared to the other men in the forensic service he worked in. Sarah contrasted what he reported as his colleagues' enjoyment of *"control and power and masculinity and being the one with the keys"* with her client's compassion, empathy, and sensitivity, creating a clear sense of differentiation between this version of traditional masculinity and her client. She talked about an instance of herself feeling shocked and upset by some of the traumatic events he had described, but that he had asked her *"how will you be?"* when she had enquired the same of him at the end of the session. This was given as an example of him being *"emotionally aware"* and wanting *"to protect me [Sarah] in the therapy"*, thereby also drawing on the notion of protectiveness as a positive masculine quality. Elsewhere, he was constructed as being comfortable with his own emotions and as *"freed"* from the constraints of traditional masculinity, drawing on the progressive hierarchical discourse within which modern masculinity is constructed as liberating men from the oppressive masculinity of the past. As such, the client's masculine presentation was constructed in entirely positive terms, and was not held up as a barrier to the therapy.

Having positioned the client as an example of modern masculinity – a discourse which she positioned herself in agreement with – Sarah expressed a high level of empathy for this client:

“I relate to him ... I can really connect with his frustration; it makes me feel often kind of really annoyed for him with that this was what he had to suffer [at work].”

In this extract, she aligned herself with the client, sharing his frustration and annoyance. The client’s concerns were treated as legitimate and righteous throughout the telling of his story:

“he has this real sense of ‘I need to do it’ ‘I need to do the trauma work’

N: what’s your, I guess, your sense of what’s that about that, ‘I need to do it’?

S: yeah, there is a real need; there is a pressure. Umm, he-he’s... he’s, I think it’s been going for so long umm, he’s sick of it. He feels really annoyed and angry that he didn’t get support, that it wasn’t helped. Umm, I think it was, I think the two-year waiting list adds to that pressure.”

In the above extract, Sarah talked about the client pushing for support to resolve his emotional difficulties and feeling angry that he had not received this support earlier. For another client, anger and a wish to stop experiencing difficult emotions might be constructed as troublesome or avoidant elements of traditional masculinity (e.g. client 5’s avoidance); however, because this client had been held up as a counterexample to that version of masculinity, Sarah was able to formulate his experiences in more empathic and less gendered terms.

In this example, Sarah did not talk about power in relation to the therapeutic relationship. The client was constructed as being disempowered at work, and Sarah’s coming alongside him in her indignation about this gave a sense of shared resistance against a powerful enemy. Given her construction of his need for help as legitimate and urgent, Sarah had placed herself in a position to meet his needs by offering the psychological therapy he was asking for, which is what she said had happened. From this therapeutic position, Sarah would be able to feel she

was helping her client with his long-standing difficulties, and helping to make things better for somebody who had been harmed – both noble goals which we might expect many therapists to aim for. The therapeutic position, then, may offer an opportunity to feel like an effective therapist, particularly in relation to a client one genuinely cares for, as Sarah seemed to here. This construction bears similarities to the rescuing position, in its construction of the client as disempowered and in need of help that Sarah was uniquely placed to offer. However, her overall construction of him as active and engaged in the therapeutic process meant that her own position did not move into a rescuing one.

Client 7. David talked about a client who worried that he did not match up to how a man ought to be in relation to traditional masculinity, particularly because he was *“quite effeminate”* and *“an emotional male”*:

“he would talk about being out in the world and feeling like he should be presenting himself in a different way to males around him, which would make him feel quite anxious because he wasn’t sure if he would manage to kind of keep the façade up and he wasn’t that good at doing it, and he also sort of judged himself for not just feeling more masculine, traditional masculine, whatever that is, and so felt quite down and critical of himself”

The client was constructed here as feeling that his true self (i.e. not the ‘façade’) was not acceptable in public, particularly to other men, leading to judgement from himself and others. While this construction suggests that the client viewed himself as failing to live up to standards of masculinity, the way David talked about him reversed this relationship, and suggested that those standards were not able to match up to the client’s positive qualities:

“when we explored what messages he’d been given about masculinity and where they came from, they’d discouraged emotionality and men being feminine, but it was his main strength, you know, he was a really kind of caring emotional guy”

In this extract, David reclassifies the client’s emotionality from a failing to a strength, questioning the validity of the messages about masculinity which had led

him to feel inadequate. In doing so, he makes use of socio-cultural discourses to question and undermine the messages of traditional masculinity, both in the interview and in the session. The result of this was constructed as a very positive therapeutic experience for both David and his client:

“I think he found therapy really... well, validating and he felt very accepted in therapy because I enjoyed his emotionality, or he would have probably experienced me enjoying it, we might make some kind of joke about something that, quite a lot of humour would come in to therapy that, you know, if I’m sitting there laughing I’m clearly appreciating it, and then the things we were talking about, about... I suppose really emotionally resonating examples of how much he gave to others by being emotional, made him feel really quite, he felt quite accepted for being an emotional male, when he was sitting in a room talking to a pretty emotional male”

David aligns himself with the client here, calling them both “*emotional males*”, and creates a sense of shared enjoyment and admiration in the therapeutic dyad. By positioning himself in opposition to the rigidity of traditional masculinity, the therapeutic alliance could be strengthened and both client and therapist could experience a mutually enjoyable interaction. As in Sarah’s story above, there was a sense of therapist and client joining forces to resist an oppressive social force (traditional masculinity), which could be viewed as a reclamation of power which had otherwise been denied. What David appeared to offer to the client within this construction was a sense of inner power, in place of the invalidation he had experienced in relation to traditional masculinity. This therapeutic position would, again, allow David to feel like a successful therapist who had helped his client; and might also offer him some personal validation, in celebrating his own identity as an emotional man with somebody similar.

Some participants gave examples in which they constructed traditional masculinity as a barrier in therapy which had been overcome by the client. Therefore, after a certain point in the therapy, the masculinity ceased to be constructed as a problem, and the overall outcome was constructed as successful.

Client 8. Michelle described a client who had a history of violence against women, which she related to childhood experiences of abuse by female family members. She said that he would initially emphasise this violence when talking to her, but that it did not feel threatening:

“he had a very clear bully, but I never felt the bully, he never took it out on me, if that makes sense? Just liked to talk a lot about it, I think with the intent of trying to scare me, but you know there’s a difference to what people say and how they make you feel isn’t there”

Michelle attributed this attempt to scare her to the client’s wish to avoid being vulnerable, and talked about him in terms of being a “perpetrator” so that he would not be a “victim” again. This attempt to avoid vulnerability was also constructed in how he approached the therapy, as Michelle said that it took a long time to get into the “real” work of addressing his trauma:

“it was more doing the work that he didn’t want to go near that was the important bit, and building the trust to do that work, I think that took longer than it might have done with a female equivalent if you like. Huge, again, variations of course, everyone’s an individual.”

She constructed herself as patient throughout this process, giving the client time to learn to trust her and the choice over whether he wanted to progress to the deeper therapy, despite her assertion that “I think he knew he needed to do the work, I kind of knew he knew he needed to do the work”. Michelle’s construction of herself knowing what the client needed placed her in an expert position, which might have served to guard against any difficult feelings brought up in relation to the uncertainty of where the therapy was going in the beginning. She spoke a lot about the client’s right to choose how far he went in therapy and the need for him to be ready for it (“I think it was probably really important to give him time to get there himself”) which may also have helped her to avoid any questioning about whether she could have done things any differently. In this example, Michelle drew on constructions that were similar to those used in both the rescuing (e.g. giving the client more time than others might have had before moving into the ‘real’ work)

and self-protective (e.g. emphasising the client's choice and responsibility in getting to the 'real' work) positions. By holding both together in her talk, she was able to balance both his needs and his responsibilities and offer a therapeutic understanding of his presentation.

That the client got to the point of being able to do the work eventually seemed to be protective against any feelings of frustration or annoyance towards his initial avoidance, and the therapy was constructed as successful and meaningful for both parties:

"It felt really privileged actually, I felt quite honoured to be one of those people [that he trusted], it also made it quite hard to end with him cause you knew in that sense how important you were even though you only saw him once every couple of weeks, by the end it was like once every three or four weeks, we were hardly meeting, but that, I still miss him, I think he's a great person, so I think, I think it made you, it made me feel quite privileged."

The final two client stories illustrate examples of clients whose traditionally masculine presentations did pose a challenge for the therapists; however, the participants described a process of being able to work through the difficult feelings this brought up for them. This enabled them to take up the therapeutic position, rather than another position, because the challenge to the therapy (and to themselves as therapists) was resolved.

Client 9. Laura talked about her work with a client she described as coming to therapy with a "*hard man persona*" which involved emphasising his strength and toughness in an attempt to appear impressive. The word "*persona*" suggested that it was little more than bravado, and in the interview Laura laughed it off: "*it doesn't impress me*". Laura constructed this persona as "*a response to a sort of shame and being disempowered and having to come to therapy*", which suggests it was

perhaps intended to intimidate Laura to some degree by emphasising the strength and success of the client. That she laughed it off and claimed not to be phased by this seemed to be her way of resisting this dynamic and not being pushed into the less powerful position.

This also enabled her to engage reflectively rather than defensively with the client, and she described a therapeutic strategy in which she did not engage directly with the 'hard man persona', but made efforts to bolster the client's self-esteem in other areas, with the hope that he would not need to adopt the persona any more:

"Erm, but with him, I really kind of worked, I sort of played the one down kind of card a little bit and did- because I'm so impractical it's untrue, so I did the kind of, you know, 'tell me about what you do and what you're good at' and you know really did the kind of building up of 'that is a - that is really skilled, isn't it? And that's a really interesting form of intelligence' and you know, and learn what he was telling me about [his areas of expertise]. [...] and we identified, you know, why this anger was, and it was kind of about, you know, feeling that people were getting one up on him, but it was also about him not feeling very confident in the skills that he did have [...] So I did a lot of sort of subtle kind of building him up really and also taking a kind of, you know, I'm a silly impractical female, and I really don't know how to do [task], and I don't know how to do [task] and 'how does that work?' and 'what kind of tool is that?' and you know, [laughs] which came naturally to me cause I am like that, but then, you know, used my expertise to sort of break down, you know, the cognitions that went with the anger and to say 'look actually you do have some control'."

In this extract, Laura was able to intentionally place herself in a less powerful position than the client, by deferring to his expertise and acknowledging the gaps in her own knowledge, in order to build his confidence and reduce his feelings of inadequacy. At the end of the extract, she reasserted her power and expertise, although really it seemed she had retained a sense of control over the situation throughout. To be able to undermine herself in this way with the client suggested a

secure position in which she was able to tolerate some vulnerability in the therapeutic encounter. Elsewhere in her interview, Laura talked about having had to actively work through some of her own difficult feelings towards threatening men following her own personal history with them, and that this had enabled her to take a more balanced approach:

“So I think it's been good for me, definitely, to have people who, you know, who if you just saw them from the outside or you just saw their record and you just saw them on a bad day, you'd just think 'that is just a nasty thug', you know, and to think, 'actually no, it's a brutalised person here and you know, this is a response to something' and this is, you know, masculinity is so kind of narrow and these people have so few opportunities to kind of be a good man”

Within this extract, Laura did not change her overall position on traditional masculinity, continuing to construct it as a restrictive and harmful ideology. However, her response to her clients demonstrated an ability to separate this discourse from the people she saw in front of her. By her description, the strategy she adopted with this client was a successful one, which enabled him to feel safe enough to continue with the therapy and experience positive outcomes. As with the other examples of the therapeutic position, this is likely to have offered a positive reward for Laura herself in being able to feel that she had done her job well and made a difference for a client who might otherwise have been dismissed as some kind of “nasty thug”.

Client 10. Finally, Amy gave a similar example of having worked through difficult feelings towards clients who presented with aspects of traditional masculinity which were perceived as challenging. In this case, she talked about an amalgamated history of clients within a forensic service, who had histories of extreme violence, often towards women. Amy had talked throughout her interview about an implicit threat posed by men towards women, which women were accustomed to checking for in new situations:

"I think it is second nature as a woman and I think you do it probably unconsciously with every man that you meet... but I think if there are warning signs ... you know, I think you pay attention to them, and then you act to keep yourself safe"

Working with such an actively threatening client group, then, unsurprisingly was constructed as evoking strong feelings for her.

In contrast, the way she talked about her work in a high secure prison earlier in her career suggested a more conscious effort to embrace and resolve her own feelings of vulnerability when working with clients who felt actively threatening to her. The following extract refers to an amalgamated example of her work with these clients, rather than one specific person:

"behaving in a deliberately threatening way, and you know sometimes laugh at your fear, cause you know sitting in a room with a man who's raped women and murdered women who's deliberately intimidating you is really frightening actually, when there's just you two in the room, and it's not necessarily even the sense you think anything is going to happen, it's more.. there's a, there's a term used in forensic service, parallel offending, which is people who are incarcerated they're not able to act out in the way that they would on the outside and so they find ways of mirroring their offending behaviour and some of the men would do that so they would kind of kill you off sort of psychologically by, almost like kind of psychologically torturing you and gaining sort of sadistic pleasure from it, it's really unpleasant, it's really unpleasant.

N: It sounds really powerful.

A: It's pretty horrible, it's very frightening, very upsetting, and I think it's something that they're, I don't work there anymore obviously, but the female therapists learn to manage and manage and manage through supervision but it evokes them very, very strong feelings for you because you're basically sitting in a room with somebody who ... probably if they could would be raping you and attacking you physically and potentially

trying to kill you and so the.. affect is there but not the behaviour .. [laughs] yeah."

The description of Amy's feelings in this extract is visceral and evocative, and effectively creates a sense of feeling extremely threatened and uncomfortable. Her laugh at the end had a nervous quality to it, which suggested an ongoing discomfort when describing the situation, even many years later. It would not have been surprising, following this, to find Amy taking up a more defensive position as a way to manage her felt sense of unsafety when talking about these men. However, her next description of her understanding of the work shifted in tone dramatically, and used highly compassionate language:

"trying hard to keep calm but also being honest with them about the impact, the emotional impact that was having, so, cause I think actually a lot of the men saw themselves as very, very insignificant and probably weren't too aware that they were able to have that kind of impact even though, it's hard to explain really, but sort of externally they, you know they were prisoners and they could look quite tough and they'd done these awful, awful things but they also had a really big child-like part of them and I think it was trying to get to that vulnerable child and you know that part that had been abused and abandoned and neglected, erm but when they were in that kind of mode that sort of bullying attack/predator mode it was, yeah, try and sort of dent that in a way by sort of feeding back your experience but sometimes that was kind of counter to what you felt like doing because you felt so frightened you didn't necessarily feel like opening up, but I think it was often helpful too.

N: Yeah, it feels, yeah, counter intuitive to admit that you're feeling vulnerable but actually it seemed to help?

A: Yeah, and I think they needed to know that, and they needed, I think that there was..[sighs] I think often they really valued the relationship, really valued the relationship, you know, kind of talking about never being able to trust anyone before, never being able to connect and open up and show certain sides of themselves, so you kind of had that on your side that really

they wouldn't want to lose the relationship and ... often they wouldn't really want to hurt you, I think, ... so you would use the relationship, ... to ki-, yeah, I think there was something about for them to be able to go away and reflect on 'I just behaved like that and I've really hurt her and I don't really want to do that', yeah, does that make sense?"

The therapeutic strategy described here involved Amy sharing her vulnerability with the clients rather than trying to defend against it. Her sigh during the description may again indicate that taking up this position was effortful for her, and she constructed it as “counter to what you felt like doing” which suggested a pull towards a defensive position which had to be resisted. Amy talked about having had to process her feelings through supervision in this setting, in order to be able to respond in this way. The contrast in the language in the first extract, in which the client felt like a torturer – somebody extremely powerful and threatening – and the second in which they are constructed as feeling insignificant (i.e. powerless) suggested an ability to step back from her own feelings and reactions and talk about the men from a therapeutic position – i.e. offer a psychological formulation – rather than remaining stuck in the earlier descriptions which emerged from a position of feeling threatened. This process also represented an ability to hold both the power and the vulnerability of both the clients and herself in mind, in order not to respond to their perceived power with a display of her own. Amy's laughs and sighs throughout her talk about this work suggested that even now she retained a sense of the discomfort she had felt at the time; however, she seemed confident that her strategy had been the right one despite having been difficult for her.

3.6 Summary and Conclusions

The therapists in this sample did make use of a number of culturally-available constructions of masculinities in their talk about male therapy clients. A divide was constructed between traditional masculinity, which could range from toxic to positive depending on its application, and modern masculinity which some constructed as liberating men from the constraints of traditional masculinity. The

discourses participants used to underpin these constructions were varied, and had different effects depending on the client and situation they were applied to.

A key finding of this analysis is that therapists' own relationships to masculinities had a noticeable effect on how they constructed and described their work with male clients. Where work with clients was experienced as challenging, constructions of masculinities were used to explain difficulties and justify different courses of action within therapy. When the clients' masculinity was experienced as less challenging, or when therapists were able to work through their own difficult feelings about clients and their masculinities, therapists were able to draw on more psychological discourses and relied less on gendered justifications for their responses. The relevance of this analysis to wider literature, and its implications, will be considered in the next chapter.

Chapter 4. Discussion

In this thesis, I set out to answer the following research questions, using data collected from semi-structured interviews with nine UK Clinical Psychologists (CPs):

1. How is therapists' talk about their experiences with male clients constructed in relation to masculinities?
2. What is the effect of the way therapists make use of discourses of masculinities in their talk about their work with male therapy clients?

