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**Are clinical psychologists, psychotherapists and counsellors overlooking the needs of their male clients?**

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## **Summary**

Around 75% of suicides are male, yet men seek therapy less than women do. Is talking about feelings unappealing to men? Our interviews with 20 experienced therapists identified ways in which therapy might be made more male-friendly.

Although men are at three times higher risk of committing suicide than women, men tend to seek help for emotional and physical problems less (Kung, 2003). This might be related to men's preferred ways of coping with problems, including preferences for types of therapy (Liddon et al, 2017). Although Wright & McLeod (2016) found that long-term outcomes for stress counselling were significantly better for women than men, sex differences in psychological therapy outcomes have been largely overlooked (Parker et al., 2011).

The present study was part of a research programme that had previously interviewed life coaches (Russ et al, 2015) and hypnotherapists (Lemkey et al, 2016) and found that most had reported sex differences in aspects of their work. The aim of this study was to interview psychologists, psychotherapists and counsellors to ask whether they had noticed sex differences between their clients relevant to their experience of therapy.

### **Grounded Theory Methodology**

The study used semi-structured interviews analysed in accordance with grounded theory (Strauss & Corbin, 1990). The study was approved by University College London's Research Ethics Committee. Several questions served as the starting point for a general discussion with a minimum of steering from the interviewer. These included:

- *In your experience, do men and women present with the same types of issues?*
- *If there are differences, what are these?*
- *'Some people suggest that men and women have different preferences for modes of therapy. How much have you seen of this in your practice, if at all?'*

## Data Credibility

To evaluate the methodological credibility of this study, the criteria described by Fossey, Harvey, McDermott, and Davidson (2002) and Charmaz (2006) were used as a guide. The first author works in a low secure unit in the NHS. The second author is a consultant clinical psychologist, and the last author is a chartered psychologist and hypnotherapist ~~and lecturer in psychology and the last author is a consultant clinical psychologist~~. The first author used memo taking methodological and theoretical reflexivity, and the ~~second~~ last author cross-checked the transcript coding initially completed by the first author.

## Participants and Sampling

Participants were talking therapists recruited from *Male Psychology Network* members using a snowball sampling technique. In other words, initial research participants recruited other participants through the network. (The Male Psychology Network is a group of therapists, students and third sector workers who, recognising the importance of male suicide and underachievement in education, work to support the wellbeing of males). The characteristics of the sample are shown in Table 1. This includes gender, years in practice, gender ratio of clients and mode of therapy. Interviews lasted approximately 25 minutes and were conducted by phone or Skype between Feb 2016 and April 2016.

**[Insert Table 1 about here]**

## **Results**

Line-by-line coding of the 20 interviews yielded 47 open codes from 1,203 line by line codes. These were grouped by meaning to form eight subcategories which fell into three categories (see Table 2). From these three categories, the core category of, '*Whether nature or nurture, men want a quick fix and women want to explore*' emerged. From this process, an empirically grounded theory of *cognitive dissonance* caused by the conflict between the therapists' experience and their expectations based on the *gender similarities hypothesis* was derived. This conclusion is elaborated in the discussion.

[Insert Table 2 about here]

### **Category 1: Impact of Gender on Aspects of Therapy**

Three subcategories emerged within Category 1 that described gender differences in therapy. This included client needs, setting and time.

#### ***Subcategory 1: Client Needs***

Although some participants said there were no difference in client needs, many said there were.

*“..I would typically see more, umm, women in my role who are seeking help because they’re finding that their emotions are not manageable, or that they’re having difficulties in their relationships. Umm, the men I tend to see, it’s more to do with problems at work.” [P7]*

- *Help-seeking*

Regarding the importance and scale of men being relatively poor at help-seeking, C3 said:

*“Oh man! If I had the answer to that question, I’d be a billionaire.” [P3]*

- *Needs in therapy*

Some participants described how men and women tend to start therapy from different places:

*“...when a guy comes through the door, you could see him off quite quickly if you went in to the ‘how does it make you feel’ line of therapy. Whereas, if you start off with more behavioural type or mechanical type interventions, [for] some men it helps them engage better” [P20].*

However, although men and women may be inclined to start off differently, their needs may converge later in therapy.

