Engaging with the emotional lives of men

Roger Kingerlee, Duncan Precious, Luke Sullivan and John Barry consider the design of male-specific services and interventions

If the principal function of health services is to keep people alive and well, then the disproportionately high male suicide rate alone suggests that the needs of men are not being optimally served. Picking up on the theme set out by Linda Morison and colleagues in the previous article of this special feature, it is argued that health services for men can be improved if gender awareness is incorporated into their design, promotion, and implementation.

It seems probable that significantly poorer health outcomes in men must have some basis in meaningful sex and gender differences. There is evidence, for example, that males have different experiences of being parented (Diamond, 2004; Pollack, 1995), and show different behaviours under stress (Kolves et al., 2010) compared to females. Gender for males, as for females, helps to shape life experience and behaviour, impacting most strikingly upon help-seeking and engagement with health services (Sullivan 2011; Sullivan et al., 2014). Sex differences in help-seeking are shown to emerge by around age six (Benenson & Koulnazarian, 2008). By the time of adulthood such differences may crystallise into recognisable patterns of avoidance, both in relation to help-seeking and psychotherapy (Sullivan et al., 2014).

Males tend to externalise distress more than females and are more likely to be destructively violent to themselves or others (Logan et al., 2008). In England and Wales men produce around 80 per cent of antisocial behaviour (UK Government, 2012). Consequently, men’s distress may lead to incarceration rather than psychotherapy (Men’s Minds Matter, 2013).

Yet even when men do seek help there is evidence that less extreme forms of male distress may routinely go unrecognised (Swami, 2012), because men, and those around them, effectively abandon psychological reflection (Kingerlee, 2012). Consequently, men’s psychological needs may go unmet until extreme behaviours come to the attention of the authorities.

Given that men experience and express their psychological needs differently, it is welcome that some innovators are starting to design services specifically to meet their needs. Below we provide some examples from a range of recently developed male-specific services that stretch the boundaries of the traditional ‘talking therapy’ model.

Reaching out to men in need

Little is yet known about how to motivate men to make more use of health services, but some work is starting in this area.

Charity campaigns

In the UK the charities Mind and Samaritans have run campaigns highlighting men’s difficulties in help-seeking and other issues, but the impact of such interventions is still too early to assess.

Action research and community psychology approaches

These methods aim to empower marginalised groups in generating change and opportunity with some promising results for male populations. For example, the Men’s Sheds’ organisation in Australia has helped to engage isolated older men in communal activity through furniture restoration; this is now also being established in the UK. There is also a scheme in Brighton (UK) called ‘A Band of Brothers’, where older males mentor troubled younger men. This scheme has been so effective that strong links have been forged between local youth, probation and police services (www.abandofbrothers.org.uk).

One of us (DP) set up a men’s mental health group in Newmarket with the aim of reducing the barriers to men accessing appropriate mental health services. The initial focus was to gain an understanding of the local issues affecting men and their mental health and then to establish the support of local charities and key stakeholders. Newmarket is renowned as the UK home of horseracing. The
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that may be explained by greater individual contact in the IE group. Above all, as the authors say, significant gains in men’s psychological health occurred via an intervention that, by combining sport and psychotherapy, neatly side-stepped male concerns around formal help-seeking.