Using the principles of Foucauldian Discourse Analysis (FDA), I was able to examine the language used by the CPs to construct an account of their experiences with male therapy clients, and the implications of this for themselves as therapists and for their clients. In this chapter, I will consider how the findings of this analysis relate to existing literature and theory, as well as the strengths and limitations of this piece of research and the implications it has for clinical practice and future research.

4.1 Masculinities

It was clear from the analysis of participants' talk that they drew on common societal discourses of what it means to be a man. This supported the finding of Russ et al.'s grounded theory analysis that life coaches continued to speak about clients in terms of gender differences in help-seeking and treatment preferences, despite expressing ambivalence about making generalisations (Russ et al., 2015).

Participants in the present study tended to relate their thinking about masculinities to the ideas outlined in models of hegemonic Western masculinity, summarised in David and Brannon's four imperatives: No Sissy Stuff; Be a Big Wheel; Be a Sturdy Oak; and Give 'em Hell (Thompson & Pleck, 1986). For the participants in the current study, the most prominent constructions were the Big Wheel ('Success and Achievement'), the Sturdy Oak ('Protect and Provide'), and Give 'em Hell ('Be strong'). The discourse of 'No Sissy Stuff', which is related in the literature to avoidance of associations with femininity and homosexuality was less present in

this sample, but participants did construct masculinities in terms of avoidance of vulnerability ('Don't be Weak'). This possibly reflects a shift in wider social discourses in which overt sexism and homophobia are discouraged, and so the concept has shifted into more socially acceptable language, while retaining its connection to the idea of avoiding being in a weak or submissive position. This again highlights a need, as identified by Wade (2015), for updated models and measures of masculine ideologies, to better capture current thinking about masculinities today.

Most participants framed this type of tough, striving and un-emotional masculinity as restrictive and undesirable, drawing on discourses of 'toxic' masculinity (Kupers, 2005) which frame traditional, hegemonic masculinity as a problem for men, women and society as a whole. However, not all participants shared this view. Melissa and James were notable exceptions, who drew on evolutionary and conservative discourses to construct traditional masculinity as natural and benign, if not positive. Other participants constructed positive elements of traditional masculinity in examples where masculine traits had been used in benevolent or productive ways, such as to protect vulnerable people. Neither positive nor toxic traditional masculinity was constructed as qualitatively different from the broader construction; they gained its 'positive' or 'toxic' status through the way the masculinity was used (i.e. to help or to harm).

Modern masculinity was also ill-defined in its own right, with few concrete characteristics which could be used to identify a 'modern man'. Instead, it was framed in terms of rejection of traditional masculinity and endorsement of acceptance of difference and diversity, similarly to its framing in wider public discourses (Itulua-Abumere, 2013; Schroeder, 2017). Participants did make reference to the widely touted 'crisis in masculinity' (Reeser, 2020) in their suggestion that changing standards of masculinity might lead to confusion and disempowerment for men. However, none were able to give an example of a client they had seen in therapy who was facing such issues in relation to his masculine

identity, and so the clinical implications of this crisis were not accounted for by this study.

4.2 Masculinities and Mental Health

One key way in which the participants in this sample offered a different perspective to contemporary psychological models of the relationship between masculinities and male mental health was that they did not suggest that masculinity in itself was sufficient to lead to mental health problems for their clients. Models such as the GRSP (Pleck, 1995), Precarious Manhood (Vandello et al., 2008) and the Masculine Mystique (O'Neil, 1982) all suggest that masculinities can cause significant problems for men, either by promoting the internalisation of harmful ideas (such as emotional disconnection or the need for aggression) or by representing impossible standards that men will inevitably fail to live up to. These ideas have been related in the research literature to numerous measures of psychological and social problems for men (O'Neil, 2008; Vandello & Bosson, 2013).

However, the participants in this study relied more on psychological discourses to explain their clients' problems in terms of experiences of childhood trauma or neglect. Masculinities discourses were incorporated to explain how men had learned to cope with their difficulties, such as by maintaining a tough exterior, but were not constructed as sufficient in themselves to lead to poor mental health. There is some evidence from cross-sectional survey studies that both insecure attachment styles (Defranc & Mahalik, 2002; Schwartz et al., 2004) and adverse childhood experiences (Easton, 2014; Easton & Kong, 2017) relate to both endorsement of masculine norms and gender role conflict, as well as to poor mental health in adult men, which echoes the interaction constructed by participants here. However, the directionality and mechanisms through which these factors influence one another remains unknown. O'Neil (2008) identified assessment of moderating and mediating factors between male gender role conflict and poorer health outcomes as a key research priority in his review of

evidence on the topic. This was echoed by Gerdes (2018) more recently in his narrative review on gaps in the literature of the psychology of men and masculinities, suggesting there may still be a long way to go in understanding these processes.

4.3 Masculinities and Psychotherapy

Participants in this sample broadly supported the notion that engaging in therapy is antithetical to the demands of traditional masculinity (Meth et al., 1990) in their talk. This construction supported a need to adapt therapy to men and their masculinities, in order for the process to be successful. Such adaptations included using humour to put men at ease, expecting the process to take longer, and not introducing concepts too early that men might find unfamiliar or uncomfortable, such as heavily emotional topics. The approaches participants took in this study, which were constructed as being successful strategies for engaging men in therapy, were consistent with the recommendations for male-friendly therapy given by Mahalik, et al. (2012) and Beel, et al. (2018) (see Section 1.1.4 for full details of these recommendations).

Some participants acknowledged a disempowering effect of coming to therapy and asking for help, which they felt could be particularly difficult for men. Scher (1990) summed up this difficulty as follows:

“Men are raised to see the world in an adversarial manner and to seek mastery of it. Psychotherapy functions best when it is a cooperative endeavor. Because of the structure of the situation, mastery remains in the hands of the therapist; mastery here does not imply complete control but rather that the therapist is in charge. This is so because it is the therapist who is the expert, who understands the structure of the interaction, and is to whom the client has come for assistance. Certainly the client has some power in the situation but by and large it is the therapist who ultimately is

in charge, even in nondirective therapy as the therapist chooses what will be responded to.” (Scher, 1990, p. 323)

The participants who had acknowledged this power difference talked about an aim of therapy being to reduce feelings of shame and disempowerment. Laura’s “one down” strategy was a clear example of this, in which she was open about not knowing about certain topics and encouraged her clients to share their expertise. She described how this had the effect of bolstering her clients’ self-esteem, and offering options for a sense of value and empowerment outside of the ‘toxic’ masculine routes (such as aggression and dominance).

This approach is consistent with the positive psychology/positive masculinity (PPPM) framework (Kiselica & Englar-Carlson, 2010), which suggests emphasising male strengths as a starting point for psychotherapy with men. The emphasis on clients’ strengths in the present study appeared to be a successful strategy, although this was based on the therapists’ retelling of the situation, and might have been perceived differently by the clients. However, that it was constructed as successful suggests that it was a strategy which was valued by the therapists who had used it, and descriptions of such work tended to be accompanied by more rounded and compassionate descriptions of clients than examples in which masculinities had been perceived as only a barrier to therapy. Matt Englar-Carlson helpfully summarised in his chapter on masculine norms and the therapy process that,

“Whereas some of these [masculine] qualities, when taken to extreme, can create problems for men, these attributions also highlight some strengths and positive qualities. Psychotherapists can tap into these positive qualities (and the corresponding tools that promote them) and harness them as an adjunct to psychotherapy and at times as a vehicle to promote change.” (Englar-Carlson, 2006, p. 36)

4.3.1 Positioning Male Clients within Therapy

Where therapy with male clients was constructed as difficult in some way, participants took different approaches to attributing responsibility for the problem. Depending on participants' broader stated stance on different masculinities, participants could be constructed as either responsible or not for difficulties within their therapies. This created a sense of a victim-perpetrator dichotomy in how participants constructed their clients, and therefore how they responded to them. Dichotomies such as these abound within psychological discourses, and speak to the idea of splitting: the tendency to form cognitive representations of the self that are either all good or all bad (or in this case, all one, e.g. victim, or all the other, e.g. perpetrator), which is understood as a psychological defence against the anxiety provoked by the ambivalences of complex situations (Myers & Zeigler-Hill, 2008). It is not surprising, then, that this tendency became more prominent when participants had found a piece of work with a male client particularly challenging. The positioning of male clients in this way justified certain responses from therapists, such as offering more help to clients who were constructed as helpless victims and defending oneself against perceived slights from clients constructed as deliberately harmful. We might think of these positionings in terms of the child, parent and adult roles in Transactional Analysis (Berne, 2011), the victim, persecutor and rescuer stances within Karpman's Drama Triangle (Karpman, 1968) or Horney's three coping styles of moving towards, against, or away from others (Broom, 2010). What is common across all three, and was evident within this analysis, is that the construction of the 'other' (in this case, the male client) opens up certain modes of response and closes down others. One notable difference between the two defensive positions in this analysis and the models outlined here, was the lack of movement between the positions. Within each of these three models, participants within an interaction might be expected to take up any of the three roles in response to the other person, rather than holding one role throughout. The lack of movement between the two defensive subject positions in my data is perhaps due to the distance created by time between the participants and the stories they were telling. In other words, the events they were describing were historical rather than happening as they spoke. It may be the case, then, that

participants had indeed moved between rescuing and self-protective responses during the therapies with their clients. However, by the time of the interview some processing of the events would have taken place, and the positions participants took up in their retelling of events likely represented the dominant stories which had been held onto about each client.

4.4 Psychotherapists and Masculinities

One question this analysis cannot answer is one of the chicken and the egg. Namely, which came first: that a client's masculine presentation made him difficult to work with, and so the therapist responded to that; or that a client felt difficult to work with, and so the therapist attributed this to his masculinity and responded to it as such. Given that this analysis is of transcripts of participants talking about their historical experiences, it is not possible to know at what stage concepts of masculinity became relevant in their thinking about the clients they described. It is also not possible to know specifically which behaviours were coded as different kinds of masculinities, and whether these assignments were consistent and logical or led more by gut reaction. What is clear, though, is that participants' stated relationship to different kinds of masculinities determined how clients and their problems would be constructed and positioned. For example, Susan and Sarah both talked about clients whose stories could be characterised as relating to emotional avoidance (Clients 1 and 5, respectively). Susan constructed her client as passive and helpless in relation to his masculinity, which meant he could not help but find emotions difficult, and positioned herself having to work harder to make up for this. Sarah, however, constructed a kind of deliberateness and passive-aggression in her client, linking him to a dominant and controlling type of masculinity. This in turn created a justification for her becoming more detached from the therapy as a way to protect herself from being undermined and controlled.

4.4.1 Female Gender Roles

The sample of therapists in this study was two-thirds female, meaning that as well as masculinity, issues of femininity will have been present in their encounters with male clients, despite not being a main focus of this study. The Bem Sex Role Inventory (Bem, 1974), a measure of androgyny which is calculated by assessing the difference in a person's scores on masculine and feminine traits, constructs femininity in terms of being 'cheerful', 'compassionate', 'does not use harsh language', 'eager to soothe hurt feelings', 'gentle', 'gullible', 'sensitive to the needs of others', 'soft spoken', 'shy', and so on. This creates a sense of femininity involving nurturing, pacifying, and submission to the needs of other people. Masculinity, by contrast, is constructed as 'acts as a leader', 'assertive', 'defends own beliefs', 'dominant', 'forceful', 'has leadership abilities', 'individualistic', 'strong personality', and so on. Within this construction, then, men are leaders, taking up a dominant position, and women are supporters and followers. Within their talk about working with male clients, there were several instances in which recognisable gender roles and dynamics relating to these constructions were apparent, such that the therapist's femininity became as relevant as the client's masculinity. For clarity, I will refer here to instances within the client examples described in Chapter 3; however, many of these roles were evident in other participants' talk and with other clients as well.

One clear example was explicitly named by Laura as an intentional therapeutic strategy with Client 9 (Page 107), in which she adopted the role of a "silly impractical female" as a way to help bolster her client's self-esteem. The role Laura took up here involved making use of her own gender to present as non-threatening to the client, and to encourage him to take up the role of a knowledgeable male who could teach her the things she did not know. This role subverts the typical power imbalance in therapy of powerful therapist and less powerful client, by enabling the client to take up the more powerful position as the person with knowledge. In Laura's narrative of this encounter, this strategy then

allowed her to re-take her powerful position as a therapist in a way which did not feel threatening to the client.

In other examples, participants' adoption of stereotypically 'female' roles was constructed as being in response to male clients' masculine roles, rather than being planned and deliberate. With Client 6 (Page 102), Sarah talked about feeling grateful that he had considered her needs in his telling of the violent traumas he had experienced. Having elsewhere constructed this client as protective over women, it seemed that Sarah in this instance was accepting the role of a woman being protected by a man. Drawing on ideas of 'chivalry', this role, again, subverts the typical power imbalance in therapy, such that the woman in the dynamic becomes the one in need of protection from the powerful male, despite her being his therapist. Similarly to Laura's strategy, the adoption of this role might allow male clients to feel less threatened by their female therapists (and the therapy process itself); and here it also seemed to offer a dual function of helping the female therapists to feel less threatened by their male clients who had the potential to harm them.

Susan notably took up a maternal role in relation to her talk about Client 1 (Page 91), in parallel to her talk about his actual mother. This mothering role was not as notable in any other participants' accounts, but there were clear elements of nurturing elsewhere – illustrating a similar dynamic in which women look after men, as described by Deering and Gannon (2005). In this dynamic, the location of power appears more complicated: it is the men who are reliant on women's help; however, it is the women who are beholden to providing the help for men who passively receive it. Similarly to the rescuing position, then, this role might allow therapists to feel more powerful and in control with a client whom they are feeling pulled to work harder to please.

Melissa made reference to Client 4 (Page 97), in terms of a hypothetical potential sexual partner, evoking ideas of sexual or romantic gendered dynamics

between men and women. Her assertion was that she could not see him as a potential partner because of his non-masculinity, which was related to her feelings of revulsion about his presentation. The advice she gave him (to dress differently and be more assertive) was constructed with the intention of making him a more acceptable potential romantic partner – not for Melissa herself, but more generally, although it likely would have served the purpose of reducing her negative feelings towards him as well. By entering this role, then, Melissa might have been attempting to remedy the difficulty she was having engaging with this client as his therapist.

Finally, Sarah's constructed passive resistance to Client 5's (Page 99) avoidance strategies within therapy speaks to a wider notion of women as passive and placating, particularly in relation to men. In this example, it was clearly the male client who was constructed as more powerful in the therapy, through his supposedly deliberate efforts to obfuscate and frustrate the process. Sarah's constructions that she still liked him and found the therapy easy despite acknowledging feeling very frustrated by him likely represent attempts to retain her sense of agency in the process, without having to challenge his (male) power more directly.

Each of these examples is illustrative of participants taking up specifically female roles in relation to their male clients, although these were expressed and negotiated in different ways. In some cases (e.g. Laura with Client 9), this was constructed as deliberate and planned – i.e. an intentional use of the feminine gender role to achieve a therapeutic aim – whereas with others, it appeared to occur in response to the therapists' perceptions of the clients' masculinities, as an attempt to navigate the challenges these presented. Therefore, while Deering and Gannon (2005) and Proctor (2008) suggest that female therapists need to be careful not to find themselves enacting such roles, it might be the case that they sometimes provide a useful repertoire for therapists to draw on in order to move through points of difficulty within a therapeutic relationship. However, as will be

explored in the next section, it is when therapist fall into such roles unreflexively that difficulties are likely occur.

It is also worthy of note that the typically 'feminine' roles observed in this dataset were not exclusively adopted by female participants. For example, James and David both adopted nurturing approaches to certain clients who were constructed as vulnerable and victimised, while Joshua constructed a similar kind of passive resistance to Sarah in his talk about some dominant male clients. Rather than being fully informed by their own gender, then, participants' responses to their clients were also based on the stance they took on different forms of masculinities, which were fairly equally represented across the sample. This finding is likely to reflect the type of participants recruited for this study, clinical psychologists. Becoming a clinical psychologist is a competitive and challenging process, and so female clinical psychologists might be expected to differ from traditional representations of femininity, such as by being more career-minded, assertive, and self-assured. Clinical psychology practice is also a female-dominated profession, and is associated with more typically feminine qualities such as compassion and caring. The men in this sample, then, are also less likely to represent typically 'masculine' men. Finally, effective therapy requires, as James put it in his interview, a combination of "compassion and challenge". This combination could be considered to represent both femininity and masculinity, respectively, which would mean that trained therapists need to adopt a somewhat androgynous stance, drawing on the strengths of both roles.

