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Title:
Challenges working with men: Australian therapists' perspectives

Date:
2021-12-01

Citation:
Seidler, Z. E., Wilson, M. J., Trail, K., Rice, S. M., Kealy, D., Ogrodniczuk, J. S. & Oliffe, J. L. (2021). Challenges working with men: Australian therapists' perspectives. Journal of Clinical Psychology, 77 (12), pp.2781-2797. https://doi.org/10.1002/jclp.23257.

Persistent Link:
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Challenges working with men: Australian therapists' perspectives

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Running title: Therapist challenges working with men

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This is the author manuscript accepted for publication and undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as doi: 10.1002/jclp.23257.

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Acknowledgements

Delivery of this survey was funded by Movember. The authors also wish to thank all participating therapists for their contribution to this research; the detail provided in their responses was hugely beneficial.

Declaration of conflicting interests

The authors declare that there is no conflict of interest.

Data availability statement

The provision of raw data analysed in this study is beyond the scope of the ethical approval provided. Raw data are therefore unavailable for distribution.

Challenges working with men: Australian therapists' perspectives

Abstract

Objective: Emerging research highlights that therapists experience difficulty engaging and retaining male clients in talk therapy. Understanding therapists' challenges when working with men can inform gender-specific training efforts.

Methods: Open-ended qualitative survey data were collected from a sample of 421 Australian-based therapists. Participants described that which they find most challenging about therapeutic work with men. Responses were analysed using inductive thematic analysis.

Results: Three themes were revealed: 1) men's wavering commitment and engagement; 2) males as ill-equipped for therapy; and 3) therapists' uncertainty. Contrasting state and trait constructs, much of the men's state-based wavering

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commitment and engagement was positioned as amenable to change whereas traits assigned men as ill-equipped for therapy and unreachable.

Conclusion: These findings underscore a clear need to better target training efforts to directly respond to the needs of therapists working with men, such that all therapists are well-equipped to meet men with gender-sensitive therapy.

Keywords: Gender; therapist; men's health; qualitative methods; self-efficacy; masculinity

Challenges working with men in therapy: Australian therapists' perspectives

The past decade has seen a significant rise in attention to Australian men's mental health needs and service provision (Smith, Watkins, & Griffith, 2020). Fuelled by high and rising male suicide rates amid a backdrop of men's reticence for mental health help-seeking, health services for men have drawn increasing research focus (Seidler et al., 2020). Upon entering mental health services, many men seemingly overcome various help-seeking barriers that are often associated with masculine socialisation (Berke et al., 2020). Specifically, men's mental health help-seeking can challenge traditional masculine ideals of stoicism, restricted emotionality and self-reliance (Seidler et al., 2016), and *needing* therapy can amplify shame and dependence narratives, thought to be incongruent with masculine socialisation (Wexler, 2013). In addition, when men overcome barriers to care, well-intended help may fail to connect with men's needs (Seidler, Rice, Oliffe, Fogarty, & Dhillon, 2018a). Underscoring these complexities, studies have indicated that a high proportion of men who die by suicide have recently accessed psychological services (NCISH, 2021).

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Contrasting long-standing commentaries that men do not seek mental health help, recent research suggests that a majority of help-seeking men are seemingly more willing to engage with psychotherapy than medication (Kealy et al., 2021). Additionally, Kealy et al. (2021) highlighted that among a sample of men with previous experience in therapy, 59% rated their experience as between neutral and dissatisfying. This highlights the growing importance for the field to focus on the role of the therapist in psychotherapeutic processes to uncover gendered considerations for working with men (Seidler, Rice, River, Oliffe, & Dhillon, 2018c). Importantly, there can be marked differences between clients' and therapists' perspectives, with evidence of only a small-to-moderate correlation between the two perspectives when considering therapeutic alliance (Fitzpatrick, Iwakabe, & Stalikas, 2005). As a result, more recently, men's own experiences in therapy have drawn empirical attention to investigate what works for men in therapy (Seidler, Rice, Oliffe, et al., 2018a; Kealy et al., 2021).

By contrast, examining therapists' perspectives as an avenue to advancing treatment engagement and outcomes for men, has gained scant attention in the research literature. In the few published studies, male and female therapists tended to report some discomfort when working with male clients relative to female clients, and often described men as being unmotivated in therapy, aggressive, abusive, emotionally restrictive and/or deficient (Beel, Jeffries, Brownlow, Winterbotham, & Du Preez, 2018; Johansson & Olsson, 2013; Mahalik, Good, Tager, Levant, & Mackowiak, 2012; Vogel, Epting, & Wester, 2003). Mental health professionals have also been shown to invoke traditional masculinity socialisation in explaining several challenging aspects thought to be emblematic of many men's presentation to therapy, such as late initiations to treatment at the point of crisis alongside expectations for

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rapid improvement (Stiawa et al., 2020). The field has focused on providing recommendations for overcoming these challenges, including an emphasis on collaboration and autonomy, use of strength-based interventions and male-specific language (Beel, Brownlow, Jeffries, & du Preez, 2020; Mahalik et al., 2012; Seidler, Rice, Oliffe, et al., 2018a). However, these recommendations demand approaches to understanding and addressing (rather than simply naming) 'therapy interfering' behaviours. Indeed, the majority of suggestions for working with men stem from individual case studies narrated by clinician experts or specialists in the area (e.g., APA, 2018; Beel et al., 2020; Carr & West, 2013; Deering & Gannon, 2005; Mahalik, 2020; Vasquez, 2006).