- *Differences in presentation*

Like Russ et al (2015) and Lemkey et al (2016), many participants described sex differences in presentation:

*“...the initial presentation is often different. Men seem to have more of a hard shell around their issues” [P12]*

### ***Subcategory 2: Setting***

- *The therapist*

A few participants mentioned that characteristics of the therapist were important. For example, that there should be a “perceived similarity” and commonality of language. Some participants suggested that the therapist should change their approach to accommodate the male client, not vice versa:

*“I think it’s the therapist that needs improving....the therapist needs to be less wedded to the ideas of what a good client is...” [P6]*

- *Gender-sensitive services*

Echoing suggestions by Kingerlee et al (2014) and Liddon et al (2017), some participants said that the services available – especially in the NHS – needed to do more to accommodate the needs of men. The use of language in the therapeutic setting was also discussed:

*“...we never talk about crying as men don’t cry, we talk about emotional releasing”. [P5]*

### ***Subcategory 3: Time***

- *Stages of therapy*

There was the notion of men and women needing to begin therapy in different ways, with women able to start at a more advanced stage of therapy than men. This was described by P5 (above) as the *port of entry*.

- *Age*

Participant 2 (P2) situates it in time and explains it in terms of a 'life cycle', with older men being readier to come to therapy.

### ***Category 2: Impact of society***

Several participants noted that men are socialized to embody masculinity, and that this might be a barrier to seeking help, but a range of views were identified on how much of an impact the socialized masculine role actually has on therapy.

*“Men are supposed to work things out on their own according to the stereotype, be stoical and stand on their own two feet and not have to go to a father figure or a mother figure, certainly not someone who’s trained, say a counsellor or a psychotherapist.” [P1]*

### ***Subcategory 1: Socialization***

- *Masculinity*

Some participants suggested or implied that masculinity was a creation of culture and was causal in creating psychological problems by making them feel a pressure to succeed, or not to seek help for fear of looking weak.

### ***Subcategory 2: Social Interventions***

Many participants suggested that the social environment might be used to remove some of the restrictions of socialized masculinity. The main suggestion was health promotion campaigns.

- *Media campaigns*

A range of views emerged on how effective media campaigns were. For example, the message from a “big name in men’s care” in the nineties was considered ineffective, with a call to men to “re-shape their masculinity”.

- *Research*

When asked about research in this field, most participants said that ongoing research is needed.

- *Government*

Two participants commented on how the issue of reducing male suicide by encouraging help-seeking needed not only to be researched more but addressed on a political level with real world solutions.

### ***Category 3: Reluctance to attribute differences to gender***

Many participants were reluctant to generalize about differences between men and women. This phenomenon was not seen in Lemkey et al (2016) but was seen in 13 of the 20 coaches in the Russ et al (2015) study. Although in the present study, 17 of the 20 participants showed evidence of reluctance to identify gender differences, these were – paradoxically - often followed by descriptions of gender differences.

#### ***Subcategory 1: Gender differences are simply a product of culture***

Many participants viewed gender differences as a result of nurture, not nature.

#### ***Subcategory 2: "It's a massive generalization, but..."***

Six of the participants suggested they had noticed sex differences and offered no explanation as to why they existed.

*"...They quite often look for a shorter-term solution, something that is very practical and that they can manage and deal with as opposed to er, really going back over historical*

*issues and trying to explore the past in greater detail. I mean these are sweeping generalisations but...*” [P8]

### ***Subcategory 3: It’s personality, not gender***

Some therapists reported seeing individual or personality differences rather than gender differences.

## **DISCUSSION**

There are several potentially beneficial practical applications of the findings, from how to use language that will increase male uptake of therapy (e.g. reframing therapy as ‘strategies for living’), how to listen (e.g. allow for some off-topic talk), and the initial aim of therapy itself (e.g. solution focused rather than emotion focused). The *port of entry* finding is novel in suggesting that although men might benefit as much from discussing emotions as women do, this might best be achieved indirectly. For example, by starting treatment talking about non-emotional issues, or by taking a solution-focused approach.

An interesting divergence of views emerged over the issue of whether masculinity is causal in creating psychological problems for men (e.g. pressure not to look weak by seeking help), or whether it is a legitimate world-view that can be harnessed to achieve the goals of therapy. Masculinity as described by the traditional male gender script (Seager, Sullivan & Barry, 2014b), is basically a set of values to encourage men to stoically strive to provide for and

protect their families. As with many beliefs and values, they are probably benign unless too rigidly adhered to (Ellis, 1962).