4.4.2 Countertransference

In cases where the therapy was constructed as difficult in some way, emotional reactions from the therapist would be expected. Therapists' emotional reactions to their clients are known in therapeutic discourses as countertransference (Hayes et al., 2015). There are many available understandings of countertransference, including that it represents activation of the therapist's own limitations and anxieties; that it is likely to emerge in the therapist regardless

of personal issues; or that it is linked to empathy and normal responses, such as feeling sad when someone talks about a loss (Tarnopolsky, 1995). The concept of the wounded healer similarly highlights that therapists are as vulnerable to suffering and struggle as any other human being, despite a widely held belief that they should be strong and invulnerable (Cvetovac & Adame, 2017), and so countertransference reactions are normal and to be expected, but may relate to specific situations which each therapist finds personally challenging or resonant. Hayes et al. break countertransference down into five components:

“Origins are areas of unresolved conflict within the therapist. *Triggers* are therapy-related events that provoke the therapist’s unresolved conflicts. *Manifestations* are the therapist’s cognitive, affective, behavioral, and visceral reactions to these events. *Effects* are the subsequent results of these manifestations on therapy process and outcome. Finally, *management* refers to the therapists’ ability to regulate their CT manifestations.” (Hayes et al., 2015, p. 127)

In this study, the triggers which evoked countertransference reactions to male clients were constructed using available discourses of masculinities: clients were too dominant, or not dominant enough; they did not know how to talk about their feelings; they were aggressive or threatening, and so on. The therapists’ own beliefs about masculinities, such as that ‘men should be men’ or that ‘men are powerful in society’ related to the origins of why these situations triggered different responses for each person, and led to different manifestations such as feelings of fear, anxiety, and revulsion.

Throughout participants’ responses, it was feelings evoked by the clients or the work which were less clearly acknowledged, or even actively minimised, which seemed to cause the most difficulty. For those in the rescuing position in particular, participants used very little emotional talk in discussing their work, despite the cases often involving a lack of progress or even failure of the therapy. In their grounded theory analysis of interviews with 18 therapists in the USA, Hayes et al.’s (2015) found that therapists whose outcomes with clients were successful

articulated more unpleasant feelings and problematic cognitive reactions in the interviews than therapists whose outcomes were unsuccessful. This suggested that awareness and management (either personally or with the client) of countertransference reactions was more likely to lead to success. In an analysis of 11 published memoirs of psychological therapists who had themselves experienced mental health problems (Cvetovac & Adame, 2017), the authors found that self-identified 'wounds' interfered in therapists' ability to work effectively clients when they were recent, currently upsetting or not attended to. This again suggests that it was unresolved difficulties that were particularly at risk of harming the therapeutic process. In the present study, in the examples where participants described cases which they experienced as more difficult, they tended to use more simplistic, stereotyped explanations of masculine characteristics in their explanations. For examples, Joshua suggested that the client he described as 'malicious and malignant' drew too much power from his masculine role, and so was not prepared to give that up in therapy. What was often lacking from these descriptions was a use of psychological discourses to fully formulate clients' behaviour in a way which would have indicated a therapeutic, rather than defensive, response.

Małus, Konarzewska, & Galińska-Skok (2018) found that psychotherapists tend to report reasons for failure in therapy as being related to factors within the client's control, and to a lesser degree to therapist errors or difficulty establishing a therapeutic alliance. In their questionnaire study of 100 psychotherapists, participants reported that therapeutic failure evoked a number of negative feelings, including concern, disappointment, and despondency. The authors posit that placing the responsibility for treatment failure with factors under the client's control may help therapists to mitigate these feelings and restore their own self-esteem and sense of self-efficacy. In the current study, by constructing the reason for a lack of success in therapy in relation to clients' masculine presentations, participants were likely to be similarly protecting themselves. Isabel Menzies-Lyth's psychoanalytic observations of nurses working in a physical health hospital found that the nurses adopted several strategies to both distance themselves from their patients as human beings and reduce their sense of responsibility (Menzies-Lyth,

1960). She explained these behaviours as attempts to reduce the anxiety provoked by working in such complex, demanding and interpersonally challenging circumstances. The therapeutic work described by my participants was also complex, demanding and interpersonally challenging, and raised feelings of anxiety, as well as other feelings (such as revulsion and anger) about clients. Their responses, which similarly served to distance themselves from their clients' unique psychological difficulties (by referring to perceived general traits of men instead) and reduce their sense of responsibility for therapies which were not successful, can conceivably be understood as attempts to manage and cope with these feelings.

In her observations of staff working in forensic settings, Hamilton observed that,

“what we find in practice is that individuals, teams, organisations and external stakeholders often adopt simplistic models based on their “pet theories”, theoretical orientation or unconscious working models developed from personal experiences of relating.” (Hamilton, 2010, p. 182).

Wider societal discourses of masculinities and how therapists relate to them may be understood as such “pet theories” in this study. Adamson (2014) noted in her study of Russian female psychotherapists talking about a lack of male representation in the profession that discourses of masculinities were used in a way which appeared conflicting and unreflexive. She concluded that if the use of gendered discourses did not provoke cognitive dissonance, participants tended not to notice and reflect on how they were used. Martin (2003, p. 344) noted that “Many gendering practices are done unreflexively; they happen fast, are “in action,” and occur on many levels,” which supports Adamson’s conclusion that the use of gendered discourses is often not consciously considered in people’s talk. This also fits with the retreat into discourses of masculinities observed in this study at times when participants had remained less reflexive about their clients in response to difficult feelings brought up in the work.

Where countertransference had been minimal or had been resolved more effectively, participants were able to make use of both masculinities and therapy discourses more flexibly and responsively, and to offer a more individualised formulation of the client's difficulties. The participants who had been able to do this most successfully described having made active efforts to process their own countertransference and the origins of the feelings, such as their wider feelings about men and masculinities. For example, Laura talked about having worked through her own difficult feelings towards men and masculinities after having been subject to domestic abuse. This is, again, consistent with Hayes et al.'s (2015) finding that the therapists in their sample with unsuccessful outcomes had described trying to "contain" their countertransference with little additional detail, whereas those with successful outcomes gave detailed accounts of strategies for managing their reactions. These strategies included remaining vigilant to their own internal experiences in sessions, reminding themselves to stay calm, objective, and attentive to the client, using their self-awareness in sessions, and taking care of themselves outside of work. Cvetovac and Adame (2017) argue that it is through the process of learning how to heal from one's own wounds that therapists' experiences of struggle and pain may inform and improve their practice with clients:

"Thus, when applied to psychotherapists, the archetype of the wounded healer represents those therapists who are able to use their wounds effectively in the service of helping others." (p.349)

Aponte and Kissil (2014) argue that being an active participant in the therapy relationship means bringing your own feeling, attitudes, culture, values, spirituality, social and political views into the room. They argue that therapists cannot be divorced from these aspects of themselves, and they will inevitably also bring their personal issues and their struggles with their families, communities, and societies into the therapy room. Again, this is not to say that this is a problem – it is simply part of being human, as all therapists are – but is something to be aware of and make positive use of in therapy, rather than letting these issues dictate and dominate our responses. They summarise that,

“in our humanity, we therapists all have our personal issues, our wounds, and in our professional role we have an obligation to be conscious of, and work on these issues; issues for which we need to take active, ongoing responsibility in the therapeutic process” (Aponte & Kissil, 2014, p. 153)

4.5 Strengths and Limitations

To my knowledge, this study is unique in its use of FDA techniques to examine how psychotherapists constructed their talk about male clients. The use of FDA enabled exploration of the way that discourses of masculinities were used to explain participants’ understandings of clients’ problems, how they positioned themselves in relation to these discourses, and how they were used to justify different therapeutic courses of action. That participants were talking to a researcher who was also a psychologist in clinical training – i.e. somebody with similar training and who could have been a colleague of theirs – created similarities between the interview and other professional settings in which therapists might talk about their clients, such as supervision or team meetings. While we cannot know how closely participants’ talk corresponded to what actually happened in the therapy room with their male clients, or how events would have been understood similarly or differently by the clients themselves, the analysis of how talk was used to explain and rationalise therapeutic decisions has real-world implications for how therapists’ work with male clients may be shaped by talk in these settings.

The analytic methods of this study had to be changed after data collection, as the originally-planned analysis was no longer appropriate to capture the variety of the data participants had provided. The two methods considered, IPA and FDA, share a common epistemological underpinning in that they are based on the assumptions that people construct their own understanding of reality based on their interpretation of experiences, which in turn will be personally and culturally-specific. Both methods also necessitate an examination of the researcher’s influence on the data generated and how it is analysed, with an acknowledgement

that the way a study is designed and interpreted will inevitably be shaped by the researcher's preferences and decisions at each step of the process. As such, the change in methods after data collection did not require a fundamental change in the approach to the study, and the methods used to gather data remained appropriate to the new analysis method. I believe the change in analysis method was necessary and important to do justice to the variety of ways participants talked about their work outside of specific descriptions of events in therapy. The resulting analysis provided a rich, nuanced examination of how participants talked about their work with men, what shaped this talk, and what the implications of it were, which has implications for the wider understanding of the relationship between masculinities and psychotherapy.

In order to strive for methodological quality in light of the change, two frameworks for ensuring rigour within qualitative research were used (Antaki et al., 2003; Elliott et al., 1999). Antaki et al.'s guidelines specifically relate to the conduct of Discourse Analyses, and offer ways to guard against under-analysis of participants' talk. I was also aware of specific limitations of FDA as a methodology which is not systematised, and so is open to interpretation to fit with a researcher's own biases (Breeze, 2011). Multiple analysts are often used within qualitative research to improve reliability of the findings. While reliability in itself is not a key concern for discourse analysts (Reicher, 2000) and it is acknowledged that each analysis can only ever represent one interpretation of a dataset, some measure of accountability in the analysis is still required. Unfortunately, due to the pandemic and subsequent move towards remote working, it was not possible to examine full transcripts together with my supervisors as originally planned. While they had access to all transcripts, and all stages of the analysis were shared with them, this only happened after I had undertaken the relevant parts of the analysis myself, and so represented discussion and consideration of the analysis rather than joint working. I attempted to mitigate some of the risk of my own biases influencing the analysis as far as possible by using an established method as a guide (Willig, 2008), keeping a reflexive journal to scrutinise my own leanings, and making use of tools as outlined in Appendix G to apply the analysis consistently across the dataset.

One particular shortcoming of Willig's method is that it does not offer a clear way to consider power and authority – both key concepts within a Foucauldian analysis. To make up for this, I included consideration of power as a specific stage in analysing participants' positionings in relation to their clients. This felt particularly important, as this research related to two potential sources of societal power: hegemonic masculinity and psychology and psychotherapy as an institution. Finally, I was aware of criticism of Critical Discourse Analysis approaches that they can be overly negative, with a focus on what needs to be changed about the power structures within the world, such that analysts can find it "easier to deconstruct than to construct" (Breeze, 2011, p. 516). I therefore found it important to consider where participants' talk related to positive experiences in therapy which were considered beneficial to clients. The therapeutic position is a clear example of this, and demonstrates that not all interactions with male therapy clients will inevitably be made more difficult as a result of masculinity. Further, I was able to identify concrete strategies within participants' talk which were said to have helped engage male clients more easily. In particular, methods of carefully sharing power within the therapeutic alliance are notable examples which serve to address the dual power issues present between men (a socially dominant group) and their therapists (who hold institutional power at a time when men are particularly vulnerable).

The influence of the framing of the study and the nature of the questions asked must be acknowledged as having shaped the responses given by participants. By informing participants that the study was interested in the relationship between masculinities and psychotherapy, it is likely that the clients they talked about were both recalled because they brought to mind specific aspects of masculinity for the therapists (such as particularly strong examples of 'toxic' masculinity or 'positive' masculinity), and framed in terms of masculinities perhaps more than they would have been otherwise. While the participants did talk about some clients for whom masculinity was not a central part of the formulation or intervention, they were in the minority and the stories tended to be linked back to masculinities in other

ways, such as by talking about how these men represented 'positive masculinity'. In a similar vein, because participants were primarily asked to talk about male clients, it was not possible to compare participants' talk about men and masculinities with how they talked about female clients and discourses of femininity. Had the study been framed in more gender-neutral terms, and invited general reflections on work with clients, it would have been possible to examine talk about male clients in comparison to other kinds of talk, rather than in isolation, and to draw further conclusions on how talk about male clients is distinctively constructed. I did not include a mechanism for confirming interpretations of the data with clients themselves. It is possible participants would have been surprised by the prominence of masculinities in their formulations of male clients, which likely does not represent how they usually talk in more natural settings. Further reflections on the analysis, such as how participants might have felt about the noted positionings of themselves and their clients (which might not have been consciously constructed), were also precluded.

The statements within the interview schedule were chosen to offer a view of masculinity that would feel safe to talk about for a group who are typically socially-conscious and egalitarian (Clinical Psychologists). As the change to FDA occurred after data collection had begun, the discourses that the statements relied upon, and the positions that they offered, had not been fully considered in their development. Re-examining the statements from the perspective of an FDA researcher, we might consider that they were aligned primarily with the discourse of modern masculinity, which frames traditional masculinity as a problem. Although this is the dominant paradigm within psychological literature on masculinity (e.g. Ronald F Levant, 2011), it means that other discourses were not represented. I had excluded items from measures which seemed to represent a more traditional construction of gender relations, because I expected that participants would find them hard to relate to or endorse. However, it is now clear that this could have given the impression that alignment with these discourses was not as permissible, and so precluded participants from this line of talk. In fact, there were instances in which participants expressed views more in line with traditional

ideas about masculinities, indicating that there would have been space within the interview schedule to contradict the view of masculinity presented in the statements. However, it is not possible to know how much more of this talk could have been observed, had the statements been selected with more awareness of the discourses and positionings they made available and unavailable. The analysis must be understood within this context, and conclusions drawn tentatively about the relevance of the findings to wider therapeutic practice.

The sample recruited to this study was not diverse in terms of ethnicity or sexuality, and was made up of a majority of female participants. This was representative of the population from which the sample was drawn – UK clinical psychologists – who are as a group overwhelmingly white and female (Bullen & Hacker-Hughes, 2016). Data are not currently available on representation of different sexualities within the profession, but in the most recent cohort of those accepted into training, only 10.1% identified as non-heterosexual (Clearing House, 2018), which is similar to this sample. This trend represents a wider problem of representation in the profession and so is not a specific limitation of the sampling method use in this study. However, the use of a sample of clinical psychologists does mean the results will have been heavily influenced by a broadly white, Western, middle-class view of gender, masculinities, and therapy. In the wake of recent events surrounding the Black Lives Matter movement across the world, there has been much conversation about addressing such disparities in clinical psychology, including an acknowledgement of the way that such a lack of diversity will shape available knowledges and serve to uphold existing health inequalities (Atayero, 2020), and it has been acknowledged for many years that research must acknowledge individual differences rather than assuming that members of a dominant group can act as representatives for all people (Pérez-Stable, 2018). Therefore, the results of this study must be generalised with caution, and further research in which additional effort was made to capture more diverse voices on the topic would be required to strengthen the conclusions drawn.

Finally, although participants were recruited from general secondary mental health care teams, so as to avoid the influence of working in specific settings on their understandings of masculinities (see page 45 for a list of excluded services), several participants talked about clients they had worked with in previous posts. For example, Amy had worked in a prison previously, and talked about her work here throughout her interview. Other participants' views had been shaped by experiences which would not have been accounted for by excluding historical places of work; for example, Joshua and David both talked about having worked in secondary mental health care services in locations which had had high levels of specific types of violence (gang and intimate partner violence), which they then saw more of in their clinical work. There was, therefore, an unavoidable lack of control over the work contexts which might have influenced participants' accounts despite attempts to recruit an homogenous sample in this respect. I do not believe this was detrimental to the study, as these experiences simply represented parts of the participants' lives which had shaped their relationships to discourses of masculinities in the same way that personal experiences (such as Laura's experience of domestic violence) would have. It would not be possible to control for all such experiences in recruiting a sample of participants, and the variability between the participants gave a richness to the data in which, despite there being overall patterns across people's accounts, each person had a unique way of relating to discourses of masculinities and made a unique contribution to the data.

4.6 Clinical Implications

The results of this study highlighted the importance of therapists' reflective capacity in how they talked about their responses to various male clients. When male clients were experienced in a way which evoked strong emotions for the therapist, such as fear or revulsion, it took additional effort to resolve these feelings in such a way that their responses could be informed by psychological theory, rather than by a desire to reduce their own discomfort or distress. It is therefore important that therapists make use of available opportunities for

reflection on their clinical work, such as supervision or reflective practice groups, especially when cases evoke a strong emotional response for them. Personal therapy might also help therapists to identify the situations which evoke strong emotions for them and which ways of thinking about the world underlie these reactions. Aponte and Kissil (2014) offer a model for training therapists to be aware of their own personal responses to situations in therapy. Called the 'Person-of-the-therapist (POTT) model', it emphasises training therapists to be aware of their 'signature theme', which is an understanding of how the underlying theme at the core of their struggles, such as a need for control, fear of vulnerability, or low self-esteem, is played out habitually in the various contexts of their life. The signature themes are not viewed as hindering therapy, but are a resource which can be used to identify with and differentiate from clients' struggles. The authors stress that therapists need not be expected to have fully resolved all of their issues – indeed, this would be impossible – but do have an obligation to make a conscious effort to reflect on their own tendencies and responses, such that they do not cause problems in therapy:

“our clients get who we are today, wherever we are in the process of working on our own emotional wounds. Therefore, our immediate task is to know as much as we can about our whole self and to have as much ability to use all of who we are as positively and proactively as we can.” (Aponte & Kissil, 2014, p. 161)

Because discourses of masculinities are so normalised in our culture, it may be difficult for therapists, supervisors or group facilitators to notice when they are being used in a way which indicates problematic engagement with a male client (P. Y. Martin, 2003). Additionally, because men are considered a powerful group in Western society, attention may not always be paid to how they might be disadvantaged or disempowered within therapy. A model such as the Social GRRRAACCEESS (Burnham et al., 2008) may offer a helpful tool to ensure that issues of masculinities are not overlooked in reflection on therapeutic relationships. Referring to various aspects of social difference which might occur between a

therapist and client, the GRRACCEESS offer a reflective framework for making conscious the areas of social identity which might represent blind-spots for therapists. The authors state that,

“Each of us, for a variety of reasons, will also find certain issues outside our ‘comfort zone’ and which tend towards becoming subjugated in our practice, sometimes without even noticing this is happening.” (p. 529)

In this way, the GRRACCEESS are not only intended to help therapists consider minority group identities, but any area of social difference (or, in the case of a male therapist and male client, similarity) which might evoke uncomfortable feelings within the work. By making the use of such tools a regular part of reflective practice, therapists will be better equipped to notice and take action when they find themselves being influenced by their feelings about a client’s masculinities.

