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Approaches to Engaging Men During Primary Healthcare Encounters: A scoping review

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Abstract

Gender-responsive healthcare is critical to advancing men's health given that masculinities intersect with other social determinants to impact help-seeking, engagement with primary healthcare, and patient outcomes. A scoping review was undertaken with the aim to synthesize gender-responsive approaches used by healthcare providers (HCPs) to engage men with primary healthcare. MEDLINE, PubMed, CINAHL, and PsycINFO databases were searched for articles published between 2000 and February 2024. Titles and abstracts for 15,659 citations were reviewed, and 97 articles met the inclusion criteria. Data were extracted and analyzed thematically. Thirty-three approaches were synthesized from across counseling/psychology, general practice, social work, nursing, psychiatry, pharmacy, and unspecified primary healthcare settings. These were organized into three interrelated themes: (a) tailoring communication to reach men; (b) purposefully structuring treatment to meet men's health needs, and (c) centering the therapeutic alliance to retain men in care. Strength-based and asset-building approaches focused on reading and responding to a diversity of masculinities was reinforced across the three findings. While these approaches are recommended for the judicious integration into health practitioner education and practice, this review highlighted that the evidence remains underdeveloped, particularly for men who experience health inequities. Critical priorities for further research include intersectional considerations and operationalizing gender-responsive healthcare approaches for men and its outcomes, particularly at first point-of-contact encounters.

Keywords

men, primary healthcare, engagement, alliance, doctor-patient

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Globally, males are twice as likely to die prematurely than females, and those who are socially, economically, and geographically disadvantaged shoulder a disparate health burden (Baker & Shand, 2017; Dobson, 2006; Global Burden of Disease 2017 Disability-Adjusted Life Years & Health-Adjusted Life Expectancy Collaborators, 2018). While there have been health-promotion investments encouraging men to seek help over the past two decades (MacDonald et al., 2022; Robertson et al., 2013; Smith et al., 2018), there has not been an equivalent level of investment to structurally improve the accessibility and responsiveness of primary healthcare services for men. Men continue to fall through the cracks

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after they engage in healthcare because their interactions do not immediately meet their needs (Lefkowich et al., 2017; Seidler et al., 2020).

Gender is a social determinant of health that affects men, which has implications for health systems and service design (Hawkes & Buse, 2013). While masculinities vary, research consistently connects men's conformity to traditional masculine norms to their poor engagement with healthcare, even when men seek professional help (Galdas et al., 2005; Mahalik et al., 2012; Seidler, Wilson, Kealy, et al., 2021). Men's propensity for nondisclosure, rationality, objectivity, and the need for control in healthcare encounters are offered as explanatory notes for men's reticence to "being" helped (Noone & Stephens, 2008; Seidler et al., 2019; Tremblay & L'Heureux, 2005). However, research has pointed to a need to adapt our primary healthcare services to be more engaging for men, rather than place all the onus on individual men to seek out and connect with "foreign" healthcare services (Seidler, Rice, Oliffe, et al., 2018). Notably, traditional masculine norms can challenge practitioner applications of person-centered care, within primary healthcare settings, that aim to establish connection, trust, and mutual understanding (Malcher, 2009; Novak et al., 2019). Person-centered care represents the core foundation of student and health professional education and practice competency standards (Dielissen et al., 2012; Gerteis et al., 1993; Gillon, 2008), yet this education is rarely delivered with necessary gender considerations.

Gender-responsive healthcare is idealized as purposefully responding to the depth and diversity of people's gendered health and illness experiences to optimize their outcomes (World Health Organization [WHO], 2016). Gender-responsive healthcare also connects gender with other social determinants to tailor services to address social inequities (Manandhar et al., 2018). Notwithstanding the critical need to invest in gender-responsive healthcare for women (Hay et al., 2019; McGregor et al., 2019), developing a gender lens for men's health is key to improving boys' and men's engagement and retention in and outcomes of health (Bedi & Richards, 2011; de Oliveira et al., 2015; Hawkes et al., 2020; The Lancet, 2019). Mainstreaming gender-responsive healthcare for men through workforce upskilling might usefully reframe what is currently a sub-specialty as a core competency for all healthcare practitioners (HCPs).

These somewhat lofty hopes can be advanced with a review of the current knowledge regarding HCP approaches that lead to effective engagement with men across primary healthcare settings. While such a review has been previously undertaken, this was limited to healthcare settings where men underwent psychological treatment (Seidler, Rice, Ogrodniczuk, et al., 2018). In this previous review, tailoring language, clarifying treatment structure, and building a therapeutic alliance were considered key practices. The aim of this study therefore was to undertake a scoping review to integrate and synthesize the literature on approaches to engaging with men used by HCPs across a range of primary healthcare settings.

Methods

Protocol and Registration

The review and reporting methodology followed the recommendations of Peters et al. (2020) and the PRISMA extension for scoping reviews (PRISMA-ScR) reporting framework (Tricco et al., 2018). Each of the five incremental steps in the scoping review framework of Arksey and O'Malley (2005) was also followed. First, the research question for the review was identified, followed by the relevant studies for the review being identified. Next, the eligible studies were selected, with the data from those studies extracted, charted, and tabled. Finally, the results were collated, summarized, and reported.

The research question developed to guide the review was: What are the key approaches for engaging men during primary healthcare encounters? Primary healthcare settings were defined as healthcare settings provided as part of national health systems that are the first level of contact for individuals and families (WHO, 2023). Healthcare delivered through community-based health-promotion programs was excluded. A healthcare encounter was defined as a formal interaction between a man (as a patient/client) and an HCP, be it a dyadic, couple, or group-based encounter, in a healthcare setting.

HCPs included medical doctors, nurses, and allied health practitioners, including social workers, psychologists, and pharmacists, as well as students and trainees working in direct contact with patients/clients. Engagement was defined as the "processes of building the capacity of patients, as well as healthcare providers, to facilitate and support the active involvement of patients in the care process, to enhance safety, quality, and people-centeredness of healthcare service delivery" (WHO, 2016). As per the definition adopted by Seidler, Rice, Ogrodniczuk, et al. (2018), the care process refers to variables clinically relevant to the interactions between the man and the HCP. These include (a) attitudes, behaviors, and experiences of men; (b) attitudes, beliefs, and behaviors of HCP

(therapeutic stance); (c) the nature of the dyadic interaction (therapeutic alliance); and (d) the treatment environment and atmosphere. The protocol was registered prospectively with the Open Science Framework on February 8, 2023 (https://doi.org/10.17605/OSF.IO/85WPG).

Eligibility Criteria

Article inclusion criteria were (a) focus predominantly or entirely on adolescent and/or adult men, (b) study sample including men, HCPs, an expert, or an expert panel; (c) encounters or interactions involving men in primary healthcare settings; (d) peer-reviewed published journal articles of primary (original) research, case studies, reviews, commentaries, or opinion pieces or editorials; (e) published in English language; and (f) published from 2000 to February 2024.

Information Sources and Search

The search strategies were initially prepared by the authors and conferred with an experienced university-based librarian and further refined through team discussion. Articles were identified through four electronic databases (OVID Medline, CINAHL, EMCARE, and APA PsychINFO). A search strategy was iteratively devised for use with Medline and the syntax adapted for the other databases. Both MeSH thesaurus terms and free text words were used. Additional articles included were extracted from the reference lists of identified articles or those recommended by expert colleagues. The final search strategy for Medline is provided in Supplemental Tables 1 and 2.