Moving forward, inclusively engaging a broad array of therapists working in diverse settings and contexts is key to developing a realistic snapshot of the challenges experienced by therapists in their work with men. Direct questioning regarding the everyday challenges experienced by therapists without specific academic expertise in men's mental health is also needed. This will build on previous literature, alongside ensuring future guidelines can respond directly to these challenges to upskill the practitioner workforce more broadly. This can also inform targeted professional development programs to address any competency needs where possible, and aid in reshaping therapeutic processes and psychological services with men in mind (Beel et al., 2020; Seidler, Rice, Ogrodniczuk, et al., 2019).

Given the current lack of a large-scale needs analysis of therapist challenges in working with men, there is a need to better understand the experiences of a broad range of therapists in working with men, with a focus on practice challenges. The present study reports on Australian therapists' perspectives about challenges when

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working with men. Collected as part of a large, national survey of therapists, the purpose of the current article was to inductively derive themes in therapists reported challenges in therapy with men.

Materials and Methods

Design

The current study reports on data collected as part of a self-report, cross-sectional survey, with a broad focus on therapists' experiences working with men (i.e., engagement strategies used, common help-seeking concerns among men, and among other topics, areas of difficulty when working with men). Participants responded to a mix of quantitative and qualitative items, including several standardised measures. Responses to the open-ended qualitative question, "*In general, what is most challenging about treating male clients, and why?*" were the focus of the current article. As an under-researched area, exploring therapists' perspectives warranted a qualitative inductive approach (Fereday & Muir-Cochrane, 2006; Guest, MacQueen, & Namey, 2011). To gain a "wide-angle picture" (e.g., Toerien & Wilkinson, 2004, p.89) of therapist perspectives, open-text survey responses represented a viable avenue to garner insights from respondents living in diverse Australian geographies and working in a range of professional settings (Braun, Clarke, Boulton, Davey, & McEvoy, 2020).

Participants

Participants in the larger study (N=507 in total) were recruited through paid and unpaid social media advertisements (i.e., Facebook, Twitter), conference and webinar events, organisation newsletters and listservs, and snowball sampling.

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Participants who clicked through to the survey link were provided brief information about the survey (i.e., ~15 minutes to complete, aiming to understand their experiences working with men in therapy), followed by a consent form. Participants were given the option to enter a draw to win one of 20, $100 gift vouchers to incentivise their participation. Ethics approval was obtained from the University of XXX Human Ethics Sub-Committee (#XXX).

A total of 421 therapists completed the open-ended question on treatment challenges in working with men. Respondents ranged in age from 23 to 76 years (*M*=42.39; *SD*=12.07), with the majority self-identifying as female (71.7%, *n*=302), reflecting the gender split of the Australian psychologist, mental health nursing (AIHW, 2021), and social work workforces (AASW, 2021). The main profession represented was psychology (55.1%, *n*=232), followed by counselling (20.0%, *n*=84), social work (14.0%, *n*=59), mental health nursing (5.9%, *n*=25), occupational therapy (2.6%, *n*=11) and psychiatry (1.0%, *n*=4). Most participants reported working in a metropolitan area (65.8%, *n*=277), with the most common workplace being public or community mental health services (40.4%, *n*=170) and private practice (34.4%, *n*=145).

Procedure

The open-ended, two-prong question was piloted with a group of practicing therapists (*n*=10) to ensure that it was understood, answerable and appropriate for the overall survey. The question was presented at the end of the survey. Respondents who skipped the question without entering any information were prompted once to respond and there was no limit on response length. The question was not answered by 86 therapists, leaving a sample of 421 responses.

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Data analysis

In preparation for analysis, the demographic and survey data were downloaded into a spreadsheet. The data were analysed using thematic analysis (TA) which involved a six-stage process of coding and theme development outlined by Braun and Clarke (2006). The aim was to become familiar with the data by reviewing responses in-depth. Basic concepts were then identified using open-coding, and codes were developed and discussed in regular group meetings with three authors (ZS, KT, MW). Cross-comparison of 10% of responses was undertaken by two authors (KT, MW) with any disagreements discussed and consensus reached with a third researcher (ZS). These initial codes were then labelled descriptively and organised into broad themes to aid grouping, defining and differentiating the preliminary findings. For example, several participants discussed the influence of masculinity and social norms in their responses. These items were coded in forms to directly reflect the meaning of the response (e.g., masculinity as a barrier to engagement; perception that therapy "isn't for men"; living up to societal expectations, etc.) During thematic analyses, these codes were subsumed first to a broad subtheme labelled "masculinity" and then further analysed and relabelled "masculine constraints", reflecting therapists' anchoring of socialised masculinity as a barrier to men's engagement. Derived themes were then reviewed by all authors, defined and named, with some themes (including low frequency responses) being subsumed under higher-order themes with clinical or training relevance. To aid rigour and reduce researcher bias, reflexive and analytic memos were developed and adjusted in weekly team meetings to guide the analyses. Finally, consensus for the themes and illustrative quotes were made through author meetings and the writing of the current article.

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Results

Three themes and four subthemes were developed from the data. Theme one details therapists' challenges for engaging and motivating men in therapy, navigating emotional states of ambivalence and/or mistrust invoking a *wavering commitment and engagement*. Sub-themes derived here reflected specificities of therapists' challenges working to engage men who ostensibly 'began' therapy with reticence and seemed resistant throughout the process. Theme two summarises therapists' perceptions of trait-based challenges wherein males were assigned as *being ill-equipped for therapy*. These challenges manifested most strongly in relation to men's emotional ineloquence and lack of insight into their reasons for being in therapy; traits limiting the feasibility of reaching males in a 'foreign' treatment environment. Finally, theme three reflects therapists' reflexive practice challenges for competently handling conflict with some male clients in therapy. See Table 1 for an overview of themes.