Participants’ accounts of their responses to difficulties with masculinities in this study tended to involve either exerting additional control or adapting themselves around the masculinities. These patterns were reminiscent of those observed in Hamilton’s (2010) observations of how staff members responded to clients in forensic mental health settings. She identified three types of roles that workers took up, which mirrored those found in this study, which she termed the security guard, the super carer, and the negotiator/mediator. The security guard will mainly focus on the offender part of the person and the danger they may pose, and they will be cold, formal, judgemental, restricting and controlling. When they experience boundary challenges, their response is to tighten boundaries and regain control. The super carer is self-sacrificing and over-involved, and they will be chronically nice, placatory, permissive, overly trusting, and focused on the client’s needs at the expense of their own. They focus primarily on the victim part of the client and try to make up for their past traumas by rescuing or giving unconditional care. When experiencing boundary challenges, their response is to loosen the boundaries to meet the person’s needs. The negotiator/mediator role is a synthesis of the less extreme versions of both of the others. They are open, balanced, reasonable, and willing to negotiate boundaries carefully in consideration of

immediate and long-term consequences. They hold both the offender and victim parts of the client and can respond to both the risk posed and the vulnerability experienced by them. From this, Hamilton developed the Boundary Seesaw model to be used as a reflective tool for clinicians to monitor their responses to clients. Given the similarities between the responses observed in her study and found in this sample in relation to male clients, the Boundary Seesaw may be another useful reflective tool for therapists working with men in community settings.

The findings of this study also have wider service-level implications for how male clients are engaged in therapy. The discourses which influenced the therapists' responses to male clients would also be expected to influence others within mental health organisations, and may affect how male clients are responded to at all levels of service provision. Several participants talked about services not explicitly considering how to engage male clients, and sometimes putting in place restrictions which they felt were harmful to attempts to engage men in therapy. Examples included limitations on number of sessions, in the context that several participants said it took longer to socialise men into the therapeutic relationship, and the exclusion from services of clients engaging in what were considered more 'male' expressions of distress such as hostility or substance use. The same reactive strategies which were observed in participants' talk about therapy with men, such as reinforcing boundaries in response to feeling threatened, are likely to occur at a more systemic level as well. Consideration of these practices should also be a key part of organisation-wide reflective practice, to facilitate a more responsive and less punitive environment for male clients across services.

4.7 Future Directions

As mentioned in section 4.5, research which enables comparison of therapists' talk about male and female clients, and in which the notion of masculinities are not explicitly introduced by the researcher, would build on the findings of this study and enable an examination of how discourses of masculinities

(and femininities) naturally occur in therapists' talk about their clients. Further to this, the analysis of recordings of therapy with male clients using a similar methodological focus would facilitate a better understanding of how these discourses shape therapists' responses to clients in the moment. This would also enable a comparison of therapists talk *with* clients against their talk *about* clients, and how discourses of masculinities shape and are used uniquely within each.

Research with a focus on both more diverse therapists, and more diverse types of clients, would also contribute a richness that this study was not able to achieve. Further research could consider how therapists from different cultural backgrounds make use of various discourses of masculinities in their work, or how discourses of masculinities are differentially applied to clients from different ethnic backgrounds. Exploration of the relationship between sexual or gender variance and masculinities in therapists' talk would add nuance to the findings. Additionally, the application of the study to therapists from different services, such as forensic, learning disability or health services, would highlight how masculinities discourses are used differentially and what the impact of this might be.

4.8 Summary and Conclusions

This study set out to understand how psychotherapists' own relationships to ideas about masculinities might influence their work with male clients. Using interview data analysed using FDA, it was observed that therapists (in this case Clinical Psychologists) do draw on wider societal constructions of men and masculinities in their talk about men in therapy. The positions they took up in relation to these constructions were important in delineating how they talked about and described responding to their clients, such that a negative view of a certain type of masculinity could be related to more difficult feelings about a client who embodied such characteristics. Where participants were able to work through these difficult countertransference reactions, a more harmonious and productive therapeutic relationship seemed to emerge. This study, therefore, highlighted a clear need for

therapists to remain reflexive about their own relationships to men and masculinities Thinking about the language we use as therapists in relation to the men we work with is essential, and might help to manage and minimise the possibility for detrimental effects on our working relationships with male clients.

References

- Adamson, M. (2014). Reflexivity and the construction of competing discourses of masculinity in a female-dominated profession. *Gender, Work and Organization, 21*(6), 559–572. <https://doi.org/10.1111/gwao.12058>
- Addis, M. E. (2010). Response to Commentaries on the Problem of Masculinity. *Psychol. Men Masc., 11*(2), 109–112. <http://0-ovidsp.ovid.com.wam.leeds.ac.uk/ovidweb.cgi?T=JS&PAGE=reference&D=pao vftk&NEWS=N&AN=00128141-201004000-00002>
- Addis, M. E., & Cohane, G. H. (2005). Social scientific paradigms of masculinity and their implications for research and practice in men’s mental health. *Journal of Clinical Psychology, 61*(6), 633–647. <https://doi.org/10.1002/jclp.20099>
- Addis, M. E., Mansfield, A. K., & Syzdek, M. R. (2010). Is “masculinity” a problem?: Framing the effects of gendered social learning in men. *Psychology of Men & Masculinity, 11*(2), 77–90. <https://doi.org/10.1037/a0018602>
- Antaki, C., Billig, M., & Potter, J. (2003). Discourse Analysis Means Doing Analysis: A Critique Of Six Analytic Shortcomings. *Athenea Digital. Revista de Pensamiento e Investigación Social, 1*(3), 14. <https://doi.org/10.5565/rev/athenea.64>
- Aponte, H. J., & Kissil, K. (2014). “If I Can Grapple With This I Can Truly Be Of Use In The Therapy Room”: Using The Therapist’s Own Emotional Struggles To Facilitate Effective Therapy. *Journal of Marital and Family Therapy, 40*(2), 152–164. <https://doi.org/10.1111/jmft.12011>
- Arribas-Ayllon, M., & Walkerdine, V. (2017). Foucauldian Discourse Analysis (Second Edition). In C. Willig & W. S. Rogers (Eds.), *The SAGE handbook of qualitative research in psychology* (2nd ed., Issue October, pp. 110–123). Sage.
- Artkoski, T., & Saarnio, P. (2013). Therapist’s Gender and Gender Roles: Impact on Attitudes toward Clients in Substance Abuse Treatment. *Journal of Addiction, 2013*, 1–6. <https://doi.org/10.1155/2013/591521>
- Atayero, S. (2020). Decolonisation among clinicians. *The Psychologist, 33*, 38–39. <https://thepsychologist.bps.org.uk/volume-33/march-2020/decolonisation->

among-clinicians

- Avdi, E., & Georgaca, E. (2007). Discourse analysis and psychotherapy: A critical review. *European Journal of Psychotherapy & Counselling, 9*(2), 157–176. <https://doi.org/10.1080/13642530701363445>
- Bailey, B., Eisikovits, Z., & Buchbinder, E. (2012). Battering men and their male therapists: The different and the similar. *Journal of Family Violence, 27*, 465–476. <https://doi.org/10.1007/s10896-012-9433-5>
- Barry, J. (2018, April 30). *Men are able to talk, are psychologists able to listen?* | BPS. The British Psychological Society Blog. <https://www.bps.org.uk/blogs/dr-john-barry/men-are-able-talk-are-psychologists-able-listen>
- Bedi, R. P., & Richards, M. (2011). What a Man Wants: The Male Perspective on Therapeutic Alliance Formation. *Psychotherapy, 48*(4), 381–390. <https://doi.org/10.1037/a0022424>
- Beel, N., Jeffries, C., Brownlow, C., Winterbotham, S., & Du Preez, J. (2018). Recommendations for male-friendly individual counseling with men: A qualitative systematic literature review for the period 1995-2016. *Psychology of Men & Masculinity, 19*(4), 600–611. <https://doi.org/http://0-dx.doi.org.wam.leeds.ac.uk/10.1037/men0000137>
- Bem, S. L. (1974). The measurement of psychological androgyny. *Journal of Consulting and Clinical Psychology, 42*(2), 155–162. <https://doi.org/10.1037/h0036215>
- Berne, E. (2011). *Games People Play: The Basic Handbook of Transactional Analysis*. Full eBook Title : *Games People Play: The Basic Handbook of Transactional Analysis*. Tantor eBooks. <https://books.google.co.uk/books?hl=en&lr=&id=2J3wAgAAQBAJ&oi=fnd&pg=PT4&dq=transactional+analysis+berne&ots=xiwp4hj-nn&sig=xphWVjF84Xc2DjHciTaDiVcl1Bc>
- Bowen, M. (1976). Theory in the Practice of Psychotherapy. *Family Therapy: Theory and Practice, 4*(1), 2–90. <https://pdfs.semanticscholar.org/b6be/63a4dd72998576ccf172d36c509dc3aa>

5e2c.pdf

- Bowers, A. M. V., & Bieschke, K. J. (2005). Psychologists' clinical evaluations and attitudes: An examination of the influence of gender and sexual orientation. *Professional Psychology: Research and Practice, 36*(1), 97–103. <https://doi.org/10.1037/0735-7028.36.1.97>
- Branney, P., & White, A. (2008). Big boys don't cry: depression and men. *Advances in Psychiatric Treatment, 14*(4), 256–262. <https://doi.org/10.1192/apt.bp.106.003467>
- Breeze, R. (2011). Critical discourse analysis and its critics. *Pragmatics, 21*(4), 493–525. <https://doi.org/10.1075/prag.21.4.01bre>
- Briffault, X., Sapinho, D., Villamaux, M., & Kovess, V. (2008). Factors associated with use of psychotherapy. *Social Psychiatry and Psychiatric Epidemiology, 43*, 165–171. <https://doi.org/10.1007/s00127-007-0281-1>
- Brooks, J. (2017, May 2). A New Generation Overthrows Gender. *NPR*. <https://www.npr.org/sections/health-shots/2017/05/02/526067768/a-new-generation-overthrows-gender?t=1596570863304>
- Broom, J. (2010). Towards, away, against: Coping role strategies as attachment styles. *ANZPA Journal, 19*, 10–20.
- Bullen, K., & Hacker-Hughes, J. (2016). *Achieving representation in psychology | The Psychologist*. <https://thepsychologist.bps.org.uk/volume-29/april/achieving-representation-psychology>
- Bunnell, D. W. (2016). Gender Socialization, Countertransference and the Treatment of Men with Eating Disorders. *Clinical Social Work Journal, 44*, 99–104. <https://doi.org/10.1007/s10615-015-0564-z>
- Burnham, J., Alvis Palma, D., & Whitehouse, L. (2008). Learning as a context for differences and differences as a context for learning. *Journal of Family Therapy, 30*(4), 529–542. <https://doi.org/10.1111/j.1467-6427.2008.00436.x>
- Bussey, K., & Bandura, A. (1999). Social cognitive theory of gender development and differentiation. *Psychological Review, 106*(4), 676–713. <https://doi.org/10.1016/j.sbspro.2011.03.261>

- Cambridge Dictionary. (n.d.-a). *Cisgender | meaning in the Cambridge English Dictionary*. Retrieved July 20, 2020, from <https://dictionary.cambridge.org/dictionary/english/cisgender>
- Cambridge Dictionary. (n.d.-b). *Western: meaning of western in English*. Retrieved February 11, 2019, from <https://dictionary.cambridge.org/dictionary/english/western>
- Clearing House. (2018). *Clearing House for Postgraduate Courses in Clinical Psychology Equal Opportunities data for 2018 Entry*. <https://www.leeds.ac.uk/chpccp/funding.html>
- Cole, B., Moffitt-Carney, K., Patterson, T. P., & Willard, R. (2020). Psychology of Men and Masculinities' focus on positive aspects of men's functioning: A content analysis and call to action. *Psychology of Men and Masculinities, April 2*, 1–9. <https://doi.org/10.1037/men0000264>
- Connell, R. W. (1995). *Masculinities*. University of California Press.
- Connell, R. W., & Messerschmidt, J. W. (2005). Hegemonic Masculinity: rethinking the concept. *Gender & Society, 19*(6), 829–859. <https://doi.org/10.1177/0891243205278639>
- Cvetovac, M. E., & Adame, A. L. (2017). The Wounded Therapist: Understanding the Relationship Between Personal Suffering and Clinical Practice. *Humanistic Psychologist, 45*(4), 348–366. <https://doi.org/10.1037/hum0000071>
- Deering, C. G., & Gannon, E. J. (2005). Gender and psychotherapy with traditional men. *American Journal of Psychotherapy, 59*(4), 351–360.
- Defranc, W. J., & Mahalik, J. (2002). Masculine Gender Role Conflict and Stress in Relation to Parental Attachment and Separation. *Psychology of Men and Masculinity, 3*(1), 51–60. <https://doi.org/10.1037/1524-9220.3.1.51>
- Doherty, M., Conway, J., Clark, J., & Merritt, F. (2017). Should I stay or should I go? The impact of a sense of control on young men's therapeutic engagement. *Counselling and Psychotherapy Research, 17*(3), 209–217. <https://doi.org/10.1002/capr.12126>
- Easton, S. D. (2014). Masculine norms, disclosure, and childhood adversities predict

- long-term mental distress among men with histories of child sexual abuse. *Child Abuse & Neglect*, 38, 243–251.
<https://doi.org/10.1016/j.chiabu.2013.08.020>
- Easton, S. D., & Kong, J. (2017). Mental health indicators fifty years later: A population-based study of men with histories of child sexual abuse. *Child Abuse & Neglect*, 63, 273–283. <https://doi.org/10.1016/j.chiabu.2016.09.011>
- Eckert, P., & McConnell-Ginet, S. (2013). *Language and Gender* (Second). Cambridge University Press. <https://doi.org/10.2350/13-08-1359-OA.1>
- Elder-Vass, D. (2012). Towards a realist social constructionism. *Sociologica, Problemas e Práticas*, 70, 9–24. <https://doi.org/10.7458/SPP2012701208>
- Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215–229.
- Englar-Carlson, M. (2006). Masculine norms and the therapy process. In M. Englar-Carlson & M. A. Stevens (Eds.), *In the room with men: A casebook of therapeutic change*. (pp. 13–47). American Psychological Association.
<https://doi.org/10.1037/0000131-004>
- Foucault, M. (2006). *History of madness* (J. Khalifa (ed.)). Routledge.
- Gee, J. P. (2014). *How to do discourse analysis: A toolkit* (2nd ed.). Routledge.
- Georgaca, E., & Avdi, E. (2012). Discourse Analysis. In D. Harper & A. Thompson (Eds.), *Qualitative Research Methods in Mental Health and Psychotherapy* (pp. 147–162). John Wiley & Sons, Ltd.
- Gerdes, Z. T. (2018). Stuck in the Present: Gaps in the Theoretical Past and Applied Future of the Psychology of Men and Masculinities. *Psychology from the Margins*, 1(1), 1–23.
<http://ideaexchange.uakron.edu/psychologyfromthemargins> Available at: <http://ideaexchange.uakron.edu/psychologyfromthemargins/vol1/iss1/1>
- Gough, B., Robertson, S., & Robinson, M. (2016). Men, ‘masculinity’ and mental health: Critical reflections. In J. Gideon (Ed.), *Handbook on Gender and Health* (1st ed., pp. 134–147). Edward Elgar Publishing.