Selection of Sources of Evidence

Search outputs were imported into Covidence systematic review software (Veritas Health Innovation, Melbourne, Australia, available at www.covidence.org), and duplicates were removed. Two researchers independently screened titles and abstracts and selected articles based on study eligibility criteria. Dual screening was performed on 30% of articles initially, and having achieved less than 5% disagreement on screening decisions, single reviewer screening proceeded thereafter. Discordant screens were resolved by consensus with a third reviewer. For the second stage of the review, full texts of the selected articles were assessed for eligibility by two reviewers and checked for accuracy by a third reviewer.

Data Charting and Items

The extracted data for charting included author(s), year, location of study, study design and type of evidence, and primary healthcare setting and primary health discipline (Table 1). The study population characteristics (sample size, average age, sub-population group), theoretical orientation of intervention (where applicable), and recommended engagement strategies/practices were also extracted. To understand nuances in approaches for different settings, articles were further categorized according to whether they described engagement with men in long-format healthcare encounters, typically occurring in dedicated mental health (counseling/psychology, psychiatry) and social work settings, or typically short-format encounters, namely medicine, nursing, pharmacy, and paramedicine settings (e.g., general practice or pharmacy consultations). Seven articles that could not be categorized were excluded from this sub-analysis (Table 1).

Synthesis of Results

Given the review scope and objective, an inductive thematic synthesis (Braun & Clarke, 2021) guided the analyses. Inductive derivation of codes was guided by a previous scoping review (Seidler, Rice, Ogrodniczuk, et al., 2018) in distilling and discussing key themes and approaches. Using NVivo (Version 12; 2018) to organize the data, thematic synthesis was undertaken to identify recurrent and unique themes. For this, two researchers read and annotated all articles, coding for common content relating to distinct engagement approaches with male patients (or clients). The coded approaches were then iteratively grouped to themes based on their overall focus (e.g., practitioner insight) or robustness of the results. The coding was reviewed by a third independent researcher, and changes were discussed to reach consensus. The coded results were tabulated, and a conceptual categorization of engagement approaches was then derived and presented with illustrative examples.

Results

The search strategy generated 15,639 references (Figure 1), and 20 references from other sources (reference lists of selected articles and colleague recommendations) were selected. Following removal of duplicates and abstract screening, 171 articles underwent assessment of the full text, resulting in 97 eligible articles for review (Figure 1 and Table 2).

Table 1. Summary of Included Articles

#	Article	Type	Primary research participants *N* (men or HCPs) age range or average age of men—years sub-group of men	Disease/condition	Primary healthcare—discipline
1	Adams et al. (2008); New Zealand	Primary research: Qualitative	*N* = 50 (men) Gay men	NS	Medicine—General Practice
2	Apesoa-Varano et al. (2010); USA	Primary research: Qualitative	*N* = 20 (HCPs) Older men	Depression	Medicine—General Practice; Nursing; Counseling
3	Bedi and Richards (2011); USA	Primary research: Quantitative	*N* = 37 (men); age range = 19–55	General mental health	Counseling
4	Blundo (2010); USA	Review	-	NS	Social work
5	Boerma et al. (2023); Australia	Primary research: Qualitative	*N* = 67 (HCPs)	General mental health	Counseling, psychiatry, social work
6	Brownhill et al. (2003); Australia	Primary research: Mixed methods	*N* = 74 (men) *N* = 14 (HCPs) Mean age = 53	General mental health	Medicine—general practice
7	Bryde Christensen et al. (2023); Denmark	Primary research: Qualitative	*N* = 7 (men); age range = 28–54	General mental health	Counseling
8	Buitenbos (2012); Canada	Primary research: Ethnography	*N* = 1 (man)	General mental health	Counseling
9	Calabrese et al. (2022); USA	Primary research: Qualitative	*N* = 36 (men) *N* = 27 (HCPs) age range = 18+; Black men; sexual minority men	HIV/AIDS	Medicine—general practice; nursing
10	Campbell et al. (2010); Canada	Primary research: Mixed methods	*N* = 73 (men); age range = 18+	Domestic/family violence	Not specified
11	Canuto et al. (2018); Australia	Primary research: Qualitative	*N* = 19 (men) Age range = 19–65 Aboriginal and Torres Strait Islander men	NS	Medicine—General Practice/ Aboriginal Health Service
12	Chen and Dognin (2017); USA	Case study	*N* = 1 (man) Age = 57 Veteran	General mental health	Counseling
13	Cheshire et al. (2016); United Kingdom	Primary research: Quantitative evaluation	*N* = 102 (men) Median age = 41	General mental health	Medicine—general practice
14	Chovanec (2014); USA	Primary research: Qualitative	*N* = 14 (men) *N* = 8 (HCPs)	Domestic/family violence	Social work
15	Cochran and Rabinowitz (2003); USA	Review	-	Depression	Counseling
16	Cochran (2005); USA	Review	-	Depression; general mental health; alcohol/drug problems	Counseling
17	Cotter et al. (2023); USA	Commentary	-	General mental health	Counseling

(continued)

Table 1. (continued)

#	Article	Type	Primary research participants *N* (men or HCPs) age range or average age of men—years sub-group of men	Disease/condition	Primary healthcare—discipline
18	Danforth and Wester (2014); USA	Commentary	Veterans	General mental health	Counseling
19	Dienhart (2001); Canada	Primary research: Quantitative—Delphi	*N* = 36 (HCPs)	General mental health	Counseling
20	Doherty et al. (2017); Australia	Primary research: Qualitative	*N* = 7 (men) Age range = 18–25 Young men	General mental health	Counseling
21	Dvorkin (2015); USA	Commentary	-	General mental health	Counseling
22	Englar-Carlson and Kiselica (2013); USA	Review	-	General mental health	Counseling
23	Englar-Carlson and Shepard (2005); USA	Commentary	-	NS	Counseling
24	Farnbach et al. (2021); Australia	Primary research: Qualitative	*N* = 20 (men) Age range = 18–44 Aboriginal men	Alcohol/drug problems	Medicine—general practice
25	Ferguson et al. (2019); Australia	Primary research: Qualitative	*N* = 30 (men) Mean age = 40	General mental health; alcohol/drug problems	Paramedicine
26	Garfield et al. (2008); USA	Review	-	Alcohol/drug problems; obesity	Not specified
27	Genuchi et al. (2017); USA	Commentary	College students	General mental health	Counseling
28	Gilliam and Hernandez (2007); USA	Primary research: Qualitative	*N* = 18 (HCPs) Black men; young men	Reproductive health	Medicine—general practice; nursing
29	Gillon (2008); Scotland	Commentary	-	General mental health	Counseling
30	González-Prendes (2007); USA	Case studies	*N* = 3 (men) Age range = 32–47	General mental health	Counseling
31	Good and Robertson (2010); USA	Commentary	-	General mental health	Counseling
32	Good et al. (2005); USA	Review	-	General mental health	Counseling
33	Gray et al. (2009); Scotland	Primary research: Mixed methods	*N* = 104 (men) Age range = 23–74	Obesity	Nursing
34	Greif (2009); USA	Commentary	-	Alcohol/drug problems	Social work
35	Griffin et al. (2018); USA	Primary research: Qualitative	*N* = 40 (men) Mean age = 23 Gay men; Black men; Latino men	NS	Medicine—general practice
36	Grove (2012); Canada	Primary research: Qualitative	*N* = 6 (men) Age range = 35–55	Depression	Counseling
37	Guilcher et al. (2016); Canada	Primary research: Qualitative	*N* = 30 (men) Age range = 26–77	Gambling addiction	Social work
38	Hancock and Siu (2009); USA	Commentary	Latino men	Domestic/family violence	Social work
39	Hinton et al. (2017); USA	Primary research: Qualitative	*N* = 15 (men) *N* = 10 (HCPs-clinic staff) Age range = 60+	Depression	Medicine—general practice; social work

