

Good evidence-based therapy begins with a coherent and comprehensive theoretical framework for treatment supported by empirical evidence. Smiler provides just that and grounds it in real-world case examples. This is one of the very best books on therapy with men to appear in the past 2 decades and is sure to become a classic.

—**MICHAEL ADDIS, PhD**, PROFESSOR OF PSYCHOLOGY,
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Andrew Smiler has devoted his career to advancing the mental health and well-being of boys and men. From his decades of experience as practitioner and scholar, he provides a highly accessible book that efficiently includes the theory and research needed to better understand this harder-to-engage population. Yet Dr. Smiler's true gift is the rich case studies that clearly identify and illustrate scientifically informed, pragmatic approaches for more effectively helping the diverse men who walk into your office.

—**CHRISTOPHER S. REIGELUTH, PhD**, ASSOCIATE PROFESSOR AT OREGON HEALTH
& SCIENCE UNIVERSITY, PORTLAND, AND AUTHOR OF *THE MASCULINITY
WORKBOOK FOR TEENS: DISCOVER WHAT BEING A GUY MEANS TO YOU*

Andrew Smiler shows us why it is difficult to engage men in therapy, then demonstrates his expertise about men and masculinity through vivid case examples where he connects to the male experience. Any therapist who works with men should read this book to understand how to make contact with the hurting men who would benefit from treatment and how to help them heal.

—**RICHARD GARTNER, PhD**, TRAINING AND SUPERVISING ANALYST, FACULTY, AND
FOUNDING DIRECTOR OF THE SEXUAL ABUSE PROGRAM, WILLIAM ALANSON
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PSYCHODYNAMIC TREATMENT OF SEXUALLY ABUSED MEN*

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1 HELPING THERAPISTS HELP MEN

Men are struggling. Over the past few years, we have heard about the loneliness epidemic among American men. Richard Reeves (2024) wrote about men's lower levels of academic achievement compared with their female counterparts and the implications this has for employment. And that's just the beginning of men's struggles. Men are also more likely to die by suicide (G. S. Liu et al., 2023), or to overdose (Spencer et al., 2024); these deaths may be understood as the result of difficulty dealing with emotional pain. Our stereotypical image of a young adult who is failing to launch is that of a young man who lives in his parents' basement and spends his time playing video games, and when we think about clients struggling to find employment or strong interpersonal relationships because of attention-deficit/hyperactivity disorder or high-functioning autism we typically think about men.

It would be easy to blame "masculinity" for men's struggles. After all, masculinity directs men to be violent, be independent, ignore their feelings, and seek power without regard to how they get it. Some research offers support for the idea that masculinity contributes to men's struggles, with evidence indicating that men who endorse higher levels of masculinity ideology or who experience more gender role conflict have worse mental health, are

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more likely to abuse substances, are more depressed, and are less likely to seek therapeutic help (O'Neil, 2015; Wong, Ho, et al., 2017). Online, I have seen people take these results to an extreme and argue that masculinity in any form is toxic and that men can never be healthy unless American culture substantially redefines masculinity or abandons it altogether.

However, masculinity and men's lives are more complicated than that. The reality is that definitions of masculinity in the United States (and other English-speaking countries) have changed over time, and vary across U.S. subcultures, which tells us that men don't all do masculinity the same way (Majors & Billson, 1992; Smiler, 2019; Stearns, 1979). This multiplicity of definitions is also evident in psychological measures of masculinity (Morawski, 1985; Smiler, 2004).

The issue is further complicated by the awareness that any individual man has the ability to choose the degree to which he adheres to our culture's (primary) definition of masculinity, from not at all to completely, with a million points in between. Research-based scales that define masculinity in positive terms, such as Sandra Bem's (1974) Sex Role Inventory and the Personal Attributes Questionnaire, developed by Janet Spence and Robert Helmreich (1978), originally had scores around the scale midpoint, but those averages increased from the 1970s through the early 2010s (Donnelly & Twenge, 2016; Twenge, 1997). In contrast, measures of masculinity ideology, such as the Male Role Norms Inventory—Revised (Levant et al., 2010) and the Conformity to Masculine Norms Inventory (Mahalik et al., 2003), tend to focus on negative elements of masculinity and have relatively low mean scores (Smiler, 2014; Thompson & Bennett, 2015). Clearly, not all men—and not all researchers—are enacting masculinity to the same degree and in the same ways.