- Graham, L. J. (2005). Discourse analysis and the critical use of Foucault. *Australian Association for Research in Education*, 11(4), 1–15.
<https://doi.org/10.1177/0959354301114006>
- Hamilton, L. (2010). The Boundary Seesaw Model: Good Fences Make for Good Neighbours. In A. Tennant & K. Howells (Eds.), *Using Time, Not Doing Time: Practitioner Perspectives on Personality Disorder and Risk* (pp. 181–194). Wiley-Blackwell. <https://doi.org/10.1002/9780470710647.ch13>
- Harper, D. J. (2003). Developing a critically reflexive position using discourse analysis. In L. Finlay & B. Gough (Eds.), *Reflexivity: A Practical Guide for Researchers in Health and Social Sciences* (pp. 78–92). Blackwell Science.
<https://onlinelibrary.wiley.com/doi/pdf/10.1002/9780470776094#page=87>
- Harper, D. J. (2012). Choosing a Qualitative Research Method. In D. Harper & A. Thompson (Eds.), *Qualitative Research Methods in Mental Health and Psychotherapy* (pp. 83–97). John Wiley & Sons, Ltd.
<https://doi.org/10.1002/9781119973249.ch7>
- Harris, T., Moret, L. B., Gale, J., & Kampmeyer, K. L. (2001). Therapists' gender assumptions and how these assumptions influence therapy. *Journal of Feminist Family Therapy*, 12(2–3), 33–59.
<https://doi.org/10.1300/J086v12n02>
- Hayes, J. A., Nelson, D. L. B., & Fauth, J. (2015). Countertransference in successful and unsuccessful cases of psychotherapy. *Psychotherapy*, 52(1), 127–133.
https://psycnet.apa.org/fulltext/2015-09187-004.pdf?auth_token=bef7998bbc41a5fac3e4acb61bae49cb2cffc231
- Heesacker, M., & Snowden, S. J. (2013). Pay no attention to that man behind the curtain: The challenges, causes, and consequences of precarious manhood. *Psychology of Men and Masculinity*, 14(2), 121–124.
<https://doi.org/10.1037/a0031369>
- Hyde, J. S. (2005). The gender similarities hypothesis. *American Psychologist*, 60(6), 581–592. <https://doi.org/10.1037/0003-066X.60.6.581>
- Hyde, J. S., Bigler, R. S., Joel, D., Tate, C. C., & Van Anders, S. M. (2019). The Future

- of Sex and gender in psychology: Five challenges to the gender binary. *American Psychologist*, 1–23. <https://doi.org/10.1037/amp0000307>
- Iazzo, A. (1983). The construction and validation of attitudes toward men scale. *The Psychological Record*, 33(3), 371–378.
<http://search.proquest.com/openview/4c3e35a884a3bb98e0308a7affad9ab0/1?pq-origsite=gscholar&cbl=1817765>
- Inbar, Y., & Lammers, J. (2012). Political diversity in social and personality psychology. *Perspectives on Psychological Science*, 7(5), 496–503.
http://yoelinbar.net/papers/political_diversity.pdf
- Isacco, A., & Wade, J. C. (2017). A review of selected theoretical perspectives and research in the psychology of men and masculinities. In R. F. Levant & Y. J. Wong (Eds.), *The psychology of men and masculinities*. (pp. 139–168). American Psychological Association. <https://doi.org/10.1037/0000023-006>
- Itulua-Abumere, F. (2013). Understanding Men and Masculinity in Modern Society. *Open Journal of Social Science Research*, 1(2), 42–45.
<https://doi.org/10.12966/ojsr.05.05.2013>
- Kachel, S., Steffens, M. C., & Niedlich, C. (2016). Traditional masculinity and femininity: Validation of a new scale assessing gender roles. *Frontiers in Psychology*, 7, 1–19. <https://doi.org/10.3389/fpsyg.2016.00956>
- Karpman, S. B. (1968). Fairy tales and script drama analysis. *Transactional Analysis Bulletin*, 7(26), 39–43.
- Kiselica, M. S., & Englar-Carlson, M. (2010). Identifying, affirming, and building upon male strengths: The positive psychology/positive masculinity model of psychotherapy with boys and men. *Psychotherapy Theory, Research, Practice, Training*, 47(3), 276–287. <https://doi.org/10.1037/a0021159>
- Kupers, T. A. (2005). Toxic Masculinity as a Barrier to Mental Health Treatment in Prison. *Journal of Clinical Psychology*, 61(6), 713–724.
<https://doi.org/10.1002/jclp.20105>
- Landridge, D., & Hagger-Johnson, G. (2013). *Research methods and data analysis in psychology* (3rd ed.). Pearson Education Ltd.

- Levant, Ronald F. (2011). Research in the Psychology of Men and Masculinity Using the Gender Role Strain Paradigm as a Framework. *American Psychologist*, 66(8), 765–776. <https://doi.org/10.1037/a0025034>
- Levant, Ronald F, Hirsch, L. S., Celentano, E., Cozza, T. M., & Al, E. (1992). The male role: An investigation of contemporary norms. *Journal of Mental Health Counseling*, 14(3), 325–337.
- Luyt, R. (2018). Masculinities Representations Inventory (MRI, English Version): A Measure of Gender (Re)Presentation. *Journal of Men's Studies*, 26(2), 157–183. <https://doi.org/10.1177/1060826517736781>
- Mahalik, J., Good, G. E., Tager, D., Levant, R. F., & Mackowiak, C. (2012). Developing a taxonomy of helpful and harmful practices for clinical work with boys and men. *Journal of Counseling Psychology*, 59(4), 591–603. <https://doi.org/10.1037/a0030130>
- Maltby, J., & Day, L. (2001). Psychological Correlates of Attitudes Toward Men. *The Journal of Psychology: Interdisciplinary and Applied*, 135(3), 335–351. <https://doi.org/10.1080/00223980109603703>
- Małus, A., Konarzewska, B., & Galińska-Skok, B. (2018). Patient's failures and psychotherapist's successes, or failure in psychotherapy in the eyes of a psychotherapist. *Archives of Psychiatry and Psychotherapy*, 3, 31–41. <https://doi.org/10.12740/APP/93739>
- Martin, P. Y. (2003). “Said and Done” Versus “Saying and Doing”: Gendering Practices, Practicing Gender at Work. *Gender & Society*, 17, 342--366. <https://doi.org/10.1177/0891243203017003002>
- Martin, S. (2016). ‘How can you be strong all the time?’ Discourses of stoicism in the first counselling session of young male clients. *Counselling & Psychotherapy Research*, 16(2), 100–108. <https://doi.org/10.1002/capr.12062>
- Marwit, S. J. (1981). Assessment of Sex-Role Stereotyping Among Male and Female Psychologist Practitioners. *Journal of Personality Assessment*, 45(6), 593–599. https://doi.org/10.1207/s15327752jpa4506_5
- Mason, J. (2018). *Qualitative researching* (3rd ed.). Sage Publications.

- Menzies-Lyth, I. (1960). Social systems as a defense against anxiety: An empirical study of the nursing service of a general hospital. *Human Relations, 13*, 95–121. <https://ciap.ca/wp-content/uploads/2015/11/Social-Systems-as-a-Defense-against-Anxiety.pdf>
- Meth, R. L., Pasick, R. S., Gordon, B., Allen, J. A., Feldman, L. B., & Gordon, S. (1990). Men in therapy: The challenge of change. In *The Guilford family therapy series*. Guilford Press. <http://0-ovidsp.ovid.com.wam.leeds.ac.uk/ovidweb.cgi?T=JS&PAGE=reference&D=psy c3&NEWS=N&AN=1990-97867-000>
- Miller, D. J., & Spengler, P. M. (2018). Clinical Evaluations of Fathers Based on Sexual Orientation and Gender Role Expression. *Journal of GLBT Family Studies, 15*(3), 272–289. <https://doi.org/10.1080/1550428X.2018.1491815>
- Murray, G., & Rucklidge, J. J. (2017). Common versus specific factors in psychotherapy: opening the black box. *The Lancet Psychiatry, 4*(12), 953–962. [https://doi.org/10.1016/S2215-0366\(17\)30100-1](https://doi.org/10.1016/S2215-0366(17)30100-1)
- Myers, E. M., & Zeigler-Hill, V. (2008). No shades of gray: Splitting and self-esteem instability. *Personality and Individual Differences, 45*, 139–145. <https://doi.org/10.1016/j.paid.2008.03.012>
- Norcross, J. C. (2003). A primer on psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of Psychotherapy Integration* (2nd ed.). Oxford University Press.
- O'Brien, R., Hunt, K., & Hart, G. (2005). 'It's caveman stuff, but that is to a certain extent how guys still operate': men's accounts of masculinity and help seeking. *Social Science & Medicine, 61*(3), 503–516. <https://doi.org/10.1016/J.SOCSCIMED.2004.12.008>
- O'Neil, J. M. (1982). Gender-Role Conflict and Strain in Men's Lives: Implications for psychiatrists, psychologists, and other human service providers. In K. Solomon & N. B. Levy (Eds.), *Men in Transition: Changing male roles, theory, and therapy* (pp. 5–44). Plenum Press. https://doi.org/10.1007/978-1-4684-4211-3_2

- O'Neil, J. M. (2008). Summarizing 25 Years of Research on Men's Gender Role Conflict Using the Gender Role Conflict Scale: New Research Paradigms and Clinical Implications. *The Counseling Psychologist*, *36*(3), 358–445.
<https://doi.org/10.1177/0011000008317057>
- O'Neil, J. M., Helms, B. J., Gable, R. K., David, L., & Wrightsman, L. S. (1986). Gender-role conflict scale: College men's fear of femininity. *Sex Roles*, *14*(5–6), 335–350. <https://doi.org/10.1007/BF00287583>
- Oláh, L. S., Richter, R., & Kotowska, I. E. (2014). State-of-the-art report: The new roles of men and women and implications for families and societies. *Families and Societies Working Paper Series*, *11*, 1–59.
- Oliver, M. I., Pearson, N., Coe, N., & Gunnell, D. (2005). help seeking behaviour in men and women with common mental health problems: cross-sectional study. *British Journal of Psychiatry*, *186*, 297–301.
- Owen, J., Wong, Y. J., & Rodolfa, E. (2009). Empirical search for psychotherapists' gender competence in psychotherapy. *Psychotherapy*, *46*(4), 448–458.
<https://doi.org/10.1037/a0017958>
- Parker, I., & Bolton Discourse Network. (1999). *Critical textwork: an introduction to varieties of discourse and analysis*. Open University Press.
- Patsopolous, N. A., Tatsioni, A., & Ioannidis, J. P. A. (2007). Claims of sex differences: An Empirical Assessment in Genetic Associations. *JAMA - Journal of the American Medical Association*, *298*(8), 880–893.
- Pérez-Stable, E. J. (2018, June 27). *Communicating the Value of Race and Ethnicity in Research | National Institutes of Health (NIH)*. National Institutes of Health: Science, Health and Public Trust. <https://www.nih.gov/about-nih/what-we-do/science-health-public-trust/perspectives/science-health-public-trust/communicating-value-race-ethnicity-research>
- Pietkiewicz, I., & Smith, J. A. (2012). Praktyczny przewodnik interpretacyjnej analizy fenomenologicznej w badaniach jakościowych w psychologii [A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology]. *Czasopismo Psychologiczne [Psychological Journal]*, *18*(2), 361–

369. <https://doi.org/10.14691/CPJ.20.1.7>

Pinsof, W. M. (2002). The death of “till death us do part”: The transformation of pair-bonding in the 20th century. *Family Processes, 41*(2), 135–157.

Pleck, J. H. (1981). *The myth of masculinity*. MIT Press.

Pleck, J. H. (1995). The gender role strain paradigm: An update. In Ronald F. Levant & W. Pollack (Eds.), *A New Psychology of Men* (pp. 11–32). Basic Books/Hachette Book Group.

<https://doi.org/10.17763/haer.41.1.91367v0h80051573>

Potter, J., & Hepburn, A. (2005). Qualitative interviews in psychology: Problems and possibilities. *Qualitative Research in Psychology, 2*(4), 281–307.

<https://doi.org/10.1191/1478088705qp045oa>

Proctor, G. (2008). Gender Dynamics in Person-Centered Therapy: Does gender matter? *Person-Centered & Experiential Psychotherapies, 7*(2), 82–94.

<https://doi.org/10.1080/14779757.2008.9688455>

Raisin, R. (2017, October 6). Men or mice: is masculinity in crisis? *The Guardian*.

Reeser, T. W. (2020). Concepts of Masculinity and Masculinity Studies. In S. Horlacher (Ed.), *Configuring Masculinity in Theory and Literary Practice* (pp. 11–38). Brill | Rodopi.

<https://brill.com/view/book/edcoll/9789004299009/BP000003.xml>

Reicher, S. (2000). Against methodolatry: Some comments on Elliott, Fischer, and Rennie. *British Journal of Clinical Psychology, 39*(1), 1–6.

<https://doi.org/10.1348/014466500163031>

Richey-Suttles, S., & Remer, R. (1997). Psychologists’ attitudes toward adult male survivors of sexual abuse. *Journal of Child Sexual Abuse, 6*(2), 43–61.

https://doi.org/10.1300/J070v06n02_03

Robertson, J., & Fitzgerald, L. F. (1990). The (Mis) Treatment of Men: Effects of Client Gender Role and Life-Style on Diagnosis and Attribution of Pathology.

Journal of Counseling Psychology, 37(1), 3–9. <https://doi.org/10.1037/0022-0167.37.1.3>

- Russ, S., Ellam-Dyson, V., Seager, M., & Barry, J. (2015). *"I hate generalising, but..."*. *Coaches' Views on Differences in Treatment Style for Male and Female Clients*, 4(3), 75–92.
- Scher, M. (1990). Effect of gender role incongruities on men's experience as clients in psychotherapy. *Psychotherapy*, 27(3), 322–326.
<https://doi.org/10.1037/0033-3204.27.3.322>
- Schroeder, J. (2017, October 12). *7 Reasons Why Millennial Men Are Reinventing Masculinity*. Forbes.
<https://www.forbes.com/sites/juleschroeder/2017/10/12/the-evolved-man-7-reasons-why-millennial-men-are-reinventing-masculinity/?sh=1935513e597c>
- Schwartz, J. P., Waldo, M., & Higgins, A. J. (2004). Attachment Styles: Relationship to Masculine Gender Role Conflict in College Men. *Psychology of Men & Masculinity*, 5(2), 143–146. <https://doi.org/10.1037/1524-9220.5.2.143>
- Seidler, Z. E., Rice, S. M., Oliffe, J. L., Fogarty, A. S., & Dhillon, H. M. (2018). Men In and Out of Treatment for Depression: Strategies for Improved Engagement. *Australian Psychologist*, 53(5), 405–415. <https://doi.org/10.1111/ap.12331>
- Smith, J. A., & Osborn, M. (2004). Interpretative Phenomenological Analysis. In G. M. Breakwell (Ed.), *Doing Social Psychology Research* (pp. 229–254). Blackwell Publishing Ltd.
- Staczan, P., Schmuecker, R., Koehler, M., Berglar, J., Cramer, A., von Wyl, A., Koemeda-Lutz, M., Schulthess, P., & Tschuschke, V. (2017). Effects of sex and gender in ten types of psychotherapy. *Psychotherapy Research*, 27(1), 74–88.
<https://doi.org/10.1080/10503307.2015.1072285>
- Strauss, A., & Corbin, J. (1990). *Discovery of grounded theory: Strategies for Qualitative Research*. Aldine Publishing.
<http://citeseerx.ist.psu.edu/viewdoc/summary?doi=10.1.1.461.6630>
- Sutherland, O., LaMarre, A., Rice, C., Hardt, L., & Jeffrey, N. (2016). Gendered Patterns of Interaction: A Foucauldian Discourse Analysis of Couple Therapy. *Contemporary Family Therapy*, 38(4), 385–399.

<https://doi.org/10.1007/s10591-016-9394-6>

Tarnopolsky, A. (1995). Understanding countertransference, *Psychoanalytic Psychotherapy*. *Psychoanalytic Psychotherapy*, 9(2), 185–194.

<https://doi.org/10.1080/02668739500700191>

Tebes, J. K. (2005). Community science, philosophy of science, and the practice of research. *American Journal of Community Psychology*, 35(3–4), 213–230.

<https://doi.org/10.1007/s10464-005-3399-x>

The Atlantic. (n.d.). *Millennials and gender: A major attitude shift*.

<https://www.theatlantic.com/sponsored/prudential-sleeping-giants/millennials-and-gender-a-major-attitude-shift/467/>

Thompson, E. H., & Bennett, K. M. (2015). Measurement of masculinity ideologies: A (critical) review. *Psychology of Men and Masculinity*, 16(2), 115–133.

<https://doi.org/10.1037/a0038609>

Thompson, E. H., Grisanti, C., & Pleck, J. H. (1985). Attitudes Toward the Male Role Their Correlates. *Sex Roles*, 13(7/8), 413–427.

Thompson, E. H., & Pleck, J. H. (1986). The Structure of Male Role Norms. *American Behavioral Scientist*, 29(5), 531–543.