(continued)

Table 1. (continued)

#	Article	Type	Primary research participants *N* (men or HCPs) age range or average age of men—years sub-group of men	Disease/condition	Primary healthcare—discipline
40	Jansen (2020); South Africa	Commentary	-	Domestic/family violence	Counseling
41	Johansson and Olsson (2013); Sweden	Primary research: Qualitative	*N* = 10 (HCPs) Young men	Depression	Counseling
42	Johnston et al. (2008); New Zealand	Review	-	NS	Medicine—general practice
43	Kahn (2010); USA	Review	-	NS	Counseling
44	Kealy et al. (2021); Canada	Primary research: Quantitative	*N* = 92 (men) Age range = 20–74	General mental health	Counseling
45	Kierski and Blazina (2010); USA/UK study	Empirical: Mixed methods	*N* = 31 (men) Age range = 25–68	NS	Counseling
46	Kilmartin (2005); USA	Commentary	-	Depression	Counseling
47	Kiselica and Englar-Carlson (2010); USA	Review	Older men; young men	NS	Counseling
48	Kiselica (2003); USA	Commentary	Young men	NS	Counseling
49	Kivari et al. (2018); Canada	Primary research: Qualitative	*N* = 7 (men) Age range = 28–60 Veterans	General mental health	Counseling
50	Kwon et al. (2023); Australia	Primary research: Qualitative	*N* = 76 (men)	General mental health	All mental health—including counseling; social work; psychiatry
51	Leone et al. (2021); USA	Commentary	-	NS	Medicine—general practice, other nonspecified
52	Lømo et al. (2021); Norway	Primary research: Qualitative	*N* = 20 (men) *N* = 15 (HCPs) Age range = 22–60	Domestic/family violence	Counseling
53	Lorber and Garcia (2010); USA	Commentary	Veterans	NS	Counseling
54	Lovett et al. (2017); Australia	Primary research: Qualitative	*N* = 20 (men) *N* = 19 (HCPs)	NS	Nursing
55	Madsen (2015); Denmark	Commentary	-	NS	Nursing; unspecified
56	Mahalik et al. (2003); USA	Review	-	General mental health	Counseling
57	Mahalik et al. (2012); USA	Primary research: Qualitative	*N* = 475 (HCPs)	NS	Counseling
58	Malcher (2009); Australia	Commentary	-	NS	Medicine—general practice
59	Marasco (2018); USA	Commentary	Young men	NS	Counseling
60	Marcell and Monasterio (2003); USA	Commentary	Young men	NS	Medicine—general practice
61	Marotti et al. (2020); United Kingdom	Primary research: Qualitative	*N* = 5 (men) Age range = 16–18 Young men	Depression	Counseling
62	Mitchell et al. (2019); USA	Primary research: Qualitative	*N* = 15 (men) Age range = 50+ Black men; older men	NS	Medicine—general practice

(continued)

Table 1. (continued)

#	Article	Type	Primary research participants *N* (men or HCPs) age range or average age of men—years sub-group of men	Disease/condition	Primary healthcare—discipline
63	Morgan (2001); Australia	Commentary	Older men; young men	Depression	Medicine—general practice
64	Nahon and Lander (2014); Canada	Review	-	General mental health	Counseling
65	Ogrodniczuk and Oliffe (2009); Canada	Editorial	-	Depression	Counseling
66	O'Loughlin et al. (2022); Canada	Primary research: Quantitative	*N* = 178 (men) Veterans	General mental health	Counseling
67	Patel and Barnett (2011); USA	Review	-	NS	Pharmacy
68	Primack et al. (2010); USA	Primary research: Mixed methods	*N* = 6 (men) Age range = 38–65	Depression	Counseling
69	Rabinowitz and Cochran (2007); USA	Commentary	-	Depression	Counseling
70	Reed (2014); USA	Primary research: Qualitative	*N* = 6 (men) Age range = 18–24 Young men	NS	Counseling
71	Reigeluth and Johnson (2022); USA	Case studies	*N* = 2 (men) Black men	General mental health	Counseling
72	Richards and Bedi (2015); USA	Primary research: Quantitative	*N* = 76 (men) Age range = 19–63	General mental health	Counseling
73	Richmond and Levant (2003); USA	Case studies	*N* = 7 (men) Age range = 15–17 Young men	General mental health	Counseling
74	Rosu et al. (2017); Canada	Review	-	NS	Nursing
75	Rubin et al. (2010); USA	Primary research: Qualitative	*N* = 17 (men) Age range = 16–19 Young men	Reproductive health	Medicine—general practice
76	Sagar-Ouriaghli et al. (2020); UK	Primary research: Qualitative	*N* = 24 (men) Age range = 18–31	General mental health	Counseling
77	Scrandis and Arnow (2023); USA	Commentary	-	Depression; general mental health	Nursing
78	Seidler, Rice, Oliffe, et al. (2018); Australia	Primary research: Qualitative	*N* = 20 (men) Age range = 23–64	Depression	Psychiatry; counseling; social work
79	Seidler, Rice, River, et al. (2018); Australia	Commentary	-	General mental health	Counseling
80	Seidler et al. (2019); Australia	Primary research: Quantitative	*N* = 53 (HCPs)	Depression	Psychiatry; nursing; counseling; social work
81	Seidler et al. (2020); Canada	Primary research: Quantitative	*N* = 133 (men) Age range = 19–71	Depression	Medicine—general practice; counseling
82	Seidler, Wilson, Trail, et al. (2021); Australia	Primary research: Qualitative	*N* = 421(HCPs)	General mental health	Counseling
83	Sharp et al. (2023); Canada	Primary research: Qualitative	*N* = 25 (men) *N* = 30 (HCPs) Age range = 27–70	Relationships	Counseling; psychiatry; social work; medicine-general (family) practice

(continued)

Table 1. (continued)

#	Article	Type	Primary research participants *N* (men or HCPs) age range or average age of men—years sub-group of men	Disease/condition	Primary healthcare—discipline
84	Shen-Miller et al. (2013); USA	Commentary	Young men	NS	Counseling
85	Smith et al. (2008); Australia	Primary research: Qualitative	*N* = 36 (men) Age range = 35–80	NS	Medicine—general practice
86	Spandler et al. (2013); United Kingdom	Primary research: Qualitative	*N* = 40 (men) *N* = 1 (HCP)	General mental health	Counseling; social work
87	Spendelow (2015); United Kingdom	Review	-	Depression	Counseling
88	Springer and Bedi (2021); USA, Canada	Primary research: Qualitative	*N* = 18 (men) Age range = 18–66	Depression; general mental health; alcohol/drug problems	Counseling
89	Strange and Tenni (2012); Australia	Commentary	-	NS	Medicine—general practice; nursing
90	Swetlitz et al. (2024); USA	Primary research: Qualitative	*N* = 13 (men) Age range = 26–77	Depression	Medicine—general practice
91	Syzdek et al. (2014); USA	Primary research: Mixed methods	*N* = 23 (men) Age range = 19–57	Depression; general mental health	Counseling
92	Todd et al. (2014); Canada	Review	-	Domestic/family violence	Counseling
93	Tong et al. (2011); Malaysia, Australia	Primary research: Qualitative	*N* = 52 (HCPs)	NS	Medicine—general practice
94	Tremblay and L'Heureux (2005); Canada	Review	-	NS	Social work
95	Westwood and Black (2012); Canada	Editorial	-	NS	Counseling
96	Wischmann (2013); Germany	Review	-	Reproductive health	Counseling
97	Yeazel (2015); USA	Review	Young men	NS	Counseling

Note. NS = nonspecific.