The *n*'s reported for each theme refer to the number of individual respondents who listed this challenge, whereas *n*'s within each sub-theme are counts for each time a participant referred to a related construct. Each respondent was counted once in a theme, but multiple times across subthemes. Though the themes (and respective subthemes) are reported as discrete findings, it is important to note that they were interconnected as evidenced by many respondents offering input to more than one theme.

Theme one: Men's wavering commitment and engagement

Two hundred and thirty-seven respondents highlighted challenges pertaining to men's wavering commitment to and engagement in therapy. These instances were

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understood as state-based emotions encompassing men's resistance to engagement that were deemed amenable to change. As a 28-year-old male psychologist shared, theme 1 was made up of "*those moments where you can tell they don't want to be there and you have to fight to keep them engaged.*"

Reluctant Starters

Reluctant starters referred to men entering therapy with reticence from a place of hesitation. This comprised suggestions that many men arrived in clinical settings somewhat sceptical and undecided about the need for being there, states permeated by beliefs that they did not actually need to be helped. Twenty-five therapists referenced some men's misconceptions of therapy as underpinning much of this early reluctance. Therapists reported that many men's adherence to social norms and problematic stereotypes fuelled their pessimism and indecision about being in therapy. These emotional states, while a barrier to the intake process and progress, were nevertheless seen as challenges that could be overcome:

> *Initially, men have some strange ideas about the therapeutic process (mostly derived from movies) so I have to work hard to break these preconceived ideas as quickly as possible…* (Male, 31-year-old, Psychologist).

Many male clients were apparently begrudgingly pressured to attend treatment by a significant other in their lives, according to 22 therapists, and to overcome this, therapists identified that they needed to deconstruct those views to legitimise men staying in therapy.

> *They feel pressured to come due to friends, family, or staff. Breaking down this barrier is certainly the most challenging aspect. If this isn't done in the first*

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session, I know that it is unlikely that they will be back for a second session (Female, 28-year-old, Psychologist).

This challenge could permeate (and truncate) the entire service provision pathway, wherein structural barriers heightened men's uncertainties towards being in therapy. These structural barriers were described by 15 therapists as important to explaining men's reluctance to engage in therapy in the first place (e.g., cost, waitlists, session caps, opening hours and work commitments).

Often the hours of practice [are challenging]. As men don't want to be off work. Or tell others where they are going (Female, 47-year-old, Psychologist).

Resistance once through the door

When the aforementioned entry challenges were overcome, therapists were also tested to convince men to remain engaged in therapy, themed here as *resistance once through the door*. Men's resistance to participating in therapy was noted by 120 therapists, characterised by the clients' therapy-interfering attitudes and behaviours. Noted by therapists among these were male clients' lack of internal motivation (*n*=11), frequent cancellations and subsequent dropout (*n*=18), and apparent disinterest in completing assigned tasks (*n*=63), as typified by the following quote:

Men I see just often would not attend pre-booked appointments, would provide reasons for 'forgetting'. They also often wouldn't do the homework and didn't see the appeal in doing work outside of treatment to assist their progression (Female, 25-year-old, Psychologist).

These men reportedly also often presented with an underlying self-stigma and belief that they were undeserving of help, with the difficulty being in "*convincing men*

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they are allowed to look after themselves and they are not at fault for all problems" (Male, 60-years-old, Nurse Practitioner). Twenty-two therapists linked this resistance to internal feelings of burdensomeness fuelled by stigmatising stereotypes around masculinity.

> *The shame, stigma etc they feel about seeking help in the first place, and how it seems to undermine their perception of being a man* (Female, 35-year-old, Psychologist).

Forty-four therapists discussed how unrealistic expectations about how therapy works, characterised by presuming quick fixes, thwarted many men's buy-in and commitment to the therapy process. It was a common experience for therapists to be challenged by working with men, "*who aren't overly interested in long term gains or genuinely improving at something, but more are looking for a quick solution from me and wish to avoid the actual issue and corresponding distress*" (Male, 29-year-old, Psychologist).

This reluctance for taking part in often time-consuming, proactive or exploratory work in therapy, combined with high expectations for swift outcomes was understood and often acted on as a means to addressing the complexity and multi-comorbidity of many presentations, "*because you have a heightened sense of urgency to develop the trust and relationship that helps to keep them safe*" (Female, 61-year-old, Psychologist).

Forty therapists reflected on the critical time-sensitive need to establish trust and rapport in the initial stages of therapy with men. As a 43-year-old male psychiatrist lamented, "*trust can be hard won - and easily lost*" and a 27-year-old

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male psychologist cautioned, "*if they lose trust in you, they don't stick around to see if you can make it up*"; triaging trust building was key. The importance of the therapist 'making space' (i.e., having patience and trust in allowing male clients to ease into therapy at their own pace) was also integral in supporting and connecting with men.

> *Most take a long time to trust in opening up, they will tell you everything else under the sun before they'll let you know what is on their heart* (Female, 43-year-old, Social Worker).

Within this sub-theme, some female therapists recognised discordance in their own gendered experiences and that of their male clients as underpinning the complex processes of gaining trust and connection. Recursively, this reflected therapists' accounts of being challenged to relate and effectively communicate with male clients.