<https://doi.org/10.1177/000276486029005003>

Thompson, E. H., Pleck, J. H., & Ferrera, D. L. (1992). Men and masculinities: Scales for masculinity ideology and masculinity-related constructs. *Sex Roles*,

27(11/12), 573–607. <https://doi.org/10.1007/BF02651094>

UKCP. (n.d.). *UK Council for Psychotherapy | What is psychotherapy?* Retrieved July 20, 2020, from <https://www.psychotherapy.org.uk/what-is-psychotherapy/>

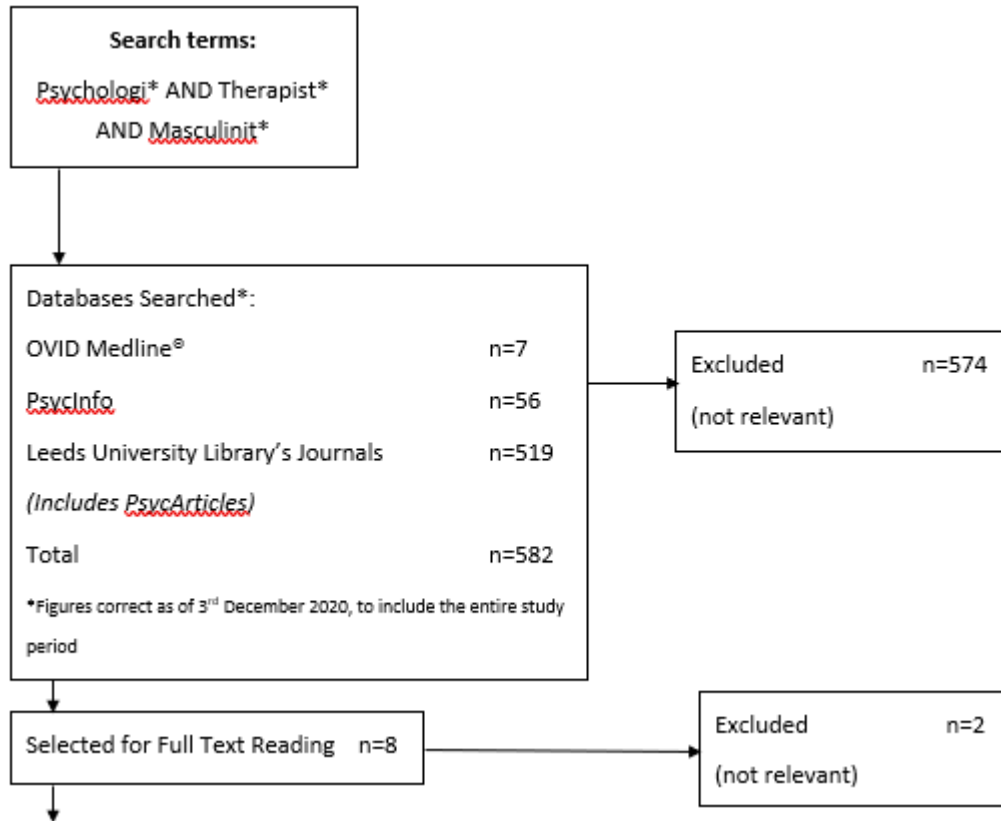
Vandello, J. A., & Bosson, J. K. (2013). Hard won and easily lost: A review and synthesis of theory and research on precarious manhood. *Psychology of Men and Masculinity*, 14(2), 101–113. <https://doi.org/10.1037/a0029826>

Vandello, J. A., Bosson, J. K., Cohen, D., Burnaford, R. M., & Weaver, J. R. (2008). Precarious Manhood. *Journal of Personality and Social Psychology*, 95(6),

1325–1339. <https://doi.org/10.1037/a0012453>

- Vogel, D. L., Heimerdinger-Edwards, S., Hammer, J., & Hubbard, A. (2011). "Boys don't cry": Examination of the links between endorsement of masculine norms, self-stigma, and help-seeking attitudes for men from diverse backgrounds. *Journal of Counseling Psychology, 58*(3), 368–382. <https://doi.org/10.1037/a0023688>
- Wade, J. C. (2015). Measurement of masculinity ideologies: A commentary. *Psychology of Men and Masculinity, 16*(2), 137–140. <https://doi.org/10.1037/a0038988>
- Waling, A. (2018). Rethinking Masculinity Studies: Feminism, Masculinity, and Poststructural Accounts of Agency and Emotional Reflexivity. *Journal of Men's Studies, 2010*, 1–19. <https://doi.org/10.1177/1060826518782980>
- Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry, 14*, 270–277. <https://doi.org/10.1002/wps.20238>
- Werrbach, J., & Gilbert, L. A. (1987). Men, Gender Stereotyping, and Psychotherapy: Therapists' Perceptions of Male Clients. *Professional Psychology: Research and Practice, 18*(6), 562–566. <https://doi.org/10.1037/0735-7028.18.6.562>
- Wilhelm, K. A. (2014). Gender and mental health. *Australian & New Zealand Journal of Psychiatry, 48*(7), 603–605.
- Willig, C. (2008). *Introducing qualitative research in psychology* (2nd ed.). Open University Press.
- Wisch, A. F., & Mahalik, J. (1999). Male therapists' clinical bias: Influence of client gender roles and therapist gender role conflict. *Journal of Counseling & Development, 46*(1), 51–60.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15*(2), 215–228. <https://doi.org/10.1080/08870440008400302>
- Zverina, M., Stam, H. J., & Babins-Wagner, R. (2011). Managing victim status in group therapy for men: A discourse analysis. *Journal of Interpersonal Violence, 26*(14), 2834–2855. <https://doi.org/10.1177/0886260510390949>

Appendix A – Literature Search



Selected for Inclusion n=6

Citations:

Bowers & Bieschke (2005)
Marwit (1981)
Miller & Spengler (2018)
Robertson & Fitzgerald (1990)
Werrback & Gilbert (1987)
Wisch & Mahalik (1999)

Articles identified through wider reading n=5

Citations:

Artkoski & Saarnio (2013)
Bailey, Eisikovits & Buchbinder (2012)
Harris, Moret, Gale & Kamameyer (2001)
Richley-Suttles & Remer (1997)
Russ, Ellam-Dyson, Seager & Barry (2015)

Appendix B – Online Survey Questions

Version 1; 12.04.2019

Question	Responses
Age	[free text]
Gender	Male Female Other (please specify)
Ethnicity	White: British Irish Gypsy or traveller Other (please specify) Mixed: White and Black Caribbean White and Black African White and Asian Other (please specify) Asian/Asian British: Indian Pakistani Bangladeshi Chinese Other Asian Background (please specify)

	<p>Black/African/Caribbean/Black British:</p> <p>African</p> <p>Caribbean</p> <p>Other Black Background (please specify)</p> <p>Other Ethnic Group:</p> <p>Arab</p> <p>Any other ethnic group (please specify)</p> <p>Prefer not to say</p>
Sexual Orientation	<p>Heterosexual</p> <p>Homosexual</p> <p>Bisexual</p> <p>Other (please specify)</p> <p>Prefer not to say</p>
Years since Qualification	[free text]
Current area[s] of work	[free text]
Please describe which models you frequently use in your clinical work	[free text]
How much of your caseload is typically made up of male clients?	<p>None</p> <p>0-10%</p> <p>11-25%</p> <p>26-50%</p> <p>51-75%</p>

	76-90% 91-99% 100%
Current employing NHS Trust:	[free text]
The information gathered in this survey will be used in a 'pen portrait' – i.e. a brief summary of your background information, to give some context to your responses. If there is any other information about yourself that you would like to include in your pen portrait, please write it here.	[free text]
Please provide some contact details so that we can contact you to arrange an interview: Phone Email	[free text]

Appendix C – Interview Schedule

Interview Schedule Version 2; 25.06.2019

Introduction:

Thank you for coming and for taking part in this study. As it may have been a while since you read the information sheet, I have a copy here if you'd like to refresh your memory. Do you have any questions about the study or your participation in it? [answer questions as required]. You gave your overall consent to take part when you completed the initial questionnaire; if that still stands, I need to ask you to also sign a consent form agreeing to take part in the interview and be recorded doing so [discuss answer as required; terminate interview if consent is revoked].

During the interview, I'm going to show you some statements about gender and masculinity and ask you to reflect on them in the context of your experience as a clinical psychologist. Where your reflections relate to your clinical work, I ask you to bear in mind client confidentiality in how much detail you give in your answers. If you give any information which might unintentionally identify a client, this will be removed during transcription. If you are concerned about your or your clients' confidentiality at any time, please let me know.

If at any time you would like to stop the interview, that's fine – just tell me. If you would prefer not to answer a question for any reason, again please let me know and we will move on to the next question. Do you have any questions before we begin? [answer questions as required].

Introductory question:

1. I'm interested to hear what drew you to taking part in this study

Main questions:

Now I'm going to show you some statements about beliefs people might have about gender, and we can talk about your views on the topic and any experiences you've had in your work where the issues had seemed relevant.

Card 1:

- Society has very definite ideas about what men should be like
- It is hard for men to do all the things society expects of them
- Men who go against society's expectations about how men should act are perceived negatively

Card 2:

- Many masculine traits are undesirable
- Masculinity does not have to exclude emotionality
- Masculinity should not require aggressiveness

Card 3:

- Many men have ideas about masculinity that they can't live up to
- Many men who seem overly masculine are really concerned about not living up to society's expectations of them as men
- Masculinity would be less stressful for men if less stereotyped

Questions for each card (to be used flexibly in response to participants' answers):

1. What are your thoughts on reading these statements?
 - a. What do they bring to mind for you?
 - b. Would you say you agree with the ideas on this card?
 - c. Are there any that you particularly agree or disagree with?
 - d. Which statements evoke the strongest feelings for you?
 - e. How does your personal experience fit with what's on the cards?
2. Can you give me any clinical examples where these issues seemed significant with a male client?
 - a. What happened?
 - b. What was the impact on the therapy?
 - c. What was the impact on you?
 - d. How might your own sense of masculinity have played a role?
 - e. Was there a time when your views differed from a client's on this?
 - f. How has that experience affected your sense of masculinity?
 - g. How do these issues present with female clients?
 - h. Can you think of a time when this wasn't the case, or the opposite was true?

Potentially challenging responses:

- If a participant asks what is meant by masculinity
 - Masculinity means different things to different people. I'm interested in how you understand masculinity and how that relates to your work with male clients
- If a participant denies any influence of gender/masculinity on their work
 - Can you tell me more about your experiences that have led you to feel that way?
 - How do you understand the relationship between gender and therapy in light of these experiences?

Ending questions:

1. Is there anything you would like to add that you think we haven't covered today?
2. What are your thoughts on the experience of the interview?

Debrief:

Thank you again for taking part in this interview. You'll find full details in the information sheet about how what you've said today will be stored and reported, but if you have any further questions about this please do get in touch with me. Is there anything that you said that you have any concerns about me using in the study at present?

It is sometimes the case that after listening back to interview tapes, areas for potentially relevant discussion which weren't picked up in the flow of conversation might be identified. Would you be willing to be contacted for a further interview if this is the case?

Appendix D – Information Sheet and Consent Forms

Participant Information Sheet; Version 4; 12.04.2019

Participant Information Sheet

Study Title: Masculinity and psychotherapy: a qualitative study of clinical psychologists' experiences working with men

Invitation and brief summary

You are being invited to take part in a research study. Taking part would involve being interviewed about your experiences of delivering therapy with adult male clients. Please read all of the information below to help you make your decision, and do not hesitate to contact the research team if you have any further questions.

Why is this research being conducted?

There is evidence that men are less likely than women to seek help for a range of problems, including mental health problems, and are more likely to try to cope with their difficulties in ways which might be harmful to themselves. However, when men are successfully engaged in therapy, they achieve similar outcomes to female clients. We are seeking a sample of 8-10 male and female clinical psychologists to reflect on their experiences with male therapy clients, with the aim of increasing our understanding of how men are, or could be, considered and engaged in the therapeutic process.

This study is being undertaken as part of a doctoral thesis submitted in fulfilment of the requirements for the degree 'doctorate in clinical psychology'.

What would taking part involve?

If you choose to take part, you will be asked to complete a short questionnaire with information about yourself, and to be interviewed about your experiences of working with male clients in therapy. It is expected that the questionnaire will take no more than ten minutes to complete, and you may choose not to answer any of the questions if you would prefer not to. Interviews may last between 1 – 2 hours. These will be arranged at a time which is convenient for you, and can take place either at the University of Leeds or at your own workplace as long as a private, quiet room is available. Interviews which take longer than 1.5 hours may be completed over two sittings, as we appreciate that it can be demanding to be interviewed for extended periods of time. These details will be negotiated between you and the interviewer to ensure that the interview is as comfortable and minimally-disruptive for you as possible.

What are the possible benefits of taking part?

To express our gratitude for giving up your time to take part in the study, and to your team for supporting our recruitment efforts, we would like to offer a summary of the results, which could be delivered in written format or in person at a team meeting. We hope that this research will inform ways in which therapy can be made more accessible to men who might be reluctant to engage with psychological support. This would have implications for our work with men throughout the healthcare system, and so we hope that the findings will be meaningful and useful to yourself and your team.

What are the possible disadvantages and risks of taking part?

Interviews necessarily require a time commitment to complete. While we have tried to minimise disruption as far as possible, taking part in this research will take around 2-3 hours of your time in total.

Taking part in this study will involve talking about therapeutic work you have completed with male clients. We are aware that it will not be possible to ask the people you might talk about for their consent to be described in the study. The following procedures are in place to ensure both your and their confidentiality:

- You will be assigned a participant ID, and your real name will not be used at any point in the write-up of the study. Only the chief investigator (Nicola Holt) will know your real name, and any documents which contain this (e.g. consent forms) will be stored separately from your study responses.
- All study data will be stored either on secure university drives or in locked storage cabinets at the University of Leeds.
- We will ask you to talk about specific incidents in therapy work with male clients, not to describe specific clients in great detail. We will ask you not to give identifying information about your clients during the interviews. However, we understand that there is a chance this might happen by mistake, and so will remove any potentially identifying information during transcription.
- Quotations selected for use in the write-up of the study will be carefully considered to ensure that only details necessary for understanding the emerging themes, and not any details which might be recognisable to a specific person, are included.

We do not anticipate that taking part in the interviews will be distressing; however, reflecting on past work may be difficult if it involved experiences which were unsatisfactory for you. If taking part in the interview raises any issues relating to your work, we would encourage you to seek support through clinical supervision. If you feel the interview raises any issues that need to be discussed with the research team, you can contact myself or my supervisors using the details on this information sheet.

What will happen if I don't want to carry on with the study?

You can choose not to answer any question you are asked during the study without having to give a reason. If you choose that you no longer wish to be involved in the study, you can tell the chief investigator (Nicola Holt) at any time up to one week after your final interview (at which point transcription will begin), and any data collected will be fully removed. Your rights to access, change or move your information are limited to one week after your interview, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study after this time, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

How will we use information about you?

The sponsor organisation for this study is University of Leeds. We will need to use information from you for this research project. This information will include your name and contact details. The researcher will use this information to arrange the interview. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a pseudonym instead. We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What will happen to my data?

University of Leeds is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. University of Leeds will keep identifiable information about you only as long as the study is running, after which time it will be destroyed.

Data from the online pre-interview questionnaire will be downloaded and stored in a secure folder on a secure University of Leeds drive. Anonymised research data will be stored for up to three years after the study period, and then be destroyed. Interviews will be recorded on an encrypted Dictaphone and transcribed verbatim. Transcription will be undertaken by the interviewer where possible. Where transcription services are required, these will be internal to the University of Leeds and will be employed in accordance with University of Leeds recommendations and guidelines to ensure compliance with data protection regulations (including GDPR and University of Leeds' data security and confidentiality protocols). Recordings and transcripts will be uploaded to a secure folder on the University of Leeds m: drive, where all other electronic data will also be stored. Paper-based data will be stored in locked filing cabinets at the University, in an office which is locked when empty. University of Leeds' [Privacy Notice for Research \(https://dataprotection.leeds.ac.uk/wp-content/uploads/sites/48/2019/02/Research-Privacy-Notice.pdf\)](https://dataprotection.leeds.ac.uk/wp-content/uploads/sites/48/2019/02/Research-Privacy-Notice.pdf) explains this in more detail.

What will happen to the results of this study?

The results of this study will form part of a thesis submitted for fulfilment of the award of Doctorate in Clinical Psychology. The thesis will be available in print at the University of Leeds library and electronically at White Rose Etheses Online (<http://etheses.whiterose.ac.uk>) and the British Library's EThOS service. The study may be submitted for publication at a peer-reviewed journal.

As outlined above, we are able to offer a summary of the results to you and your psychology team. This will be an overview of the results of the whole study, and we will ensure that your responses are not identifiable.

Who has reviewed this study?

This study has been approved by the University of Leeds School of Medicine Research Ethics Committee (SoMREC) on [DATE, REFERENCE NUMBER]. Approval from the NHS Health Research Authority (HRA) was also granted on [DATE, REFERENCE NUMBER]. Local approval has been provided by your employing NHS Trust's Research and Development department (please contact Nicola Holt for details).

Further information and contact details

If you have any questions about this research, please do not hesitate to get in touch and we will be happy to answer them. If you would like to take part, please contact the chief investigator.

Chief investigator:

Nicola Holt

Clinical Psychology, Level 10, Worsley Building, University of Leeds, Clarendon Way, LS2 9NL
umnah@leeds.ac.uk

Supervisors:

Dr Thomas Cliffe

Clinical Psychology, Level 10, Worsley Building, University of Leeds, Clarendon Way, LS2 9NL
T.D.Cliffe@leeds.ac.uk

0113 343 3407

Dr Carol Martin

Clinical Psychology, Level 10, Worsley Building, University of Leeds, Clarendon Way, LS2 9NL
C.Martin@leeds.ac.uk

0113 3430812

Study Consent Form; Version 3; 31.07.2019

(Form to be part of online survey, where university and NHS logos will be added)

IRAS ID: 258747

REC Reference: MREC 18-085

STUDY CONSENT FORM

Title of Project: Masculinity and psychotherapy: a qualitative study of clinical psychologists' experiences working with men

Name of Researcher: Nicola Holt

Please initial box

1. I confirm that I have read the information sheet dated 01.11.2019 (version 4.1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, up to one week after my final interview, without any adverse effects for myself.
3. I give my permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.
4. I permit the use of my anonymised data in future research
5. I agree to take part in the above study.

Name of Participant Date Signature

Name of Person Date Signature
taking consent

Interview Consent Form; Version 3; 19.08.2019

INTERVIEW CONSENT FORM

Title of Project: Masculinity and psychotherapy: a qualitative study of clinical psychologists' experiences working with men

Name of Researcher: Nicola Holt

Please initial box

1. I confirm that I have read the information sheet dated 01.11.2019 (version 4.1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, up to one week after my final interview, without any adverse effects for myself.
3. I give my permission for my interview to be audio-recorded and transcribed. I understand that this might be completed by a transcriber external to the study team, who will be employed in accordance with University of Leeds recommendations and guidelines to ensure compliance with data protection regulations.
4. I give my permission for extracts from my interviews, including direct quotes, to be used in the write-up and any publications resulting from this study. I understand that these will be anonymised.
5. I permit the use of my anonymised data in future research
6. I agree to take part in the interview.