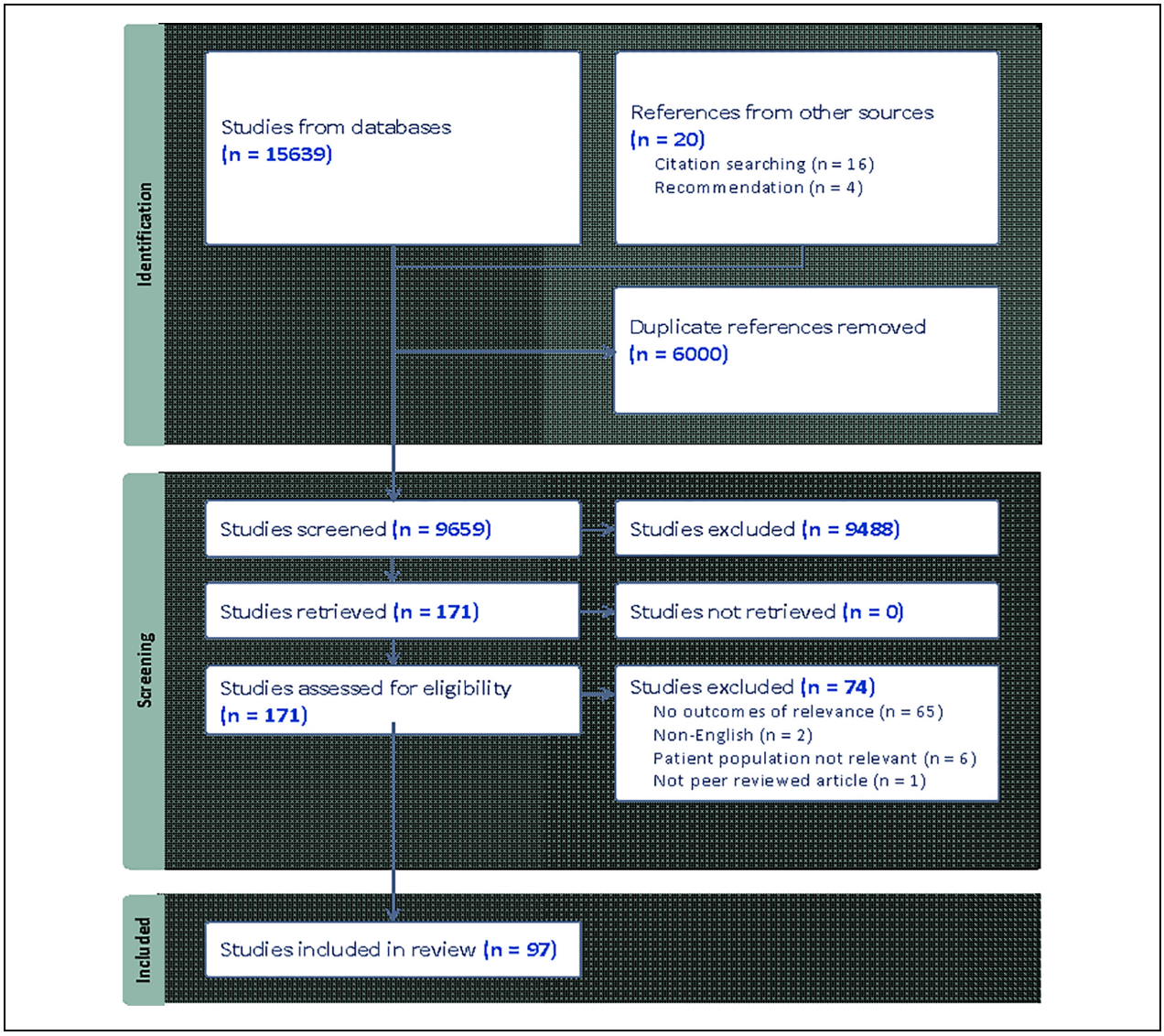

Figure 1. PRISMA Flowchart

Article Characteristics

Year, Author, and Origin of Studies. The included articles (n = 97) were published between 2000 and 2024 and included 88 unique first authors. Half of the studies (n = 49; 50.5%) were from the United States of America (Table 2).

Article and Study Type. Forty-eight articles (49.5%) were categorized as a commentary, review, case study, or editorial. Of the 49 studies reporting primary data, 35 (71.4%) used qualitative methods, and eight (16.3%) used quantitative methods.

Sample and Participant Characteristics. Empirical studies reported data from 1,559 boys and men (patients/clients) and 1,276 HCPs. Sample sizes ranged from 1 to 475. Sixty-two articles (63.9%) were from counseling/psychology settings. Sixty-four (66%) articles focused on healthcare settings with typically long-format (namely counseling/psychology, psychiatry and social work) encounters. Thirty-seven (38.1%) studies were focused on a specific male sub-group, the largest cohort being young men (15.5%).

Synthesis of Evidence

In the 97 articles, 33 approaches were offered for engaging men in primary healthcare encounters (Table 3). The approaches were coded and are detailed in three themes: (a) the tailoring of communication to reach men, (b) purposefully structuring treatment to respond to men, and (c) the centering of the

Table 2. Key Characteristics of Included Articles (N = 97)

Characteristic	n	%
Country/region (lead author)		
USA	49	50.5
Australia	16	16.5
Canada	16	16.5
United Kingdom	7	7.2
Scandinavia	4	4.1
Other	5	5.2
Primary care discipline[a]		
Counseling/Psychology	62	63.9
Medicine—general practice	23	23.7
Social work	13	13.4
Nursing	10	10.3
Psychiatry	5	5.2
Pharmacy	1	1.0
Paramedicine	1	1.0
Not specified	4	4.1
Format of encounter		
Long format	64	66
Short format	26	26.8
Mixed/Not specified	7	7.4
Disease/condition focus[a]		
General mental health	36	37.1
Depression	20	20.6
Alcohol/drug problems	6	6.2
Domestic/family violence	6	6.2
Reproductive health	3	3.1
Obesity	2	2.1
Gambling	1	1.0
HIV/AIDS	1	1.0
Relationships	1	1.0
No focus	29	29.9
Type of study/article		
Primary (original) research	49	50.5
Commentary	24	24.7
Literature review[b]	18	18.6
Case study	4	4.1
Editorial	2	2.1
Primary research study design (*n* = 49)		
Qualitative	35	71.4
Quantitative	8	16.3
Mixed methods	6	12.2
Primary research study population (*n* = 48)		
Practitioners	31	64.6
Consumers	9	18.8
Practitioner & consumer	8	16.7
Sub-group of men in focus[a]		
Men in general	68	70.1
Young men	15	15.5
Veterans	5	5.2
Black American men	5	5.2
Older men	4	4.1
GBTQI+ men	3	3.1
Latino men	3	3.1
Aboriginal and Torres Strait Islander men	2	2.1

[a]Thirteen articles covered two or more disciplines. Five articles focused on two or more diseases/conditions. Six articles focused on two or more sub-groups of men. Cumulative % will therefore exceed 100.
[b]Literature reviews excluded comprehensive (scoping, systematic) reviews.

therapeutic alliance to retain men in care. The key approaches for each theme are described in the following part. Concordance or differences in the approaches extracted for typically long-format encounters and short-format encounters are also summarized.