> *In my view, as a female clinician, the most challenging part can be the level of trust and connection. Finding the same language with young males, to understand their world and perception, in particular, sexuality identity and relationship issues. Many times, I felt lack of engagement during the session and in general, with the counselling care plan* (Female, 45-year-old, Psychologist).

Theme two: Males as ill-equipped for therapy

While certain aspects of men's behaviour discussed above were deemed amenable to intervention and change, therapists often inferred static trait-based characteristics and sex differences (between males and females) that were seemingly worked around, rather than discussed openly to diffuse their influence in treatment. The second theme encompassed one-hundred and seventy-eight therapists'

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perceptions of males being, to varying degrees, ill-equipped for therapy. As a 41-year-old male psychologist noted, some male clients they see have "*entrenched repression and isolation of affect – in other words, an almost total emotional illiteracy."*

Emotional ineloquence

Thirty-nine therapists described experiencing men's emotional ineloquence. They credited this to restrictive masculine socialisation that limited opportunities to practice open and honest emotional communication. As such, men were said to lack the necessary vocabulary to engage effectively with emotional exchanges required for therapy to achieve change.

> *I think one of the most challenging things can be when male clients struggle to elaborate on their thoughts and feelings. Some male clients may struggle to identify their emotions or respond such as "it feels weird" or "it's odd"* (Female, 25-year-old, Psychologist).

Here, therapists reported that some male clients' rigid and socialised avoidance of their emotional experience acted as a barrier to participation through traditional modes of therapist engagement (e.g., self-disclosure, deep engagement with one's emotional experiences). Many therapists referred to socialised masculinity manifesting in a restraining mask, where male clients had to be encouraged to "*acknowledge and live with emotions, whether positive or negative, rather than masking them, as well as understanding other people's emotions*" (Female, 24-year-old, Psychologist).

In addition, 46 therapists referenced men's estrangement from feelings, suggesting that they experienced male clients as both deeply uncomfortable with

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addressing their emotions, and/or demonstrating "*limited insight into emotional states and connecting deeply with those emotional states*" (Male, 35-year-old, Psychologist).

> *I find their lack of awareness of emotions and feelings challenging. Their ambivalence to exploring their internalised feelings* (Female, 24-year-old, Counsellor).

Lacking insights into issues

Therapists also reflected on men lacking insights into issues including the nature, source or extent of their mental health challenges, and difficulties in identifying their core needs during sessions. Seventy-two respondents outlined male clients' lack of reflection and introspection, as illustrated by a 64-year-old female psychologist who regarded male clients as fundamentally "*not psychologically minded*". Such assertions were also often relative wherein a 32-year-old female psychologist suggested men were "*tougher to crack than my female clients*". This perceived lack of mental health literacy was described as contributing to "*awkward*" and often "*ambivalent*" communication in session.

They can be very passive in sessions (i.e., respond briefly to questions, are not particularly reflective, do not have a real sense of what they want out of counselling but indicate that they want to keep coming back and that it's helpful)... it can feel like a lot of hard work, and it can be hard to see the value for some young men (Female, 31-year-old, Psychologist).This lack of insight into their presenting issue(s) often extended to therapists' challenges around helping male clients understand their contribution to antisocial behaviours. Thirteen therapists noted that an ostensibly

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innate lack of accountability for problematic behaviours exhibited by male clients could render therapy ineffective.

> *Not seeing anger as something they are personally responsible for but rather something that is a natural reaction to others "provoking" them* (Male, 46-year-old, Psychologist).

The influence of masculine socialisation was implicated by fifty-six therapists as a heuristic for explaining the trait-based challenges they experienced when working with men who displayed limited insight into their reason(s) for presenting to therapy. The influence of masculinity culminated for many therapists in the perception that their male clients' presenting concerns were believed to be "*buried under layers and layers of masculine norms*" (Female, 30-year-old, Psychologist), that these norms were *"constantly undermining any progress"* (Female, 27-year-old, Psychologist) and that stereotypes that govern how these men should act "*do not provide them with the language or acceptance to address [mental illnesses]*" (Female, 31-year-old, Psychologist).

The therapists themselves were not immune to gender-based assumptions and similar restraints surrounding masculinity. One respondent reflected that his own masculine beliefs around how male clients should behave might also limit his effectiveness in identifying distress in their male clients.

> *I think what I have found most challenging is the realization of how much of my early practice was gendered and subscribed to popular rhetoric about masculinity that just wasn't true when it got down to the individuals I was*

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working with in the room. When I realized this massive blind spot in my thinking, and in my training, I was alarmed at how much distress and abuse I had overlooked in my male clients (Male, 37-year-old, Counsellor).

Theme three: Therapist uncertainty about establishing boundaries and dealing with conflict

The final theme encompassed evidence of an array of uncertainties experienced by seventy-five therapists in their efforts to establish boundaries and manage various forms of interpersonal conflict in session. Dealing with conflict included instances of anger, aggression, irritability and even violence that challenged respondents' management strategies. Difficulties constructing a therapeutic pathway in response to anger and/or irritability in session were noted by 38 therapists, wherein some respondents lamented that they lacked confidence in working with men who expressed these emotions.

I find that I am ill-equipped to deal with anger/irritability in session. It doesn't happen a whole lot, but I do find myself holding back on digging deeper on some issues with (some) men for fear of invoking this response... (Female, 29-year-old, Psychologist).