**Internet-based services**
Young males are a high-risk group for suicide but also widely use the internet – including for support (Gould et al., 2002; Strasburger et al., 2010). Evidence for the general value of computer-based interventions is beginning to accumulate (e.g. Andrews et al., 2010). Consequently, internet-based services that target young men are starting to emerge. For example, in Australia between 2003 and 2006, Reach Out Central (ROC: http://roc.reachout.com.au/flash) was developed as a ‘serious’ computer game that could help change health-related behaviours (Burns et al., 2010). The design of ROC incorporated various elements, including cognitive behaviour therapy. The game was highly marketed and included young men in its target audience. Focusing on such themes as depression, alcohol use and loss, ROC aimed to help players build skills in communication, problem-solving and optimism, in a virtual but realistic setting (Burns et al., 2010). The results of the intervention were mixed. On the one hand, site uptake figures were quite high. ROC was launched in September 2007, and there were 76,045 website visits, with 10,542 new members joining Reach Out. Moreover, 52 per cent of new members were male. As Burns et al. (2010) say, the advertising campaign was effective. On the other hand, while ROC initially attracted young men, it did not keep them engaged, nor did it significantly impact their symptomology. A single-group, quasi-experimental design with repeated measures of well-being, stigma, and help-seeking (pre-game, post-game, and two-month follow-up) showed that female players became less distressed, and improved in the areas of life-satisfaction, problem-solving and help-seeking. However, there were no significant changes for male players, whose recruitment to the study was lower, and attrition rate from the study was relatively high. Only 88 of the 266 participants (33 per cent) were male; and 22 dropped out before two-month follow-up (Shandley et al., 2010). The ROC game, however, underlines the potential of the internet in reaching younger males – something also recognised in Ireland, where a similar game targeting young men was launched in autumn 2012 (www.workoutapp.ie).

**Male-specific psychotherapies**
Although it is known that men and women can respond differentially to medications such as antidepressants (Bigos et al., 2009), sex differences in the efficacy of psychotherapies have seldom been investigated. What data there is, however, is striking. For example, within the field of infertility counselling it is established that it is ‘essential that infertility counselors be aware of how men and women experience infertility differently’ (Peterson et al., 2012: p.245). In a review of studies of CBT for depression, Parker et al. (2011) found a sex difference in treatment response in a third of the studies, though the reasons for these differences remain unclear and require further investigation. Some clinicians have targeted psychotherapeutic interventions at key aspects of male psychology. One such psychotherapy, developed in the United States, is alexithymia reduction treatment (ART) (Levant et al., 2009). The designers of the treatment argue that male socialisation leads men to develop fewer emotional disclosure can unintentionally present barriers to men.
al. (2009) note, alexithymia could be considered to be an aspect of ‘normative’ or traditional masculinity and as such poses a major barrier to men seeking therapy, getting benefits from therapy and achieving a general relationship satisfaction. ART involves men being guided through in-session and homework exercises aimed at increasing their emotional skills. In a small pilot study, Levant et al. (2009) hypothesised that ART would lower scores on alexithymia, reduce endorsement of traditional masculine ideology and increase willingness to seek psychological help. There were six participants in the treatment group, aged 18–33 years, with an average age of 24. The six-session, manualised intervention included: (1) male emotion socialisation; (2) developing a vocabulary for emotions; (3) learning to read the emotions of others; (4) keeping an emotional response log; (5) practice; and (6) moving to deeper issues. The results were promising. The experimental group showed significant reductions in normative male alexithymia and in the endorsement of traditional masculinity ideology. The treatment as usual group did not show these changes. However, neither group showed significant change in help-seeking. As Levant et al. (2009) admit, there were significant methodological limitations to their study over and above the small sample. Nevertheless, the fact that significant changes of this kind were found does hold some clinical promise for the future.

Conclusion

Traditional models of mental healthcare, with their heavy and implicit reliance on overt help-seeking and on individual face-to-face encounters involving direct emotional disclosure, can unintentionally present barriers to men. Now, perhaps more than ever, we need to provide and promote psychological interventions and services that, drawing on existing scientific and epidemiological evidence, tackle the stigma associated with help-seeking, engage men more effectively in treatment and, above all, at critical points in their existence, help men put life before death.

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The Trainer: Louise Hayes, PhD,
Clinical Psychologist, Orygen Youth Health Research Centre, The University of Melbourne and Private Practice
Louise is a world expert in ACT for young people and the co-author of Get Out of Your Mind and Into your Life for Teenagers: A Guide to Living an Extraordinary Life, the first ACT book for adolescents. Louise is an academic, clinical psychologist and peer reviewed ACT trainer. She has developed ACT with young people and found it is engaging, engaging and makes therapy a shared journey in development. She completed one of the first research trials using ACT for adolescents, she has an active research program in schools, therapy settings, and online. Louise also works in private practice with young people. Find out more at www.actforadolescents.com or www.louisehayes.com.au