Theme 1: Tailoring of Communication to Reach Men. Nine engagement approaches themed under the tailoring of communication to reach men, centered on the communication style used by the HCP during the primary healthcare encounter. Communication approaches were offered in 37 (57.8%) articles describing long-format encounters and 20 (76.9%) articles describing short-format encounters (Table 3). The use of informal language and encouraging and enabling men to tell their story and raising issues directly were the most common for both formats. Other language adaptations such as the use of metaphors and male-relevant language were more often approaches offered in the articles describing long-format encounters, whereas the use of informal language was more commonly referenced in articles describing short-format encounters.

The Use of Informal Language. The use of informal language, described in 26 articles (26.8%), served to enhance health messages and helped facilitate a perception of HCPs as "down to earth" (Madsen, 2015), with a "laidback and respectful manner" (Malcher, 2009). This builds trust and mutual respect and establishes a relaxed environment for interactions with men who may enter primary healthcare environments with uncertainty and/or discomfort. This also helps to alleviate men's anxieties and reduce paternalistic healthcare dynamics or historical reticence around help-seeking.

Encourage and Enable Men to Tell Their Story. Approaches that encourage and enable men to tell their story (19 articles, 19.6%) included the use of explorative, open-ended questioning and avoiding checklist-style discussions. This aims to develop "a shared understanding by asking questions rather than dictating answers" (Marotti et al., 2020). It helps to convey a HCP's genuine interest for the men's life, to foster connection. Practitioners who "allow more opportunity to talk more about what else is happening in the man's life" (Morgan, 2001) provide space for the whole man in the room and thus create more holistic healthcare encounters. This approach was also offered by Rosu et al. (2017) with the caveat of time permitting HCPs to do so.

Table 3. Synthesized Engagement Approaches by Theme and (Typical) Format of Encounter

Theme and engagement approach	Number of articles coded (%)		
	All = 97	Long format = 64	Short format = 26
Tailoring of communication to reach men	**62 (63.9)**	**37 (57.8)**	**20 (76.9)**
Use informal language (e.g., humor)	26 (26.8)	13 (20.3)	11 (42.3)
Encourage and enable men to tell their story	19 (19.6)	10 (15.6)	7 (26.9)
Raise issues directly	18 (18.6)	8 (12.5)	9 (34.6)
Use male-relevant language	14 (14.4)	11 (17.2)	1 (3.8)
Use alternative labels for treatment or symptoms	12 (12.4)	9 (14.1)	2 (7.7)
Use culturally appropriate language	7 (7.2)	3 (4.7)	4 (15.4)
Use metaphors	7 (7.2)	6 (9.4)	0 (0)
Use gateway conversations	5 (5.2)	1 (1.6)	4 (15.4)
Focus on nonverbal communication	2 (2.1)	1 (1.6)	1 (3.8)
Purposefully structuring treatment to respond to men	**76 (78.4)**	**56 (87.5)**	**14 (53.8)**
Understanding the influence of gender socialization	31 (31.9)	27 (42.2)	3 (11.5)
Collaboratively set goals	25 (25.8)	20 (31.3)	3 (11.5)
Action-oriented, solution-focused treatment	25 (25.8)	20 (31.3)	2 (7.7)
Seek opportunities to educate about treatment and health	19 (19.6)	15 (23.4)	2 (7.7)
Allow for flexibility, timing, and pace of treatment	18 (18.6)	11 (17.2)	5 (19.2)
Transparently breakdown treatment options, structure, and direction	16 (16.5)	12 (18.8)	2 (7.7)
Explore expectations of roles and responsibilities	14 (14.4)	10 (15.6)	1 (3.8)
Help men access and describe their internal emotional experience	13 (13.4)	11 (17.2)	0
Build a male-friendly space	9 (9.3)	6 (9.4)	2 (7.7)
Build in a treatment feedback process	6 (6.2)	5 (7.8)	1 (3.8)
Employ masculine-sensitive assessment strategies	4 (4.1)	4 (6.3)	0
Centering the therapeutic alliance to retain men	**88 (90.7)**	**63 (98.4)**	**20 (76.9)**
Explore strength-based masculinities	43 (44.3)	35 (54.7)	5 (19.2)
Promote men's autonomy and empowerment	37 (38.1)	29 (45.3)	4 (15.4)
Validate, normalize and encourage men's personal experience	31 (32)	26 (40.6)	4 (15.4)
Accommodating diversity and debility	29 (29.9)	24 (37.5)	4 (15.4)
Meet men where they're at with their openness, motivation and willingness	26 (26.8)	19 (29.7)	6 (23.4)
Listen with empathy	25 (25.8)	17 (26.6)	8 (30.8)
Self-reflect on gender socialization	25 (25.8)	21 (32.8)	3 (11.5)
Build collaborative relationship	22 (22.7)	16 (25)	4 (15.4)
Create a nonjudgmental environment	18 (18.6)	11 (17.2)	6 (23.4)
Allow appropriate self-disclosure	13 (13.4)	13 (20.3)	0
Reinforce confidentiality	13 (13.4)	6 (9.4)	5 (19.2)
Convey confidence and competency	11 (11.3)	5 (7.8)	5 (19.2)
Avoid challenging traditional masculine norms	8 (8.3)	7 (10.9)	1 (3.8)

Long-format articles were classified as articles from disciplines of counseling/psychology, psychiatry, and social work. Short-format articles were classified as articles from disciplines of medicine, nursing, pharmacy, and paramedicine. This classification excludes seven articles that could not be definitively categorized.

Raise Issues Directly. Approaches that favored a "direct and matter of fact style communication" (Smith et al., 2008) style were typically mentioned when working with other men (18 articles, 18.6%). A focus on nonverbal communication was also mentioned as an approach for specific sub-groups of men (2, 2.1%). Malcher (2009) suggested this is important for HCPs working with men from First Nations in general practice, where a "less confronting, side-by-side communication with opportunities for silence and reflection" is favored over a direct approach to raising issues.

Additional Key Communication Approaches. Other approaches included the use of male-relevant language (14, 14.4%), including alternative labels for treatment or symptoms (12, 12.4%), culturally appropriate language (7, 7.2%), and metaphors (7, 7.2%). Metaphors may help bridge men's everyday language to help them describe their symptoms and express their feelings (Dvorkin, 2015). The use of jargon may distance men, especially those who have limited health literacy. It is also important to "ensure information is understood" so as not to reinforce power dynamics (Farnbach et al., 2021). This is especially the case for men who may be living in marginalizing conditions. The integration of male-relevant language, "which respects, and in-part conforms, to masculine norms" (Seidler et al., 2019) was detailed as needing to ensure

cultural responsiveness, recognizing the futility of an essentialist, one-size-fits-all approach to communicating with men.

Insights gained through storytelling and history taking can afford opportunities for gateway conversations (5, 5.2%) to elaborate other health or social welfare issues that might otherwise exist as peripheral and therefore redacted health concerns (e.g., violence, obesity, work-related matters). These conversations provide "a useful tool for interviewing men as it moves from areas of greater to lesser comfort" (Malcher, 2009).

Theme 2: Purposefully Structuring Treatment to Respond to Men. Eleven approaches that were grouped under purposely structuring treatment to respond to men centered on the key elements of healthcare optimally responding to men's healthcare needs. Fifty-three (86.9%) articles from the literature describing long-format encounters offered one or more approaches in this theme. Approaches that were responsive to gender socialization, need for collaboration in care, and tapping into healthy masculinities were each offered in over 30% of these articles (Table 2). Eleven (47.8%) articles describing typically short-format encounters offered approaches in this theme.