The issue becomes even more complicated when we recognize that many of the well-known large-group differences between men and women are driven by relatively small subgroups of men. Although men, when examined at the large-group level, are more violent than women, it is only a relatively small group of men who perpetrate the vast majority of that violence (Cooper & Smith, 2011; Uniform Crime Reporting Program, 2016). Similarly, as mentioned, men are more likely to die by suicide, but deaths by suicide occur among a relatively small group of men (Liu et al., 2023). In addition, although men are more likely to say they want multiple sex partners in the next 30 days (Schmitt & International Sexuality Description Project, 2003), and report more sex partners in the past year (Dariotis et al., 2008; Humblet et al., 2003) than women do, these findings are also driven by relatively small groups (see critiques by Smiler, 2011, 2013). Although these statistics

indicate that violence and promiscuity are driven by a minority of men, the ideas that any man could become violent and that most men are interested in sex, but not relationships, are common.

Masculinity's complexities don't stop there. Some scholars have argued that the psychology of men has been dominated by a focus on the negatives and that the field needs to embrace and explore a positive masculinity. Authors such as Mark Kiselica and Matt Englar-Carlson have argued that American definitions of masculinity include a range of positive elements, such as the idea that men demonstrate caring through efforts to protect others; that they demonstrate *action empathy*, by doing things to help others who are struggling; and that they band together for common purposes that promote their communities (Englar-Carlson & Kiselica, 2013; Kiselica, 2010; Kiselica et al., 2016). These scholars believe that most men are fundamentally good, prosocial, and concerned about more than just themselves. Research that has used the positively focused Bem Sex Role Inventory and the Personal Attributes Questionnaire supports this position: Men (and women) with higher masculinity scores report a range of positive outcomes, such as greater self-esteem (Bem, 1993).

When we consider this research collectively, we can see that masculinity is a complicated subject and that men's adherence to masculinity—whatever that might mean to them—is also complicated. In order to work effectively with men in a therapeutic setting, we clinicians need a better understanding of what masculinity is, how men understand themselves, and how to apply this knowledge. That is my goal for this book. I want to expand how you think about men and masculinity and help you move away from cultural stereotypes so you can meet your male clients where they are and recognize the positive and negative components of their masculinity.

CHALLENGES MEN FACE WHEN STARTING THERAPY

Despite the struggles men face, they are less likely than women to attend therapy and less likely to return for a second session even when they do make it to a therapist's office, in the United States and around the world (Addis & Mahalik, 2003; Gough & Novikova, 2020). Recent data from the Substance Abuse and Mental Health Services Administration (SAMHSA; 2021) indicate that less than 10% of adult men report having used any type of mental health service—psychiatric medication, outpatient therapy, or inpatient therapy—in the prior year, a rate that is approximately half of women's use. Usage rates also vary across racial and ethnic lines, poverty status, and insurance

coverage (SAMHSA, 2021). Men report that the top three reasons they do not seek mental health services are (a) lack of insurance/cost, (b) structural barriers, and (c) stigma.

Stigma, which we might also think about as shame, may be a particularly strong reason for men to avoid therapy. American expectations of men, and stereotypes about men, position men as being rational, self-sufficient, strong, in control, and able to solve problems—and certainly not controlled by their feelings! In the United States, young men are taught to “take it like a man” and “play through the pain.” In order to schedule an appointment with a therapist, and then arrive for that first session, a man needs to acknowledge that he is not meeting expectations in at least one of these areas. In effect, he will need to overcome his own expectations of himself as a man before he can begin to seek support for his mental health needs (Addis & Mahalik, 2003; Real, 1997).

Many people imagine that therapy consists of talking about deep feelings that elicit sadness and tears, or otherwise bearing one’s soul. The imaginary interactions probably involve a lot of eye contact while sitting in an intimate setting that has comfortable seating and soft lighting. This exercise in sharing feelings while making eye contact in a comfortable setting fits into masculine conceptions of (heterosexual) romance—it doesn’t fit into current-day masculine conceptions of friendship or getting help with a problem. These conflicting images of therapy and expectations of appropriate male behavior create a bad fit between therapy and male socialization (Rochlen & Rabinowitz, 2014).