For 15 therapists, fear, intimidation and/or threats to safety caused unease in their sessions with male clients stalling or entirely derailing their efforts to engage and lead the treatment process. These fears and anxieties, described by therapists who were almost all women (14/15), reflected their own safety concerns:

I find it difficult to not feel intimidated by adult male clients. Even though I make an effort to remind myself of reasons for irritability, anger, defensiveness in

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session that likely have nothing to do with me, I find I often take it personally and can feel less confident in my abilities when treating them (Female, 30-year-old, Psychologist).A further 16 therapists noted challenges confronting behaviours while maintaining a therapeutic relationship, expressing the difficulty in working through conflict in a timely but patient manner while also continuing to foster what were often times fragile therapeutic alliances. This dynamic was described as a complex balancing act, making the client feel understood prior to attempting directive interventions.

> *At times I find it a delicate balance between letting male clients lead sessions vs maintaining direction towards client goals; and between building rapport vs challenging their patterns of thinking and behaving* (Male, 26-year-old, Psychologist).

Female therapists also consistently referenced challenges in processing (and addressing) some male clients' belittling, derogatory or abusive comments directed at them or women more generally. Wanting to 'call out' these behaviours drew uncertainties for challenging these peripheral yet triggering comments, versus ignoring what was said to avoid an overwhelming emotional response or alliance rupture.

> *Having to balance feminist principles of the work I do (often related to clients who have engaged in sexual offending) with not pushing a feminist stance too hard - some men react poorly to this and I lose them…* (Female, 37-year-old, Psychologist).

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Nine female therapists reasoned that their uncertainties about tactically engaging some male clients was due to transference and countertransference, and the fact that they felt their own gender identities might be marginalized in session. These women noted that they had yet to find effective ways to overcome these tensions.

> *I've had clients tell me that I remind them of their daughter and they would not tell their daughter their problems, I've had them tell me I have no idea what it is like to be a man, I've had them self-censor because I'm female - or conversely, be very upset if I say something that is not feminine - I've had them comment on my appearance, I've been told that some of my male clients only attend because of the way I look. There seems to be a lack of the natural understanding and concept of inherent sameness than when treating female clients* (Female, 31-year-old, Psychologist).

In discussing their difficulties related to holding space for challenging interpersonal confrontations in therapy, some therapists discussed the need for targeted training in handling these situations therapeutically, "*I have little training in dealing with anger…*" (female, 38-year-old, Psychologist) and "*resources or training to deal with masculinity*" more broadly (female, 29-year-old, Psychologist); with one respondent concluding that this would help them "*be more effective in [their] practice with male clients*" (Female, 29-year-old, Psychologist).

Discussion

This is the first published study to explore specific challenges experienced by a diverse sample of Australian-based therapists regarding their work with male clients. Findings here represent insightful, nuanced snapshots into the complex daily

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interactions of therapists who work with men. The study inductively derived therapists' *experiences* of challenges in therapy, providing a benchmark of areas amenable to adjustments in their practice with men. Our approach extends research by Mahalik and colleagues (2012) who reported therapists' endorsement of pre-determined strategy items, by providing respondents opportunities to openly share acumens to where men's challenges might originate (i.e., state and trait) amid reflexively considering the strengths and limits of their own practice. Taken together, the current findings make available important considerations for improving the gendered dimensions of therapist training for working with men.

The three themes highlighted therapists' perspectives of male clients' attitudes and behaviours. This was through somewhat competing lenses reflecting the complexities inherent to working with (and to transform) masculinities. Therapists tended to describe some aspects of men's behaviour (such as emotional inexpression) as trait-based; rigidly socialised and ostensibly inaccessible to change in therapy. In contrast, some components of working with men were viewed through a state lens; while they might impede therapeutic processes, they were amenable to interventions and change through targeted efforts. Also highlighted were the therapists' efforts, biases, fears and discomfort in trying to build relationships with some men, and how their competence and confidence levels (entangled with their own gender identities) might influence their views (and adjustments). The findings suggest that effective therapy with men might benefit from specific skills, awareness and understanding of masculinities on the part of therapists (Seidler, Rice, Dhillon, et al., 2019). Notwithstanding this, it is important to acknowledge that the findings presented here may be influenced in part by what is known about the timing of men's help-seeking. Often due to socialised self-reliance, many men will only seek help as a last resort in

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the context of crisis (Cleary, 2017). The perception of men as challenging clients may in part have been influenced by their experience with men who may present to treatment in a more symptomatically complex crisis state, which could have compounded their perceptions of men's barriers to engagement and emotional reticence or lack of insight.

Principally, these findings affirm the gendered, relational nature of therapeutic interactions. Both client and therapist enter treatment with pre-existing beliefs and assumptions tied to their own and others' gendered identities, roles and relations (Sweet, 2012). Permeating the findings were masculinities, wherein therapists (albeit to varying degrees) were challenged by the gendered dimensions of their work with men. This suggests that while many therapists recognise the potential for men presenting to therapy as reluctant, ambivalent, hostile and/or defensive, the strategies used by the therapist in working to overcome these can, at least in part, prove influential in the ongoing therapeutic relationship. This supports work espousing the importance of therapists working with men to collaboratively support therapeutic change through person-centred treatment hinged on the co-construction of goals and treatment focus and male client's agency in the therapeutic process (Beel et al., 2020; Mahalik et al., 2012; Seidler et al., 2018b).