Understanding the Influence of Gender Socialization. The most common approach offered (31 articles, 31.9%) in this theme was that HCPs understand the influence of gender socialization (i.e., adherence to masculine norms) on males' health service access, symptom presentation, and interactions with HCPs. This includes understanding "the ways by which the traditional male gender role both inhibits and complicates" (Rabinowitz & Cochran, 2007) the expression of common conditions in men. With this, HCPs will in turn be better able to assess, diagnose, and tailor treatment. Rosu et al. (2017) described this as adopting a "masculinities" perspective that acknowledges the many and varied ways of being a man and responding to, and reducing, biases toward stereotyped masculinity. Practitioners should be sensitive to diversity including men "whose principles and expectations relating to masculinity and gender are less pronounced" as well as those who "strongly ascribe to hegemonic masculine principles" (Doherty et al., 2017).

Collaboratively Set Goals. In 25 (25.8%) articles, approaches recommended including men in the decision-making processes and collaboratively setting goals and expectations by "asking what the man wants to have accomplished in terms of success with respect to the challenges he identifies" (Blundo, 2010). This included establishing a shared understanding of roles and responsibilities with men so they "understand their role and are affirmed in their engagement, knowledge, and confidence to have and express opinions" (Rosu et al., 2017) regarding their care. Agreement in expectations can ensure men are across all key aspects of the healthcare process. This approach responds to men's "need to have tailored and holistic plans" (Guilcher et al., 2016) facilitating autonomy and empowerment over what can be experienced as a passive treatment process.

Action-Oriented, Solution-Focused Treatment. Related to this, several articles (25, 25.8%) suggested being responsive to men's preference to take control, act, and problem-solve. Action-oriented solution-focused treatment care can resonate more with men, with this framing of treatment "more likely to make clinically significant and reliable change" (Richards & Bedi, 2015). These approaches should also be accompanied by "periodically checking in with men about their preferences, goals, needs" (Kealy et al., 2021).

Allow for Flexibility, Timing, and Pace of Treatment. Orienting treatment around men's needs includes allowing for flexibility of space, timing, and pace of treatment (18, 18.6%) around. "the content and focus of the contact." This included more psychotherapy-specific approaches of allowing men the "choice of meeting places, duration or intensity" which can increase comfort and engagement (Kivari et al., 2018).

Additional Key Structural Approaches. By seeking opportunities to improve men's health literacy throughout encounters (19, 19.6%) and transparently breaking down treatment options, structure, and direction (16, 16.5%), HCPs can "temper men's expectations accordingly, thus engaging and empowering their client as an equal partner in treatment" (Seidler et al., 2020). Exploring roles and responsibilities in care (14, 14.4%) and helping men access and describe internal experiences (13, 13.4%) may assist in tapping into their needs, motivators, and preferences for "structure and a clear context" (Tremblay & L'Heureux, 2005) in healthcare. Finally, building a male-friendly space (9, 9.3%), a treatment feedback process (6, 6.2%), and employing masculine-sensitive assessment strategies were also noted as key factors in adapting treatment to respond to men (4, 4.1%).

Theme 3: Centering the Therapeutic Alliance to Retain Men in Care. The third theme "centering the therapeutic alliance to retain men in care" comprised 13 approaches. The majority of articles (98.4%) describing healthcare typically delivered through long-format encounters included one or more approaches synthesized to this theme (Table 3). This compared to 76.9% of articles describing settings with typically short-format encounters. Approaches that explored strengths and positives of men's masculinities, promoted men's autonomy, and validated their personal experience were regularly offered in the longer-format encounter articles. Listening with empathy, creating a nonjudgmental environment, conveying confidence, professional competencies, and confidentiality were more often focused on shorter-format encounter articles.

Explore Strength-Based Masculinities. Adopting a strength-based approach and leveraging masculinities when engaging with men in care were recommended in 43 (44.3%) articles. Juxtaposing men's defeat, awkwardness, or "fear of femininity" (Kealy et al., 2021) during healthcare encounters with strength-based approaches lobbied HCPs to reinforce men's masculine self-worth by "using solution-focused skills to pose constructive questions that elicit the man's taking responsibility to make things better for himself and others" (Blundo, 2010). Transforming men's vulnerabilities by affirming their help-seeking can be positioned as an "expansion of positive masculine qualities" (Kealy et al., 2021). Patel and Barnett (2011; pharmacy) also highlighted the importance of dispelling men's concerns for burdening their HCP and/or taking up finite resources by reframing "complaining" as merely describing one's experience. Normalizing universal statements such as "Many of my patients forget to . . ." were suggested as approaches to "remove the embarrassment often associated with certain feelings and experiences." Indeed, normalizing certain experiences as common for men was noted in 31 (32%) articles as validating help-seeking as manly, particularly in mental health settings. Key strengths included promoting men's autonomy over their health and establishing them as experts in their health and behavior change, described in 37 (38.1% articles). This affords men control during healthcare interactions and indeed the therapeutic alliance, to reinforce their "inner strength and ability to take ownership of their situations as an important driver of their journey to recovery" (Guilcher et al., 2016).

Accommodating Diversity and Debility. The intricate intersections between men's masculine identities and other social determinants of health including "social class, race, sexual orientation, ability status, religion, and other salient identities and roles" (Englar-Carlson and Kiselica, 2013) diversely influence men's health and illness behaviors. In 29 (29.9%) articles, the necessity to respond to the diversity within and between men, and accepting men's socialized identities, was reinforced. The value of listening with empathy (25, 25.8%) and creating a nonjudgmental environment (18, 18.6%) was linked as an approach to affirm "the dignity of the client" (Guilcher et al., 2016) and de-stigmatize antisocial or risk-taking behaviors to aid men's self-disclosures. González-Prendes (2007) highlighted the need to focus on "building the therapeutic alliance by demonstrating empathy through the acknowledgment of the difficulties that the clients had experienced," and in doing so avoid hastening to "challenge clients' cognitions." Related to this, a philosophical bend for HCPs meeting men where they are at in their health needs was discussed in 26 (26.8%) articles. Such an approach allows "carefully monitoring the client's cues regarding his comfort level with certain topics" (Kiselica, 2003).

Self-Reflect on Gender Socialization. In 25 (25.8%) articles, it was recommended HCPs self-reflect on their own gender socialization and resultant biases, "how masculinity and gender affect their conceptualisations of clients" (Marasco, 2018), and how that translates to their practices for engaging with men. Indeed, taking the first step by calling this out could break down barriers between practitioners and men, fostering deeper connections through shared experiences and understanding as "some male clients may look to see if the counselor will take the first risk and break the silence about socialisation" (Englar-Carlson & Shepard, 2005)

Build Collaborative Relationship. Twenty-two (22.7%) articles noted the value of purposefully establishing a collaborative relationship with men. As a specific example, Dvorkin (2015) described "mirroring" to provide men opportunity and space to reflect on their needs in the exchange: "Starting with the phrase 'So, what I'm hearing you say is . . .' and ending with 'Did I get that right?' allows men to step into a leadership position within the relationship." This helps to equalize power dynamics between the HCP and client, overcoming any sense of defeat (and associated shame) men might experience in healthcare settings, and instead encourage active collaboration.