Name of Participant Date Signature

Name of Researcher Date Signature

Appendix E – Ethical and HRA Approval

The Secretariat
University of Leeds
Leeds, LS2 9JT
Tel: 0113 3431642
Email: FMH.UEthics@leeds.ac.uk



UNIVERSITY OF LEEDS

School of Medicine Research Ethics Committee (SoMREC)

Dr Nichola Holt
Psychologist in Clinical Training
Leeds Institute of Health Sciences
School of Medicine
Faculty of Medicine and Health
Worsley Building
Clarendon Way
LEEDS LS2 9NL

19th August 2019

Dear Nichola

Ref no: MREC 18-085

Title: Masculinity in psychotherapy: experiences of clinical psychologists

Thank you for submitting your documentation for the above project. Following review by the School of Medicine Research Ethics Committee (SoMREC) I can confirm a conditional favourable ethical opinion based on the documentation listed below, received at date of this letter and subject to the following conditions which must be fulfilled prior to the study commencing:

- Evidence of HRA approval / RSD permission must be submitted once available

The study documentation must be amended as required to meet the above conditions and submitted for file and possible future audit. Once you have addressed the conditions and submitted for file/future audit, you may commence the study and further confirmation of approval is not provided.

Please note, failure to comply with the above conditions will be considered a breach of ethics approval and may result in disciplinary action.

Document /Received	Version	Date /Received
MREC 18-085 IRAS Form Version 3 02.08.2019	3.0	02/08/2019
Confidentiality Statement for Transcribers v1 22.03.2019	1.0	02/08/2019
DrTomCliffe_CV 2019	1.0	02/08/2019
Email to Psychology Teams Version 2 25.06.2019	2.0	02/08/2019
Interview Consent Form Version 3 19.08.2019	3.0	19/08/2019
Interview Schedule Version 2 25.06.2019_TC CM	2.0	02/08/2019
NH CV for IRAS v1 15.04.2019	1.0	02/08/2019
Online Survey Questions Version 1 12.04.2019	1.0	02/08/2019
Participant Information Sheet Version 3 31.07.2019	3.0	02/08/2019
Research Panel Summary QAS4-1	1.0	02/08/2019
Study Consent Form Version 3 31.07.2019	3.0	02/08/2019
Thesis Study Protocol Version 3 25.06.19	3.0	02/08/2019

Please notify the committee if you intend to make any amendments to the original research as submitted at date of this approval. This includes recruitment methodology and all changes must be ethically approved prior to implementation. Please contact the Faculty Research Ethics Administrator for further information FMH.UEthics@leeds.ac.uk

Ethical approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The SoMREC takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Page 1 | 2

You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, risk assessments and other documents relating to the study. This should be kept in your study file, and may be subject to an audit inspection. If your project is to be audited, you will be given at least 2 weeks notice.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

The committee wishes you every success with your project.

Yours sincerely

Dr Naomi Quinton
Co-Chair, School of Medicine Research Ethics Committee



Dr Nicola A Holt
Psychologist in Clinical Training
Leeds Teaching Hospitals NHS Foundation Trust
77 Farrar Lane
Leeds
LS16 6BN

Email: hra.approval@nhs.net
HCRW.approvals@wales.nhs.uk

01 November 2019

Dear Dr Holt

**HRA and Health and Care
Research Wales (HCRW)
Approval Letter**

Study title: Masculinity and psychotherapy: a qualitative study of clinical psychologists' experiences working with men
IRAS project ID: 258747
Sponsor: University of Leeds

I am pleased to confirm that [HRA and Health and Care Research Wales \(HCRW\) Approval](#) has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, [in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.](#)

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](#) in accordance with their procedures.

What are my notification responsibilities during the study?

The ["After HRA Approval – guidance for sponsors and investigators"](#) document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The [HRA website](#) also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is 258747. Please quote this on all correspondence.

Yours Sincerely
Beverley Mashegede

Email: hra.approval@nhs.net

Copy to: Faculty Research Ethics and Governance Administrator, Sponsor Contact

RE: MREC 18-085 Amd 1 Nov 2019 - Approval

Rachel De Souza [Medicine] <R.E.DeSouza@leeds.ac.uk>

on behalf of

Medicine and Health Univ Ethics Review <FMHUniEthics@leeds.ac.uk>

Tue 26/11/2019 13:31

To: Nicola Holt <umnah@leeds.ac.uk>

Cc: Medicine and Health Univ Ethics Review <FMHUniEthics@leeds.ac.uk>; Tom Cliffe <T.D.Cliffe@leeds.ac.uk>

Dear Nikki

MREC 18-085 Amd 1 Nov 2019 - Masculinity in psychotherapy: experiences of clinical psychologists

Many thanks for the above amendment submission. I can confirm the amendment has been reviewed and approved and may be implemented with immediate effect. *Please retain this email as evidence of approval in your study file.*

You will also need to submit for HRA approval but please email governance-ethics@leeds.ac.uk to notify the Sponsor representative first, in case their review of the amendment is required prior to submission to the HRA.

Please notify the committee if you intend to make any further amendments to the information in your ethics application as submitted at date of this approval as all changes must receive ethical approval prior to implementation. The amendment form is available at <http://ris.leeds.ac.uk/EthicsAmendment>.

Please note: You are expected to keep a record of all your approved documentation and other documents relating to the study, including any risk assessments. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited. There is a checklist listing examples of documents to be kept which is available at <http://ris.leeds.ac.uk/EthicsAudits>.

We welcome feedback on your experience of the ethical review process and suggestions for improvement. Please email any comments to FMHUniEthics@leeds.ac.uk

Best wishes

Rachel

Rachel de Souza, Research Ethics & Governance Administrator, The Secretariat, Room 9.29, Level 9, Worsley Building, Clarendon Way, University of Leeds, LS2 9NL, Tel: 0113 3431642, r.e.desouza@leeds.ac.uk

RE: MREC 18-085 Amendment2 April 2020 – Approval

Rachel De Souza [Medicine] <R.DeSouza@leeds.ac.uk>

on behalf of

Medicine and Health Univ Ethics Review <FMHUniEthics@leeds.ac.uk>

Thu 28/05/2020 12:47

To: Nicola Holt <umnah@leeds.ac.uk>

Cc: Medicine and Health Univ Ethics Review <FMHUniEthics@leeds.ac.uk>; Medicine and Health Research Governance <governance-ethics@leeds.ac.uk>

Dear Nicola

MREC 18-085 Amd 2 April 2020 - Masculinity in psychotherapy: experiences of clinical psychologists

NB: All approvals/comments are subject to compliance with current University of Leeds and UK Government advice regarding the Covid-19 pandemic.

With sincere apologies for the delay. I am pleased to inform you that the above research ethics application amendment as described in your email below dated 14th May 2020 has been reviewed by the School of Medicine Research Ethics Committee (SoMREC) and on behalf of the co-Chairs I can confirm a favourable ethical opinion based on the documentation received at date of this email.

Please retain this email as evidence of approval in your study file and contact governance-ethics@leeds.ac.uk regarding any requirements for submission to the HRA for approval.

Please notify the committee if you intend to make any further amendments to the research as submitted and approved to date. This includes recruitment methodology; all changes must receive ethical approval prior to implementation. Please see

<https://leeds365.sharepoint.com/sites/ResearchandInnovationService/SitePages/Amendments.aspx> or contact the Research Ethics & Governance Administrator for further information FMHUniEthics@leeds.ac.uk if required.

Ethics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, risk assessments and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

I hope the study continues to go well.

Best wishes

Rachel

On behalf of Dr Naomi Quinton and Dr Anthony Howard, co-Chairs, SoMREC

Rachel de Souza, Lead Research Ethics & Governance Administrator, The Secretariat, Room 9.29, Level 9, Worsley Building, Clarendon Way, University of Leeds, LS2 9NL, Tel: 0113 3431642, r.deSouza@leeds.ac.uk

Appendix F – Examples from Analysis of Transcripts

Outlined here is a stage-by-stage example of how analysis was conducted for each participant's transcript, in accordance with the guidance in Willig (2008). Analysis was completed for each participant before moving onto the next. All pictured excerpts here are from the same participant, to show how the analysis progressed through the stages.

Stage 1: Discursive Constructions and Stage 3: Action Orientation

After reading a transcript several times and noting initial impressions, analysis began with line-by-line coding of the different ways certain objects were constructed in the participant's talk. These were labelled using Microsoft Word comments, using the following codes to refer to each object:

Main discursive objects:

MMH: Male Mental Health

TWM: Therapy with Male clients

Secondary discursive objects:

MA: Masculinity

MEH: Mental Health

THY: Therapy

Comments were added in italics to note linguistic features and what particular pieces of talk seemed intended to achieve (Action Orientation).

39 distinction made within psychology broadly which is between, and I might be
 40 going off on one here so I'll try and keep this brief, so but, on, on, on skills
 41 focussed work which is somehow being like, the, the second rate cousin of the
 42 real deal which is reflective psychotherapy work, and I think that, I think that's
 43 bullshit if I'm frank about it, I think it's just not true, we don't! - [cuts self off]
 44 anyway. So the, the, so I thought that there were, there was opportunities
 45 for developing groups that just fit more broadly and with a better fit shall I say
 46 with the demographic here, more broadly, but also with men in particular, that I
 47 was one thing, and the other thing that I use is a project called Five Session
 48 CAT, which is, it's, really it's kind of cognitive analytic therapy formulation and
 49 care planning really that's what it is, but it's a way of working, it's not gendered
 50 issues, not a gender specific model at all, but it's a way of working with people
 51 who for one reason and other are not able to use therapy because of often
 52 because of maybe very poor emotional regulation, lots of self-harm and other
 53 risky issues, real difficulty in managing helping relationships, but still
 54 presenting as needy, and I've found that some of the men who came who we
 55 would generally be saying no to or no they're not ready for therapy they need
 56 stabilisation work they're not for us, this approach is working really well with,
 57 and so far I've just been doing an audit of that, and there's been a 100 percent
 58 engagement, no one's dropped out of that work so far, and the majority of the
 59 people I'm doing that work with are men, so that feels like a good adaptation
 60 really, because it's very structured, it's very focussed on, in a very - there's
 61 phrase in CAT push what moves, and there's a sense in which we work just
 62 how things are now and in a very pragmatic way trying to work out what could
 63 we do that would help, and tailoring that to the person rather than, you know,
 64 slot, you know -. So that would be the two main things I've been thinking about
 65 groups and this adaptation of CAT really.

NH
 Nicola Hoik
 Passionate.
 Cuts self off - to stop himself 'going off on one' -
 passionate advocate
 Sense of him feeling silenced in his service
 throughout

NH
 Nicola Hoik
 Service not getting it right for anybody

NH
 Nicola Hoik
 TMM: doesn't need to be specifically male-
 designed therapy

NH
 Nicola Hoik
 TMM: adaptation as successful: a way around
 service constraints (beat the system)

NH
 Nicola Hoik
 Frames this adaptation as 100% successful, with
 evidence to back it up.
 Appeal to scientific credibility

NH
 Nicola Hoik
 TMM: needs structure

NH
 Nicola Hoik
 TMM: needs to work with where men are rather
 than expecting them to change too soon

This was followed by a second coding of each transcript, taking larger sections of text, and commenting on their overall discursive features (e.g. overarching constructions; wider discourses; positioning; function of the talk; etc.). This stage allowed for a 'zooming out' from the line-by-line analysis to obtain an overall sense of the features of each account.

39	distinction made within psychology broadly which is between, and I might be	Positions self as both within and outside of psychology – use of 'we', but also 'that's bullshit' – construction of self as being different from the others, more adaptive to clients' needs. Cutting self off leaves question of what he was going to say; implication of it being unprofessional, too critical to share
40	going off on one here so I'll try and keep this brief, so but, on, on, on skills	
41	focussed work which is somehow being like, the, the second rate cousin of the	
42	real deal which is reflective psychotherapy work, and I think that, I think that's	
43	bullshit if I'm frank about it, I think it's just not true, we don't – [cuts self off]	
44	anyway. So the, the, the, so I thought that there were, there was opportunities	
45	for developing groups that just fit more broadly and with a better fit shall I say	
46	with the demographic here, more broadly, but also with men in particular, that	
47	was one thing, and the other thing that I use is a project called Five Session	
48	CAT, which is, it's, really it's kind of cognitive analytic therapy formulation and	
49	care planning really that's what it is, but it's a way of working, it's not gendered	Nicola Holt Formulation and care planning as opposed to full therapy Needing to offer therapy suited to where men are at, rather than expecting them to adapt to service version.
50	issues, not a gender specific model at all, but it's a way of working with people	
51	who for one reason and other are not able to use therapy because of, often	
52	because of maybe very poor emotional regulation, lots of self-harm and other	
53	risky issues, real difficulty in managing helping relationships, but still	
54	presenting as needy, and I've found that some of the men who came who we	Nicola Holt Says is not gender-specific, but is framing this approach as one which is good for men. Linking to list of problems: is the implication that all men have these issues and so aren't ready for therapy, or that it's only a specific subset of male clients?
55	would generally be saying no to or no they're not ready for therapy they need	
56	stabilisation work they're not for us, this approach is working really well with,	
57	and so far I've just been doing an audit of that, and there's been a 100 percent	
58	engagement, no one's dropped out of that work so far, and the majority of the	
59	people I'm doing that work with are men, so that feels like a good adaptation	Nicola Holt Persuasive talk: building a case for why this approach works. Hard to argue with 100% effectiveness
60	really, because it's very structured, it's very focussed on, in a very- there's	
61	phrase in CAT push what moves, and there's a sense in which we work just	
62	how things are now and in a very pragmatic way trying to work out what could	
63	we do that would help, and tailoring that to the person rather than, you know,	
64	slot, you know. So that would be the two main things I've been thinking about	Nicola Holt Doesn't finish sentence, but implication is that other people (his service?) slot clients into their way of working, rather than adapting to clients' needs – positions self as difference
65	groups and this adaptation of CAT really.	

Following this, the various ways each discursive object had been constructed were listed in a separate document. Where constructions were similar, even if not labelled identically, they were grouped together under a label appropriate to the examples contained within it.

Male Mental Health as ...

- Complex
- Unhelpful coping strategies
- Perceived as a problem for others
 - 'damage-doing' - what men do, not how they feel
 - Angry
 - Feelings/vulnerabilities not seen/acknowledged
- Rejected / excluded
 - From society
 - From services
 - By women
- Based on shame / avoidance of shame or vulnerability
- Sensitive to perceived judgement
- Threat as a response to vulnerability
- Socio-cultural, not always psychological
 - MMH maybe just seeing the problems others accept/ignore
 - Trying to fit with a society that doesn't accept them
 - Therapy won't fix this
- Related to loss of value/status
 - Identity linked to work
- Don't ask for help / suffer in silence

Therapy with men as ...

- Not the norm
 - Services don't adapt therapy to suit men
- Needing to be flexible/adaptable to where men are at / what they're able to engage with
 - 'Push what moves'
 - Structured, practical
- Enough to focus more on skills and understanding

Stage 2: Discourses; Stage 4: Subject Positions; Stage 5: Practice; and Stage 6: Subjectivity

The discourses which underpinned these constructions were summarised underneath these lists. For each discourse, a comment box was assigned in which were listed initial thoughts on the position(s) the participant had taken up in

relation to it; what actions would be available to a person in that position; and what the subjective experience of a person in such a position might be

- Accepting the whole person
- Requiring sensitivity to avoid client feeling judged/rejected
 - Puts clients in vulnerable position / in touch with shame
 - Non-judgemental space (where you normalise, validate, accept) leads to diffusion of shame
 - Requires seeing things from client's perspective
- Somewhere (maybe the only place) to talk about their feelings

Discourses

- Traditional masculinity
 - Avoidance of emotions
 - Strength/power/success
 - Provider
 - Aggression/externalising
- Precarious masculinity
- Evolutionary
 - Sexual selection
 - Alpha/beta
- Psychological vs sociological

NH **Nicola Holt**
Position: sympathetic observer (doesn't talk about it in terms of himself)
Practice: give reasons for why men are like this; emphasise strengths of this position; emphasise difficulty of expectations changing; adapt self around it
Subjectivity: sympathetic; respectful of this kind of man; protective; admiring; angry at those trying to change it

NH **Nicola Holt**
Position: Respectful therapist
Practice: Don't push men further than they want to go; agree with them; adapt therapy; advocate for men; acknowledge any engagement as a successful outcome
Subjectivity: Empathetic; gratitude/liking from clients; clients engage; feel successful and kind

NH **Nicola Holt**
Position: agrees with these ideas
Position (unsaid): seems to identify with beta male status
Practice: Find reasons for sex differences; blame external forces for lack of success; little power to change anything
Subjectivity: identify with 'betas'; anger/resentment towards 'alphas'; externalise problems; find community with other 'betas', including clients;

NH **Nicola Holt**
Position: sides with sociological (on side of masculinity as marginalised)
Practice: find explanation in society/socialisation for men's problems; change the culture, not the man; validate men's experiences
Subjectivity: empathetic; angry at wider society on men's behalf; feel rejected by dominant group (in therapy this is made up of women)

From here, participants' accounts were written up into a narrative summary, detailing the various constructions of each discursive object and the effects they had on the narrative. Here, quotes relating to each construction were included, which provided an opportunity to re-ground the analysis in participants' original talk and ensure that interpretations were rooted in clear examples from the text. This stage also allowed for consideration of how different constructions of the same objects related to one another within the overall account.