It is important to acknowledge Australian cultures and the interconnections with masculinities in contextualising the findings. The findings regarding men's emotional guardedness and lack of self-awareness in therapy likely reflect some aspects of normative Australian masculinities (Daraganova & Quinn, 2020; Mahalik, 2007). Specifically, reluctance for introspection, self-disclosure and being helped might be interpreted by therapists (and embodied by male clients) as alignments to

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much valued Australian masculine ideals, particularly given established links between masculine norms and patterns of help-seeking in Australian men (Pirkis et al., 2017). In the absence of comparable empirical insights into provider perspectives about working with Australian men specifically, there is strong potential for culture-informed masculine norms to influence some of the current study responses. Building on this, the findings might be understood as reflecting those cultures, and limited in what they can generalize elsewhere.

Theme one: Men's wavering commitment and engagement

Firstly, therapists noted structural barriers (e.g., cost, waitlists, session caps) that can interfere with men's up-take of, and engagement with treatment. This finding adds to previous literature describing barriers to service access among help-seeking men (Seidler et al., 2019). Previous research has also indicated that men's attitudinal barriers (e.g., likelihood of disclosing distress) had a stronger predictive effect on men's help-seeking relative to structural barriers (e.g., cost; not knowing where to find a therapist; Rice et al., 2020). Taken together, it is clear that both structural and attitudinal barriers (among both male clients and therapists) influence men's engagement with care. This highlights the need to address structure and agency in developing and delivering services tailored to men. Additionally, a commonly-cited challenge among therapists related to perceived barriers surrounding men's wavering commitment to and engagement with therapy. These findings augment previous research highlighting men's accounts of entering what often feels like a 'foreign' treatment environment (Oliffe et al., 2016). This echoes existing calls for therapists to pay specific attention to orienting and educating male clients early in therapy and gaining collaborative agreement on a treatment plan (Seidler et al., 2018b).

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Importantly, descriptions of men's resistance as state-based and amenable to skilled therapy, highlight the need for specific skills to target interventions to achieve therapeutic progress. Yet, this view among some therapists that men are reticent to involve themselves in the more free-flowing, unstructured aspects of therapy, contrasts existing research highlighting that some men prefer open, exploratory therapy as opposed to more structured and goal-oriented treatment (Kealy et al., 2021). Previous qualitative research has reported men's initial discomfort with therapy could not be overcome by prematurely traversing into a treatment plan (Hussain, Mia & Rose, 2020). Rather, as Seidler et al (2018c) suggests, that initial resistance should be affirmed, discussed in the context of masculine socialisation and ideally give rise to appropriate pacing and goal setting of initial sessions. The current study results further underscore the diversity among male clients, where some will desire particularly structured and goal-oriented treatment, while others will prefer open exploration; it is important that therapists are equipped with the skills needed to involve either client in an engaging and effective course of therapy. Akin to Johansson and Olsson's (2013, p. 537) suggestions that therapists working with males experiencing depression had to "act carefully" so as to keep the client on side with therapeutic progress, the current findings highlight the need for therapists' strategies to understand and work with masculinities. Given the widespread descriptions of challenges for establishing connection, it is understandable that many therapists reflected men's therapy-interfering behaviours; repeated cancellations and premature termination of treatment are patterns reflecting men's disengagement with mental health services reported elsewhere (Seidler et al., 2020; Zimmermann et al., 2017). Therapists noted that it can require persistence, patience and appropriate pacing to help some male clients gain the insight required to reach previously unacknowledged

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goals. Given therapists also drew on premature dropout as a consequence of failed engagement, their responses implicated therapy as being time-sensitive with some men; that is, therapists are working within a short window of opportunity to prove both themselves as worthy of men's disclosure, alongside proving the therapeutic environment as conducive to supporting reluctant men's needs. It is important to note that although this challenge is framed as occurring in the initial stages of therapy, building a therapeutic alliance and maintaining engagement is an ongoing process, and clinicians should continually check in with male clients regarding the pace, agenda and collaborative nature of the therapy (Mintz & Tager, 2012).

Theme two: Males as ill-equipped for therapy

Results presented in theme two highlighted that therapists experience particular difficulty with male clients who come to therapy with either restricted capacity to engage with their emotional experiences through language, and/or lack of insight into the nature of their affective experiences and the consequences of their behaviour. Regarding men's emotional capacity, it may seem as though the tone of some responses suggested a degree of gender essentialism, casting men as unilaterally unemotional and "not psychologically minded". Yet what accompanied these responses, were reflections commenting on challenges in helping men to remove the "mask" of their masculine socialisation in order to engage with their emotional experiences. Other respondents commented on challenges in not necessarily helping men to remove the "mask", but being able to bypass this to deliver the therapeutic benefits deemed to be associated with emotional introspection. This suggests that many participants did not necessarily perceive their challenges with male clients to be insurmountable; the result of hard-wired underpinnings that position men as

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categorically unequipped for therapy. Rather, participants seemed to communicate an understanding of the role of masculine socialisation in these barriers, and their trait-based lens for appraising this potentially arose due to the perceived intractability of working with some men with limited emotional language or insight into their issues. In other words, it was the expression of behaviour associated with masculine norms that was perceived as challenging to work with for many respondents, rather than the masculine norms themselves.