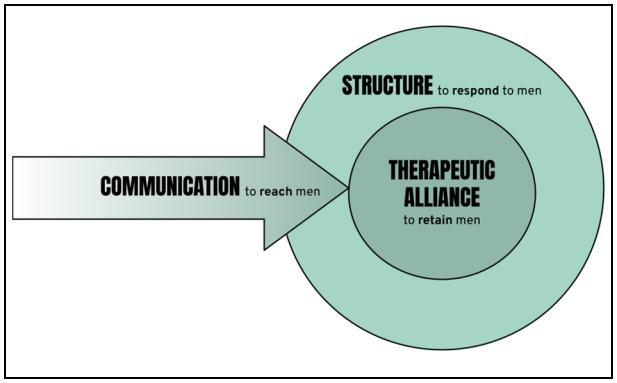

Figure 2. Key Elements of Gender-Responsive Approaches to Optimally Engaging Men During Healthcare Encounters

Additional Key Therapeutic Alliance Approaches. To further strengthen the therapeutic relationship with men particularly during initial encounters, conveying confidence and competency (11, 11.3%) with appropriate self-disclosure (13, 13.4%) to build trust and help "reduce the shame-based intensity of the encounter" (Rabinowitz & Cochran, 2007) was discussed. Approaches that reinforce confidentiality (13, 13.4%) especially if ailments are imbued with feelings of shame and vulnerability are important. Eight articles specifically called out the avoidance of HCPs challenging masculine norms. For example, by actively "avoiding language that is negative about masculinity" (Johnston et al., 2008), HCPs become "more likely to be able to form a successful working alliance with male clients" (Good et al., 2005).

Discussion

There has, to date, been an absence of a clear summation about the approaches used for engaging men in healthcare encounters across primary healthcare settings. This review provides a synthesis of the literature to describe 33 engagement approaches, informed by HCPs and male patients, the parts and sum of which may usefully guide HCPs to better reach, respond, and retain men in primary care. The approaches were grouped across three interrelated and coalescing themes (Figure 2). First, themed under tailoring of communication, was a range of suggested language adaptations to initially engage men and keep them connected throughout healthcare encounters. These included the use of accessible language and constructs to make space for men's contextual stories and health practices. Second, approaches for purposefully structuring treatment detailed the necessity to integrate approaches that are strategically flexible, collaborative, action-oriented, and solution-focused to alleviate potential power imbalances in healthcare settings. Finally, the importance of centering the therapeutic alliance combined communicative and structural approaches, suggesting HCPs be receptive, affirming, and responsive to men's patterned and diverse gendered help-seeking practices within primary healthcare contexts.

The approaches to engaging with men are offered for consideration with the caveat that the evidence is emergent, particularly in the noncounseling literature, which represented less than a quarter of the articles in the current review. This may account, in part, for their lack of translation into healthcare workforce education. A review of health and medical curricula of Australian Universities in 2022–2023 indicated that while men's health was deemed important, communicating and engaging with men in practice was one of the least likely topics to be covered in curricula (Seidler et al., 2024). For practising HCPs, there is also little training about gender-responsive approaches (e.g., Osborne et al., 2018; Seidler et al., 2022).

The current review findings regarding communicative, structural, and relational (alliance) elements for primary HCPs align with three of the eight dimensions of person-centered care described by Gerteis et al. (1993): (a) respect for patient values, preferences, and expressed needs; (b) information and education; and (c) emotional support to relieve fear and anxiety. Moreover, offered here are gender-responsive specificities for those elements of person-centered care—making available key content and strategy for incorporating these results to inform education curricula and established practices, when providing primary care to men. Understanding men's motivations and preferences for healthcare engagement in essence affords a much-needed tailoring for person-centered care. Highlighted herein is the fundamental need and ease for incorporating gender competencies as person-centered care for all HCPs (Dielissen et al., 2012).

The most striking difference between the approaches offered from the literature describing typically long-format versus short-format encounters was the greater focus in the long-format encounters on sensitivity and responsiveness to the gendered needs of men. Gender competencies of HCPs aims to strengthen the therapeutic alliance that is recognized as a pivotal predictor of engagement and treatment outcome in mental health contexts (D. J. Martin et al., 2000; Seidler et al., 2020). The importance of the therapeutic alliance extends to any HCP working with men. In contrast to long-form encounters, it could be suggested that time-restricted short-form encounters,

such as during general practice or pharmacy consultations, may encumber the integration of what is being fast established as gender-responsive care. Yet these primary care settings are the first entry point to healthcare and preventive health for most men (Simons et al., 2023), and the implications of men's poor engagement during primary healthcare encounters are stark. Gender-competent HCPs have heighted receptivity for discrete and nuanced gendered cues and symptoms in men's presentations that may reside outside routine screens (Fisher et al., 2021; Rice et al., 2020). This will support gateway conversation approaches and male-sensitive assessment strategies, both noted in this review as important in first-line encounters with men. This is pertinent when considering men frequently present with physiological ailments in general practice that can obscure underlying chronic disease risk (Serefoglu et al., 2014), psychological distress, or suicide risk (Zajac et al., 2022). Up to 95.7% of men who die by suicide have contact with primary care in the year prior to their death (Laanani et al., 2020), highlighting the risk of missed diagnosis of depression in men (S. Martin et al., 2021). Legitimizing the therapeutic alliance with men at the healthcare entry point, through gender responsivity, aims to ensure value for men and confidently and successfully participate in healthcare (Lefkowich et al., 2017). Finding ways to practically embed gender competency into HCP training and practice should therefore be prioritized.

Many of the gender-responsive engagement approaches and "male-friendly" examples offered in the articles extracted within this review were typically emblematic of traditional masculinity as the singular lens to view and respond to men during their engagement with healthcare rather than it being a consideration. This was also identified by Zielke et al. (2023) in their review of the operationalisation of "masculinity" across gender-transformative health interventions. Gender is dynamic and modifiable, and this includes men's masculine identities which will adapt to the different social environments including healthcare settings. By prioritizing engagement catered to diversity in and across men (Doherty et al., 2017), HCPs can help men with transformative masculinities to "legitimise help-seeking as the rational, courageous, and 'manly' course of action" (Carroll et al., 2020; Seidler et al., 2022). Such strength-based approach in health programming is increasingly being recognized as an essential ingredient in advancing men's health equity (Galdas et al., 2023; Smith et al., 2020). In their efforts to promote men's health, and by extension advance the wellbeing of their family and friends, students and HCPs should also be encouraged to address their own gender biases to ensure that these do not translate into practice and influence how they engage with men. Indeed, knowing one's gender biases, anticipating male diversity, and where applicable, aiding transformative masculinity changes could all break down barriers between HCPs and men, fostering a deeper connection through shared experience and understanding.

Critically, this review reveals a dearth of studies focussed on engaging with men from diverse ethnic and racial backgrounds, who may have unique health beliefs and practices and social norms that influence their gender identities. This included a lack of global indigenous scholarship. This means research funders need to seek proposals that explicitly call for an examination of social determinants of health and health inequities, and researchers need to be explicit about examining intersectional factors when framing research questions. At the practitioner level, an increased uptake of evidence-based intersectional practices such as trauma-informed care, tailored to sub-populations of men, would be an example of translating this intersectional research into practice. This responds to the notion that men from minority cultures are typically socially conditioned to deny injury and/or isolate themselves to conceal their trauma (Affleck et al., 2022). Furthermore, intersectional practices such as this could be accompanied by a formal evaluation of outcomes, assessing whether these methods adequately fit or robustly fail. Resulting insights into the specificities for what works may offer some potential for transferability and translation to other local settings where primary healthcare systems have struggled to engage men. The sensitivities and nuances in approaches to engagement then need translation into HCP education, if we are to reduce health inequities (Baker & Shand, 2017; Zielke et al., 2023) experienced by the most marginalized and vulnerable groups of men globally.

For future translation of these review findings into practice, service delivery interventions could look similar to the "Men in Mind" gender competency-based training curricula, which was developed, in part, from the scoping review of approaches by Seidler, Rice, Ogrodniczuk, et al. (2018) for optimally engaging men in psychological treatment. This review informed the design of a world-first randomized controlled trial that validated the training for mental health professionals (Seidler et al., 2023). While developed for mental health service contexts, the core tenets of "Men in Mind" are likely relevant to all healthcare settings serving men and reflect many of the core findings of this review.