An interesting aspect of the study was that although all participants reported at least one gender difference in therapy, 80% appeared to show reluctance to attribute differences to gender. This finding is very similar to Russ et al (2015). Although it would be unreasonable to expect people not to contradict themselves during an interview, it is interesting to find different people contradicting themselves over the same issue.

A popular and strongly held view in the social sciences today is the *gender similarities hypothesis* (Hyde, 2005). The hypothesis suggests there are more similarities than differences between men and women. The fact that Hyde's paper has been cited over 2000 times in just over a decade testifies to its influence in academia. It should not therefore, be surprising that people who are educated in the social sciences tend not to focus on sex differences. When a therapist is asked to describe sex differences though, one might observe some *cognitive dissonance* (Festinger, 1962), as evidenced in our study.

The *gender similarities hypothesis* promotes what Hare-Mustin & Marecek (1988) call *beta bias*, the tendency to ignore or minimise gender differences. This might feed into a culture of not recognising men's needs in therapy and might explain why the sex of clients is so often overlooked in studies of the outcomes of psychological therapy (Parker et al, 2011).

## **Limitations**

Although the findings may be of importance to therapists, the sample in this study isn't representative of therapists in general. In other words, 75% of the sample were male but in

general around 80% of clinical psychologists are female. Also, almost half of our sample had more male than female clients, which is an unusual gender ratio in psychological therapy.

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**Table 1.** Participant demographics and characteristics

#	Sex	Years in Practice	Gender ratio of clients	Type of therapist
1	M	21 - 43	50% M; 50% F	Psychotherapist
2	M	6 - 10	50% M; 50% F	Psychologist
3	M	15 - 20	50% M; 50% F	Counsellor
4	M	21 - 43	80% M; 20% F	Counsellor
5	M	21- 43	80% M; 20% F	Counsellor
6	M	21 - 43	50% M; 50% F	Psychotherapist
7	M	2 - 5	60% F; 40% M	Psychologist
8	M	15 - 20	70% M; 30% F	Counsellor
9	M	21-43	75% M; 25% F	Psychologist
10	F	21 - 43	50% M; 50% F	Psychotherapist
11	F	2 - 5	60% M; 40% F	Psychologist
12	M	2 - 5	60% F; 40% M	Psychologist
13	F	6 - 10	80% F; 20% M	Psychotherapist
14	F	2 - 5	50% M; 50% F	Psychologist
15	M	2 - 5	60% M; 40% F	Psychotherapist
16	M	2 – 5	80% M; 20% F	Psychotherapist
17	M	6 - 10	50% M; 50% F	Psychologist
18	F	6 - 10	80% M; 20% F	Psychotherapist
19	M	6 – 10	50% M; 50% F	Psychologist
20	M	6 – 10	80% M; 20% F	Psychotherapist

Note: to protect anonymity, the number of years in clinical practice has been categorized; # = participant number; M = Male; F = Female

**Table 2.** Categories and subcategories that emerged from participant interviews (N = 20)

<b>Core Category</b>	<b>Category</b>	<b>N (%)</b>	<b>Subcategory</b>	<b>N (%)</b>
<b>Whether nature or nurture, men want a quick fix, women want to explore.</b>	<b>Impact of gender on aspects of therapy</b>	N = 20 (100%)	<b>Client needs</b> Help-seeking Needs in therapy Differences in presentation	N = 20 (100%)
			<b>Setting</b> The therapist Gender-sensitive services	N = 19 (95%)
			<b>Time</b> Stages of therapy Age	N = 15 (75%)
	<b>Impact of society</b>	N = 19 (95%)	<b>Socialization</b> Masculinity	N = 15 (75%)
			<b>Social interventions</b> Media campaigns Government Research	N = 19 (95%)
	<b>Reluctance to attribute differences to gender</b>	N = 17 (80%)	<b>Gender differences are simply a product of culture</b>	N = 8 (40%)
			<b>"It's a massive generalization, but..."</b> Reluctance to generalise while simultaneously describing gender differences.	N = 6 (30%)
			<b>Its personality, not gender</b> Seeing individual or personality differences rather than gender differences.	N = 4 (20%)