The SAMHSA (2021) report indicated that structural barriers are the second most common reason men do not seek therapy, after insurance coverage/cost, which is the most common reason. For men who are their family’s primary (or only) breadwinner, arranging time off work to meet a therapist may carry a real financial cost. These concerns are magnified for men with relatively low incomes. (This financial dynamic is one of the few ways the gender wage gap adversely affects men.) Asian men may be particularly concerned about lost wages because of the importance they place on supporting their families (Iwamoto & Kaya, 2016).

Among men who do not control their work schedules, who are required to use sick time in half-day increments (instead of hour by hour), or who need to formally ask for time off from a supervisor, leaving work to see a therapist during the work day can be that much more costly and stigmatizing. Travel time to see a therapist, which can be lengthy if one has to use public transportation or resides in a rural area, further compounds the costs and is evident in the racial and ethnic disparities SAMHSA (2021) reported. Those concerns are further exacerbated if he needs to request time off on a regular

basis, even if only for a short-term course of therapy that lasts six to 10 sessions. Although virtual (e.g., Zoom) sessions can ameliorate some of these challenges, they are not sufficient to address all of them.

CREATING A GOOD FIRST SESSION

If a man is able to overcome his own shame, the logistical problems, and the financial concerns, he then needs to find a therapist who seems like someone he can work with (and hope that therapist has availability in their schedule). Then he needs to have a good experience during that first session and walk away with the feeling that his therapist can and will understand his concerns. It is important that men not leave a therapist's office believing "You just don't understand," a thought that is consistent with linguist Deborah Tannen's (1990) description of male–female differences in communication patterns.

Creating a good therapeutic relationship—which entails connection, comfort, and confidence between client and therapist—requires *cultural competence*, defined as the development of knowledge, awareness, and skills relevant to a specific cultural group. To be explicit, I am referring to cultural competence in working with men. Psychologist William Liu provided the rationale for doing so in a 2005 article in the *Journal of Clinical Psychology*. He observed that "Men are socialized in a specific culture, with values, norms, customs, and expectations, to which men must adhere" (Liu, 2005, pp. 685–686). The need for cultural competence is exacerbated by the fact that most therapists are female and thus were not raised in masculine cultures. The demographics of the field of clinical and counseling psychology and its student body suggest that the problem will get worse before it gets better. The percentage of male therapists will almost certainly decrease for at least the next 10 years because the majority of students entering the field are female, and the generation currently retiring has a higher percentage of male therapists than the generation replacing them (American Psychological Association [APA], Boys and Men Guidelines Group, 2018; APA Task Force on Race and Ethnicity Guidelines in Psychology, 2019; Salsberg et al., 2017).

APA recognized men's needs when they approved their first set of *Guidelines for Psychological Practice With Boys and Men* in 2018 (APA, Boys and Men Guidelines Group, 2018). In contrast, the first set of guidelines for work with women and girls was published in 2007 (APA, 2007) and updated in 2018 (APA, Girls and Women Guidelines Group, 2018); for lesbian, gay, and bisexual clients the first guidelines were published in 2000 (APA, 2000) and

updated in 2021 (APA Task Force on Psychological Practice With Sexual Minority Persons, 2021); and, for transgender and gender nonconforming people, the first guidelines were published in 2015 (APA, 2015).

The 10 guidelines provided in the *Guidelines for Psychological Practice With Boys and Men* (APA, Boys and Men Guidelines Group, 2018) consistently call for the need for psychological services that are sensitive to masculinity (as the male gender role), the unique ways in which boys are raised, and the need to tailor services accordingly. This book specifically fulfills Guideline 9, which states “Psychologists strive to build and promote gender-sensitive psychological services” (APA, Boys and Men Guidelines Group, 2018, p. 17), as well as several other guidelines.

Several authors have recognized and attempted to articulate what male-friendly therapy could look like. Some have written about ways of accepting the client’s concerns, awkwardness, and communication difficulties in the clinical setting (Kiselica et al., 2016; Wexler, 2014). Others have argued for using action-oriented language that can help create momentum, build a sense of efficacy, and tap into men’s orientation toward problem-solving and task completion (Brooks, 2017; Rochlen & Rabinowitz, 2014). Still others have emphasized the use of colloquial language, humor, and metaphors men are likely to be familiar with (Bhatia, 2014; Kilmartin, 2014). In the seven case studies presented in Chapters 3–9, you will find examples of these strategies.