■■■■ constructs a change in society, in which men used to access power through crude, strength-based means, but this is no longer a celebrated option. Therefore they will either seek power and status through other means, such as one client engaging with more subtle, corporate power structures rather than ones based on physicality, or they will not be able to feel powerful anymore and so will develop what are labelled as mental health problems (hence needing therapy).

“I think the overly masculine thing is, is about, like a carapace, it’s a kind of shell to protect a vulnerability because, and, and, and if you are in an environment that is conflictual and aggressive and you know as the criminal world can be, or as certain work places can be, then that might be, but if you’re shut out from the corridors of more subtle power then those quite crude things might work but they don’t work in places where you need to be subtle like that client I mentioned to you who attacked his ex-partner who was trying to move in to a professional environment, and now is having to roll back on things and become less aggressive.” (1105-1113)

He constructs men as generally disempowered in society – by changing job roles, by being disparaged

“the impasse that men are getting in to is that they have ways of securing social status that have worked in some environments and still do in certain, but they’re becoming unstuck in many of the modern environments in which the softer skills and what we might regard as more traditionally female skills have really come to the fore and then men find themselves disenfranchised, at the same time as there’s lots of critical discourses on men that are actually ridiculing, that is not helpful, at all, and it happens a lot.” (1149-1155)

The earlier construction of men needing to fight injustice and do what needs to be done could relate to this, and could be understood as a justification to fight back, by any means necessary, against what he elsewhere constructs as an oppressive system

Each of these summary documents also included an overall summary of the analysis of the participant’s account.

Summary

█ constructs masculinity primarily in terms of social status. He talks positively about theories which suggest that achieving social status is essential for men's well-being, and positions men as victims of a changing society which no longer allows them to access this power and status in the same way. He draws strongly on evolutionary discourses in support of this idea, as well as discourses of the value people have in society (alphas/betas). While most participants constructed power as a primarily male object, █ constructs men as disempowered, excluded and forgotten about. In this way, he uses discourses typical of those who label themselves 'men's rights activists', who focus exclusively on the ways that men might be disadvantaged in today's society. █ avoided personal disclosure throughout his interview, but his talk still felt deeply personally resonant, suggesting he positions himself among these disadvantaged men. Where he does have some power, though, is as a psychologist, and he uses this to advocate for his male clients, who he constructs as further excluded from psychology services which are staffed mainly by women. This position evokes feelings of anger and injustice, and would enable █ to feel like a rescuer or liberator in his work to ensure fair treatment for his male clients. This fits with his description of an ideal masculinity in which men 'do what needs to be done' in the face of injustice or unfairness.

Within this construction, █ questions whether his clients' difficulties are psychological, or if there are sociocultural in origin and so not something which therapy can fix. He advocates for therapies which are based on formulation and skills-building, suggesting he sees the benefit for male clients as being in understanding how they have been harmed (whether through abuse or through wider societal means) and learning to cope with it. He stresses the importance of not seeming to criticise male clients – a common practice in therapy, but in this case constructed as specific to male

clients because they are likely to feel highly ashamed and vulnerable through having to access therapy. This is evidenced throughout his interview, where he constructs each example of his work with men as successful, despite them making differing levels of progress in therapy.

█ advocates for men embracing their vulnerability and softness, in order to be the most effective versions of themselves. However, he frequently cautions against too much softness, for men generally and in working with men. He suggests that men need to keep their 'teeth' or strengthen their 'legs' in order to be able to defend themselves and to be able to 'do what needs to be done', as outlined above. This is a threat-based discourse, which constructs men as existing in a hostile society and requiring some degree of aggression to survive. With this in mind, it is not surprising that █ does not identify working with his clients to reduce aggression and violence in the same way that other participants did, except insofar as to help one person get ahead in a world which did not value physical aggression. Many participants talked about examples where men have needed to be aggressive to survive, such as in criminal gangs, and questioned the value of therapy in these circumstances. █' construction of a world which is dangerous for men widens this net, and suggests that aggression is necessary to some degree for all men to survive.

These summary documents were long (9-17 pages) and, once they had been checked and refined against the participants' transcripts, were used to build an overall understanding of the similarities and differences between participants' accounts.

My research supervisors had access to all of the documents outlined above, and provided comments on each stage of the analysis. This was done both through written comments on the documents, and through discussion in supervision meetings.

Appendix G – Examples of Analysis Across the Dataset

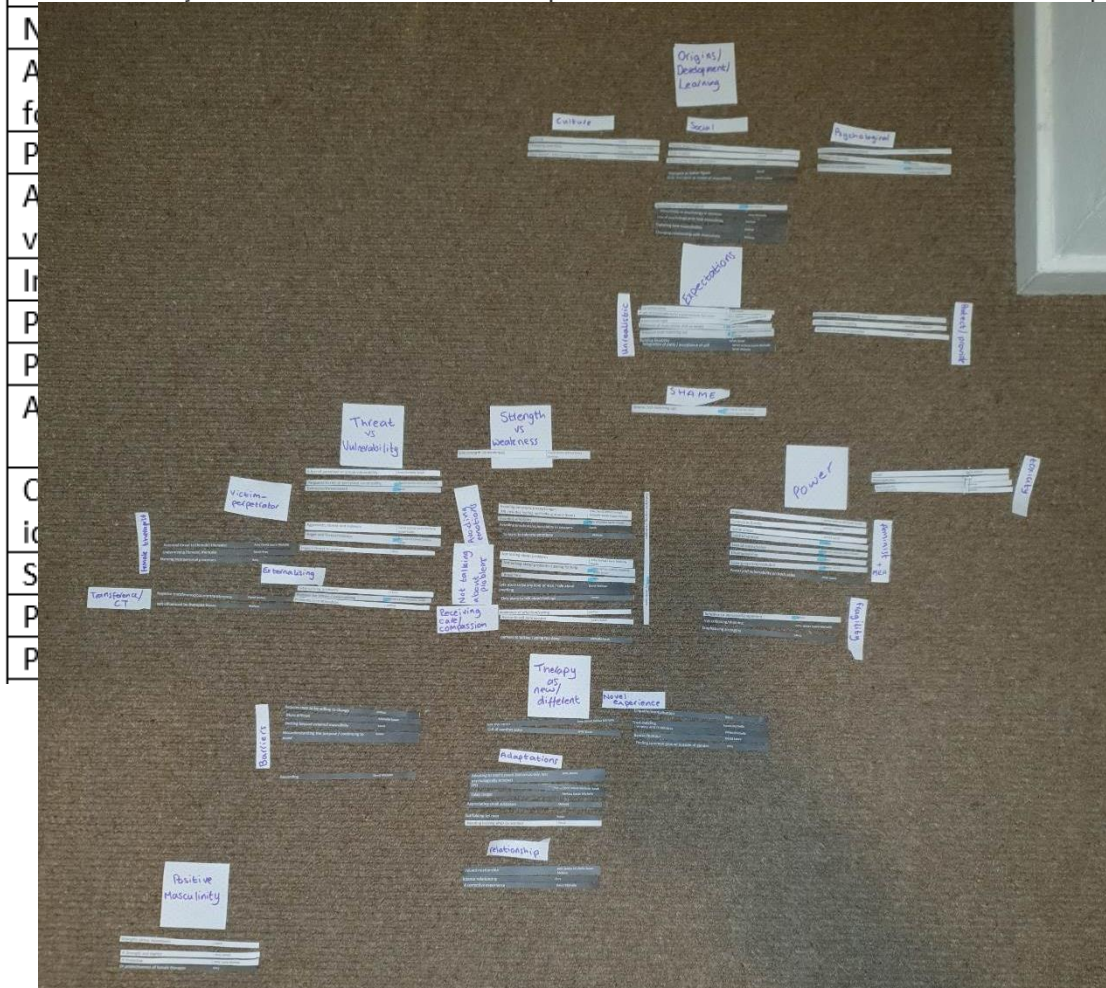
There was no pre-prescribed format to the method of synthesising the analysis across the dataset, as outlined in Chapter 2. This Appendix does not represent every stage of the analysis, as this would not be possible. Changes were made to the analysis throughout the process as a result of verbal discussions in research supervision and through writing and re-writing the results chapter, which it would not be possible to succinctly capture here visually. Rather, this Appendix demonstrates some of the tools which were used to aid my thinking about the data and to introduce systematisation of the analysis where possible.

Discursive Constructions

To assist with synthesising the different ways that objects were constructed, I copied every different construction of masculinities, male mental health, and therapy with men from participants' transcripts into a table, and noted who had used them. Where constructions were similar, they were merged.

Masculinity

Avoiding emotions (except anger) (NB includes feeling and talking about them)	Amy David James Joshua Michelle Sarah Susan Melissa
---	--



From here, the constructions were cut up and grouped together thematically by hand. The aim here was to develop a narrative of how the constructions impacted one another (e.g. how did constructions of masculinities relate to constructions of therapy with men).

These were then transferred to a Publisher document, to facilitate ease of use and modification

Social

Passed down from father
Role models
Enforced by female partners
Therapist as father figure
Male therapist as model of masculinity

Cultural

Cultural
Changing over time
Class-based / intersecting other identities

Origins

Psychological

Developmental/maturational
Linked to identity
Linked to early experiences

Sociological vs psychological
Masculinity vs psychology in sessions
Use of psychological to help masculinity
Exploring new masculinities
Changing relationship with masculinity

Power

Power
Control/authority
Social status
Disempowering
Lack of control
Loss of status/value
Feeling rejected/excluded
Power and vulnerability on both sides

These groupings were refined through discussion with a clinical psychologist from my training cohort.

Client Stories

The individual stories therapists told about their clients were collated in a large summary table, which had been organised around an early categorisation of constructions of clients and their masculinities (this was later changed). This table was referred back to throughout the analysis, to ensure all clients' stories were considered within each developing analytic framework.

	Child	Passive (emasculated)	Threatening (extreme masculinity)	Integrated	Good enough	Other/unsure
			<ul style="list-style-type: none"> 3 find a way to help him (didn't work) 4 ER 			
		<ul style="list-style-type: none"> 1 charity shop story 2 feels emasculated / excluded / wrong sort of man 3 empower and increase <u>self esteem</u> – happens externally to therapy (sense of belonging) 	<ul style="list-style-type: none"> 1 Hard man persona – farmer 2 avoiding vulnerability; low self-esteem 3 flexible thinking, assertive (saving face) 			
Laura		<ul style="list-style-type: none"> 1 intrusive thoughts 2 wrong sort of man – small, passive, unsuccessful in relationships 3 ? 	<ul style="list-style-type: none"> 1 Hard man persona – ex gang 2 feeling threatened, avoiding vulnerability 3 empower to confront voices 			
			<ul style="list-style-type: none"> 1 fashion – overachiever 2 unrelenting standards, boom and bust 3 realistic expectations, 			

No power struggle → helper position. (TM normal)
(reformed TM)
(non-TM)
(MM)

Power struggle - Submit to - rescuer position (helplessly TM) TP
CP (Caus)

- Depend against - enforcer position (avoiding TM) TP (Caus)

- resist - position (perpetrating TM) CP
TR (Caus)

- Negotiate / manage - helper position (TM victim + perp)

Understanding of the implications of each subject position was developed using the following proforma of headings, under which notes and quotations from transcripts would be added.

Client

Construction of Client

Construction of Therapist

Location of Power

Possibilities for Practice

Subjectivity

Appendix H – An Example from my Reflexive Journal

The example given here relates to an experience of a strong emotional reaction to literature surrounding ways to adapt therapy for male clients. As the journal entry demonstrates, I struggled with the idea of having to specifically make men feel powerful in order not to alienate them from therapy. I reflected on a feeling that this was ‘pandering’ to a certain type of men, and on how this related to wider societal power structures through a comparison with other identities and with how the same kind of thinking might apply to women. The image this literature brought to mind for me (described in the second photograph) was related to a perception I held of certain kinds of men as powerful, and as disempowering others in order to remain powerful. This is why encouraging this sense of powerfulness within therapy felt inherently uncomfortable for me – as it felt like it involved disempowering the therapist in order to allow the male clients to continue to feel powerful.

This issue for me represented a dilemma I had to work through often, with one the one hand the question of whether avoiding some of the normal tasks of therapy (such as talking about feelings, striving for an equal power relationship) was really beneficial for male clients, and on the other hand the notion that if men did not feel comfortable in therapy and stopped attending, they would also not benefit. This dilemma was notably brought up for me again when I was analysing Laura’s transcript, as she described a strategy of playing “one-down” with her own expertise in order to make some men feel more powerful in therapy. I experienced an initial negative reaction to the strategy, for the same reasons outlined above and in the images here. However, through examining my response and re-reading Laura’s words, I was able to come to a place of respect for the strategy, which had seemed to balance the needs of both sides of the dilemma effectively.

31/01/19 Reading recommendations for
Male-friendly therapy (Beel) & feeling angry.
"Egalitarian behaviour" - invitations for
collaboration, therapist self-disclosure. I don't
disagree with these - as a matter of course for
all therapy. It's framed like men have to be
given power to feel welcome.
"Reframing as a place for winners" "view client
as heroic". Avoid too deep emotions - why
are we there then?
But if this helps then why does it make me
angry?
Positions men as victims b/c they risk losing
some of their power. Other x-sensitive therapy
would be about not further oppressing people.

Imagine if it was written re: white -
sensitive therapy - "view client as heroic" - esp.
if therapist was POC.
Is this just badly phrased, or does it
reflect complicity in upholding patriarchy?
Also back to Q of whether these needs
(power, restrictive emotionality) should be
challenged by therapy for client's benefit?
- But how can you if they don't stay?
Is some pandering necessary? Would a
woman w/ gendered problem with engagement
(e.g. martyr / don't want to bother you) be catered
to the same way?
NB, my image is of a smarmy, white, middle-
class, middle-aged man here. The (few)
men I have worked with have not been
like this - maybe why more didn't feel
as problematic?
★ Read more about the empathy gap.

Appendix I – Summary Table of Client Stories

Participant	Client	Client Construction	Therapist Position
Susan	Su1	Passive, doesn't understand emotions	Therapeutic
	Su2 (Client 1)	Child-like, anxious, neglected	Rescuing
	Su3	Provider, neglected	Not enough detail
	Su4	Doesn't understand emotions	Not enough detail
	Su5f	Emotionally demanding	Self-protective
	Su6f	Emotionally demanding	Self-protective
James	Ja1	Passive, avoidant of masculinity	Therapeutic
	Ja2	Misunderstood, rejected	Rescuing
	Ja3	Abusing and abused	Therapeutic
	Ja4 (Client 2)	Misunderstood, rejected	Rescuing
Joshua	Jo1	Harsh, abusive, but changing	Therapeutic
	Jo2 (Client 3)	Malicious, malignant	Self-protective
	Jo3	Traumatized, stoical	Therapeutic
	Jo4	Tough but connected to emotions	Therapeutic
	Jo5	Narcissistic, avoidant	Self-protective
	Jo6	Avoidant, emotionally disconnected	Therapeutic
Melissa	Me1	Avoidant, exploited	Self-protective
	Me2 (Client 4)	Avoidant, weak	Self-protective
	Me3	Avoiding masculinity	Therapeutic
	Me4	Passive	Self-protective
	Me5	Tough, unemotional	Therapeutic
	Me6	Protective	Therapeutic
Sarah	Sa1	Ashamed, anxious	Therapeutic
	Sa2 (Client 5)	Dominant, avoidant	Self-protective
	Sa3	Avoidant	Self-protective
	Sa4	Avoidant	Self-protective
	Sa5 (Client 6)	Protective, principled, victimised	Therapeutic
David	D1 (Client 7)	Feminine	Therapeutic

	D2	Violent, avoidant	Rescuing
	D3	Violent, avoidant	Rescuing
	D4	Striving, unrelenting standards	Therapeutic
Michelle	Mi1 (Client 8)	Avoidant, aggressive, vulnerable	Therapeutic
	Mi2	Avoidant, seeking status, vulnerable	Therapeutic
	Mi3	Dominant, unpleasant	Self-protective
	Mi4f	Dominant, demanding	Therapeutic
Laura	L1	Emasculated, excluded	Therapeutic
	L2 (Client 9)	Defended, tough	Therapeutic
	L3	Defended, tough	Therapeutic
	L4	Passive	Not enough detail
	L5	Seeking success and achievement	Therapeutic
	L6	Violent and a victim of violence	Therapeutic
	L7f	Self-conscious	Not enough detail
Amy	A1	Violent with men, caring with women	Therapeutic
	A2	Violent with men, caring with women	Therapeutic
	A3	Sexually inappropriate, lonely	Self-protective
	A4	Avoidant, ashamed	Therapeutic
	A5 (Client 10)	Violent, fragile	Therapeutic
	A6	Ashamed, avoidant	Self-protective
	A7	Strong, dignified	Therapeutic
	A8f	Angry	Not enough detail
	A9f	Extremely distressed	Therapeutic

Key:

Clients identified in brackets and bold are those described in the main body of the text.

f – female client