For therapists who indicated a perception of rigid socialisation, it is important that they are encouraged to reflect on the extent to which experiences with these ostensibly intractable gendered dimensions might shape what they expect to encounter in therapy with men. Previous literature has communicated that therapists who are not trained to understand and expect diversity in masculinities, can inadvertently reinforce the exact norms they struggle to work against in therapy. This idea has been discussed by Good et al (2005), who reported that therapists' biases regarding masculinity can hinder progress toward the establishment of an effective working alliance with men. Past work examining doctors and nurses perceptions of male patients has also communicated the ways in which traditional masculinity can be critiqued for its role in men's reticence for care, while also being protected through the framing of men who embodied alternative masculinities as deviant (Seymour-Smith et al., 2002). As such, a core component of any future efforts to better equip therapists to work alongside masculine socialisation in therapy should be an exploration of therapists' gendered attitudes, biases and assumptions about "the way men are" in therapy, such that these do not stymie the achievement of effective therapeutic alliances with men. A useful contextual scaffolding to provide therapists with this knowledge is the gender role strain paradigm (GRSP), originally formulated by Pleck (1981; 1995).

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GRSP holds that gender roles are widely-accepted, but largely unattainable standards about the ways in which men should exhibit their masculinity, and the violation of these roles (e.g. expressing vulnerability) is thought to give rise to negative psychological consequences. To avoid this perceived failure, compensatory coping can manifest as some men over-subscribe to 'acceptable' gender-role conformant behaviour (e.g. increased aggression) in order to reassert their masculine status (Pleck, 1981; 1995). Understanding the cyclical pressures facing some men through this GRSP lens and its link with their presenting problems may help therapists reduce barriers to engagement by building a shared understanding and formulation for achieving clinical goals with their male clients.

Deep engagement with one's affective experiences and exploration of one's issues via targeted self-awareness and insight are widely considered to be two core tenets of effective psychotherapy (Greenberg & Pascual-Leone, 2006; Lane & Schwartz, 1992). It is therefore not surprising that in this study, among the most commonly reported difficulties were working with men who have been socialised to have limited emotional vocabulary or emotional insight. Levant (1992) coined the term 'Male Normative Alexithymia' to describe this phenomenon, which unlike true clinical alexithymia was posed as a commonly occurring, subclinical, mild to moderate emotional skills deficit. The current findings broadly accord with this body of literature discussing the difficulty in navigating psychotherapy with 'unemotional' men. Traditionally-masculine men are thought to have less experience and fewer skills when it comes to understanding and linguistically expressing their affective experiences (Good et al., 2005). Additionally, Wong and Rochlen (2005) discussed the process model of emotional expression and non-expression as a useful guide to adapting one's clinical process based on the aetiology of emotional reticence in men.

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For example, men who withhold their emotions due to the evaluation of emotional expression as feminine or negative, might benefit from targeted cognitive therapy to redress these maladaptive cognitions (Mahalik, 2005). Given therapists' perception of some men's paucity of emotional 'skill', it should follow that therapists are appropriately confident and competent in responding to this initial barrier, through targeted, evidence-based training focusing on ways of working with men who are less adept at communicating their affective experiences.

Theme three: Therapist uncertainty about establishing boundaries and dealing with conflict

The therapists reported challenges with establishing boundaries and uncertainty managing conflict in session, specifically dealing with anger, irritability and the threat of violence. Beyond safety concerns, knowing how and when to intervene in working with anger was noted as uniquely challenging for some therapists, reinforcing Mahalik and colleagues' (2012) finding of missed opportunities to validate male anger if and when appropriate, and explore its role for clinical benefit. There exists a growing evidence base appraising anger as a socially-condoned manifestation of depressive symptomatology for many men, deserving of appropriate validation and intervention (Walther et al., 2021). Yet respondents in the present study described feeling ill-equipped in trying to "manage" or "bypass" men's expressions of anger, often perceiving it as a 'secondary emotion' and tending to prioritise trying to find the primary emotion (i.e., shame, guilt) at the 'core' of the issue (e.g., Pascual-Leone et al., 2013). This highlights that men may require unique modes of intervention (e.g., the use of emotional vocabulary aids to help some men identify the language that reflects their 'primary' emotional experience) that are yet to

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be effectively embedded in existing training. Indeed, there is a gap in the anger management intervention research for solo practitioners, as the vast majority of work stems from forensic (i.e., prison) group-based, multidisciplinary settings (e.g. Saunders, 2008), which may not be filtering down to community-level mental health intervention for men.

A key theme noted specifically by female therapists was the difficulty navigating the therapeutic environment alongside sexist or patriarchal attitudes from some male clients. The preponderance of this data may in part be explained by the sample being mainly comprised of women. The tone of responses highlighting this issue was such that many female therapists appeared to try to 'push through' the discomfort of therapy with men harbouring these attitudes. Limited research has focused on the experiences of female therapists working with men specifically (Silver et al., 2018), and those that have, focus on specific subpopulations of men such as veterans (Deering & Gannon, 2005), domestic violence perpetrators (Päivinen & Holma, 2011), and men with borderline personality disorder (Schapiro-Halberstam, Liberta & Josephs, 2019). Drawing on gender relations theory, it appears female therapists in the current study often adopted so-called 'ambivalent femininities' when working with men adhering to challenging socio-political attitudes (Howson, 2006). In order to maintain a sense of progress and ensure their own safety, perhaps female therapists exhibited a tendency to ignore comments which inherently challenged their own personal views. Concurrently however, Schapiro-Halberstam and colleagues (2019) pose in their in-depth case study that successful interventions for overcoming microaggressions towards women may require a degree of assertive confrontation to challenge men's biases against them. This reflects a clear need for further training and research in this area to help strengthen therapists' confidence and competence in

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managing these types of encounters in ways that are consistent with their values, while also supporting therapeutic progress.