Zac Seidler et al. (2018) reviewed the literature and identified three common themes across all of the above-mentioned suggestions. One theme was building rapport and a collaborative relationship. Strategies here include adopting a strengths-based approach that includes positive aspects of manhood and masculinity as well as appropriate self-disclosure by the therapist. Each of the case study chapters (i.e., Chapters 3–9) describes the strengths associated with the masculine role highlighted in that chapter.

Another theme Seidler et al. (2018) identified was clarifying the structure or “how” of therapy. This theme includes explanations of how therapy works, including the road map for treatment and specification of short- and long-term goals. Every case study in this book includes a discussion of treatment planning. At a minimum, I ask clients if they want to use therapy time over the next several sessions to address an issue, often with a discussion of the potential benefits and likely challenges of doing so. Some of those discussions are as simple as asking clients if they would prefer to address Issue A or B first.

The final theme Seidler et al. (2018) identified is related to tailoring language to male clients. They observed that many authors emphasize the importance of using language that is action oriented, future focused, and

progress driven in order to increase motivation and reduce shame. These strategies often contribute to a problem-solving framework. The sample dialogue in each chapter of this book illustrates this approach, in particular with respect to ways in which the therapeutic conversation is often oriented toward identifying and solving problems, while also providing sample dialogue that does not rely on the explicit discussion of emotions. The linguistic pairing of problem-solving strategies and reducing the focus on emotion is consistent with the idea that many men prefer therapy that is more focused on problem solving to improve a difficult situation instead of learning to cope with that difficult situation.

LAYOUT OF THIS BOOK

My goal for this book is to help you, as a clinician, become more culturally competent in working with men. I do this by explaining and illustrating some elements of masculinity that American culture positions as important elements of how men should be. I focus heavily on ways to conceptualize your work with male clients, given that the authors cited in this chapter have offered a broad range of suggestions for facilitating those interactions.

In the next chapter, I provide a way of understanding and thinking about masculinity: the multi-faceted masculinity framework (MFMF). The MFMF is useful because it taps into a range of psychological and sociological approaches to gender and brings them all together to gain a more thorough understanding of the range of ways that we therapists, and the male clients we serve, might understand masculinity. If Jim thinks his masculine behavior is driven by his beliefs about masculinity, the MFMF explains why. If Neil thinks trying to be what society considers a Real Man is inherently stressful because masculinity has competing directives, the MFMF explains why. And if Ray believes there is a hierarchy of masculinities, and that U.S. culture rewards some versions of masculinity more than others, the MFMF explains why.

The next several chapters, 3–9, contain case studies of seven men. Given my preference for identity work, I titled the chapters using identities, and the identities I have chosen are centered on specific masculine criteria. In Chapter 3, for example, I talk about the breadwinner identity, which emphasizes the masculine criteria of breadwinning and providing financially for one's family. Similarly, the discussion of the player in Chapter 8 is centered on the masculine criterion of promiscuity.

In each chapter's case study, I introduce a client and describe how I conceptualized my work with that client. In doing so, I identify two themes that

were the focus of our therapeutic work. For one of these themes, I provide additional detail about what makes this particular issue masculine or particularly important for men. I also provide some cultural context and history, including popular or noteworthy examples from the media.

In each chapter, I address mental health strengths and concerns that are common to the masculine identity being presented. I also discuss ways in which intersectional concerns may appear. I focus on intersectional concerns related to race and ethnicity, social class/socioeconomic status, and ability/disability status.

You, the reader, should also know that each of the case studies I present is an amalgamation of two or three clients who had similar underlying concerns and that I use pseudonyms throughout. If I was actively working with a client while writing this book, I obtained verbal consent to use (part of) their story and offered them the option of providing their own pseudonym. APA's (2017) *Ethical Principles of Psychologists and Code of Conduct* do not require me to obtain consent, written or verbal, when using a brief and anonymized description of a client, so I did not reach out to clients who had completed their work with me to obtain their permission. (And, if any of them are reading this, I hope none of them mind.)