Implications

The reflexivity and depth of introspection amongst respondents about their internal challenges working with men highlights how amenable many therapists are to tactic and strategy building in their work. This suggests an openness and readiness to learn amidst a reflective understanding of one's current practice limitations (Knowles, 1984). Additionally, given established understanding of adult learning as predominantly problem-focused (Knowles, 1984), the current findings will ideally inform dedicated training for therapists in engaging and motivating male clients, helping them to identify and understand their emotional experiences, and responding therapeutically to interpersonal difficulty whilst clearly asserting one's boundaries. These findings are a call to action derived directly from the therapists themselves, dovetailing existing research highlighting that some therapists have been found to have poorer clinical outcomes specifically with male clients compared to others (Owen et al., 2009) and that many therapists feel less competent and willing to work with suicidal men than women (Almaliah-Rauscher et al., 2020). Improving therapists' understanding of masculine socialisation as an underpinning factor in men's presentation to therapy and the manifestation of their distress, could have far-reaching impacts in helping therapists achieve positive outcomes with their male clients. Despite an emergent knowledge base of techniques for engaging male clients (Seidler et al., 2018b) and strong support for targeted training in the international scholarly community, such training is yet to be included in formal clinical curricula or on a wide scale in continuing education offerings (Seidler et al., 2019). The current

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challenges expressed by practicing therapists point to some consistent patterns in their experiences with some men that can be widely addressed through the design and dissemination of comprehensive, evidence-based professional training.

Limitations and future directions

Several limitations are noted for the present study. First, it adopted a somewhat unconventional approach to interpreting and reporting a single open-ended qualitative question focussed on therapist challenges. Though drawing free-text responses from a large sample of therapists is novel, it is an established methodology (Braun et al., 2020). Yet there were no opportunities to probe for elaboration reflecting the limits for collecting data via a single item. Additionally, the item used assumed that therapists did experience challenges working with men, where a more neutral item might have been less leading. Yet the survey methodology applied precluded any scope to probe participants' responses, and the focus of the article was on directly cataloguing therapists' challenges to form a needs analysis of areas requiring professional development. The present item therefore represented a worthwhile avenue to distilling the insights needed. Future qualitative studies might aim to test and elaborate on the current findings to distil additional insights, particularly given the Australian-based context limits the reach of the current findings internationally. The relationship between challenges experienced by therapists and particular help-seeking concerns of their clients was not available here. Understanding and comparing challenges experienced by therapists with greater accompanying contextual information (e.g., group comparisons across gender, age, professional experience, treatment modalities) will help to localise future training efforts, ensuring they reach particular sub-samples of therapists experiencing greatest need for

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professional development. It is possible that challenges experienced may differ according to profession and treatment modality (i.e., for therapists applying cognitive-behavioural versus psychodynamic therapy with men), and given this information was not incorporated into the analysis reported here, future studies should aim to assess for differences according to these factors. Finally, were these results to be considered alone, this could unintentionally contribute to the rhetoric that many men simply cannot be helped in therapy. It is important to note that this is only one side of the story, and these findings should in future be considered in tandem with that which therapists enjoy about working with men in therapy, alongside amplification of success stories, to help motivate therapists to seek out opportunities to upskill in the area and purposefully increase their male clientele.

ConclusionThe current study elucidated challenges experienced by a diverse sample of Australian-based therapists in their therapy work with men. That therapists were deeply aware and expressive of their challenges for working with male clients highlights the need to better educate and equip therapists to expertly work with a diversity of men. By up-skilling therapists to effectively respond to the diverse needs of male clients, retention and engagement will be bolstered to enhance men's treatment outcomes.

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Table 1: *Overview of Themes and Subthemes*

Theme (n)[a]	Exemplar quote
Men's wavering commitment and engagement (237)	*Engagement. Many I see have a view that a psychologist gives them the answers and fixes things quickly. It's hard to engage them when I start to practice collaboratively and I often wonder if they stop seeing the value in it if it's not a quick fix* (Female, 30-year-old, Psychologist).
Reluctant starters	*High expectations regarding change, progress and solutions... scepticism about the value of the process generally and whether this is worth the time/money* (Male, 34-year-old, Psychologist).
Resistance once through the door	*Some clients are uncomfortable with being vulnerable in the therapy space, making them resistant to therapy. I find young male clients, in particular, the most challenging to engage* (Female, 25-year-old, Psychologist).
Men as ill-equipped for therapy (178)	*Emotional restriction, rigid thinking and set patterns of [behaviour] and communication, poor insight, not psychologically minded at times* (Female, 64-year-old, Psychologist).
Emotional ineloquence	*Some young men may have limited emotional literacy which can make therapy challenging as it requires the time to build the very basic foundation for therapeutic work* (Female, 27-year-old, Psychologist).

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Lacking insights into issues	*I find that men have more difficulty understanding and expressing their emotions so it can take a lot of digging, time, questions and reflection to understand what's going on for them. I feel that there is more risk of not understanding the problem or being able to connect* (Female, 30-year-old, Psychologist).
Therapist uncertainty about establishing boundaries and dealing with conflict (75)	*Indirect anger (sarcasm, constant negative comments about the dynamics within the room), and less often, direct anger, in a group setting. Also, belittling comments about women (e.g. about 'middle age women', when I am a woman who is facilitating a group), and power plays for dominance in a group setting* (Female, 46-year-old, Psychologist).

Note. [a] Counts reflect the overall number of therapists reporting at least one item encompassed by each theme. Counts are not provided for subthemes given overlap among therapists across items within subthemes.

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