Given the small sample, analysis of the nuances in approaches used by non-counseling disciplines and health setting could not be undertaken. A further limitation of the review was that nearly one third of the articles were a commentary, case study, or editorial. While clinician insights and recommendations from the practice interface are important, this may introduce opinion bias or limited viewpoints. A further caveat is that there remains a lack of rigorous research that has formally validated the efficacy of gender-responsive healthcare engagement approaches for men (Phillips et al., 2023; Smith et al., 2018).

This review excluded articles where healthcare was delivered as part of community-based health-promotion programs. Gender-responsive and transformative frameworks for engaging men within these public health settings have however been previously synthesized (Galdas et al., 2023; Robertson et al., 2016). There is considerable alignment of approaches to those offered herein. These include framing delivery to tap into and inspects masculine ideals (e.g., self-reliance), reinforcing healthy diverse masculinities, being direct and using informal communication styles (e.g., avoiding jargon, use of colloquial language). These are all caveated with the need to apply approaches judiciously so as not to reinforce potentially harmful gender stereotypes. This creates efficiencies for the creation of education curricula that has interdisciplinary reach across the healthcare professions included in this review and beyond. This includes in specialist care settings where similar approaches have been called for to optimize the healthcare provision and outcomes for men. Examples include when communicating with men about active surveillance (Mróz et al., 2013) and when supporting men in care after a diagnosis of male-factor infertility (Obst et al., 2023).

Conclusion

The findings of this review, while warranting further applied research, offer practice considerations for HCPs that may improve men's engagement during primary healthcare encounters. Moreover, they continue an important lobby for the tailoring of person-centered primary healthcare tenets to advance men's health. Building and translating evidence-based approaches into student and HCP education is critical, and these andragogical investments need to be concurrent with adjusting broader primary healthcare structures to ensure a sustained focus on addressing men's health inequities.

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Authors' Contributions

All authors contributed to the conceptualization and study design, with ZES responsible for funding acquisition, and ZES, JLO, and JAS providing supervision. Articles were reviewed, extracted, and coded by MS, MAM, and ZES and thematically analyzed by RB, MJW, KF, and ZES. The original draft manuscript was prepared by MAM, RB, KF, and MJW, with ZES, MS, JLO, and JAS involved in the reviewing and editing process. ZES, JLO, and MJW provided clinical and public health practice insights. All authors read and approved the final manuscript and met ICJME criteria for authorship.

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Supplemental Material

Supplemental material for this article is available online.

References

Adams, J., McCreanor, T., & Braun, V. (2008). Doctoring New Zealand's gay men. *The New Zealand Medical Journal*, *121*(1287), 11–20.

Affleck, W., Oliffe, J. L., Inukpuk, M. M., Tempier, R., Darroch, F., Crawford, A., & Séguin, M. (2022). Suicide amongst young Inuit males: The perspectives of Inuit health and wellness workers in Nunavik. *SSM:*

Qualitative Research in Health, *2*, 1–8. https://doi.org/10.1016/j.ssmqr.2022.100069

Apesoa-Varano, E. C., Hinton, L., Barker, J. C., & Unützer, J. (2010). Clinician approaches and strategies for engaging older men in depression care. *The American Journal of Geriatric Psychiatry: Official Journal of the American Association for Geriatric Psychiatry*, *18*(7), 586–595. https://doi.org/10.1097/JGP.0b013e3181d145ea

Arksey, H., & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology*, *8*(1), 19–32. https://doi.org/10.1080/1364557032000119616

Baker, P., & Shand, T. (2017). Men's health: Time for a new approach to policy and practice? *Journal of Global Health*, *7*(1), 10306. https://doi.org/10.7189/jogh.07.010306

Bedi, R. P., & Richards, M. (2011). What a man wants: The male perspective on therapeutic alliance formation. *Psychotherapy*, *48*(4), 381–390. https://doi.org/10.1037/a0022424

Blundo, R. (2010). Engaging men in clinical practice: A solution-focused and strengths-based model. *Families in Society*, *91*(3), 307–312.

Boerma, M., Beel, N., Jeffries, C., & Krishnamoorthy, G. (2023). "It's all about rapport": Australian therapists' recommendations for engaging adolescent males in counselling and psychotherapy. *Counselling and Psychotherapy Research*. Advance online publication. https://doi.org/10.1002/capr.12716

Braun, V., & Clarke, V. (2021). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*, *21*(1), 37–47. https://doi.org/10.1002/capr.12360

Brownhill, S., Wilhelm, K., Eliovson, G., & Waterhouse, M. (2003). "For men only." A mental health prompt list in primary care. *Australian Family Physician*, *32*(6), 443–450.

Bryde Christensen, A., Krohn, S., Høj, M., Poulsen, S., Reinholt, N., & Arnfred, S. (2023). "Men are not raised to share feelings" exploring male patients' discourses on participating in group cognitive-behavioral therapy. *The Journal of Men's Studies*, *31*(1), 3–24. https://doi.org/10.1177/10608265221077298

Buitenbos, P. (2012). "Good grief! It's a men's group, Charlie Brown."*Canadian Journal of Counseling and Psychotherapy*, *46*(4), 335–343.

Calabrese, S. K., Rao, S., Eldahan, A. I., Tekeste, M., Modrakovic, D., Dangaran, D., Boone, C. A., Underhill, K., Krakower, D. S., Mayer, K. H., Hansen, N. B., Kershaw, T. S., Magnus, M., Betancourt, J. R., & Dovidio, J. F. (2022). "Let's be a person to person and have a genuine conversation": Comparing perspectives on PrEP and sexual health communication between black sexual minority men and healthcare providers. *Archives of Sexual Behavior*, *51*(5), 2583–2601. https://doi.org/10.1007/s10508-021-02213-3

Campbell, M., Neil, J. A., Jaffe, P. G., & Kelly, T. (2010). Engaging abusive men in seeking community intervention: A critical research & practice priority. *Journal of Family Violence*, *25*(4), 413–422. https://doi.org/10.1007/s10896-010-9302-z

Canuto, K., Wittert, G., Harfield, S., & Brown, A. (2018). "I feel more comfortable speaking to a male": Aboriginal and Torres Strait Islander men's discourse on utilizing primary health care services. *International Journal for Equity in Health*, *17*(1), 185. https://doi.org/10.1186/s12939-018-0902-1

Carroll, P., Richardson, N., & Grace, B. (2020). "Connecting with young men": The impact of training in Ireland. *International Journal of Men's Social and Community Health*, *3*(1), e24–e35.

Chen, C. K., & Dognin, J. S. (2017). Addressing the influence of hegemonic masculinity on veterans through brief dynamic interpersonal therapy. *Psychology of Men & Masculinities*, *18*(3), 238–242. https://doi.org/10.1037/men0000118

Cheshire, A., Peters, D., & Ridge, D. (2016). How do we improve men's mental health via primary care? An evaluation of the Atlas Men's Well-being Pilot Programme for stressed/distressed men. *BMC Family Practice*, *17*(13), 1–11. https://doi.org/10.1186/s12875-016-0410-6

Chovanec, M. G. (2014). The power of learning and men's stories in engaging abusive men in the change process: Qualitative study across programs. *Social Work with Groups*, *37*(4), 331–347. https://doi.org/10.1080/01609513.2014.901207

Cochran, S. V. (2005). Evidence-based assessment with men. *Journal of Clinical Psychology*, *61*(6), 649–660.

Cochran, S. V., & Rabinowitz, F. E. (2003). Gender-sensitive recommendations for assessment and treatment of depression in men. *Professional Psychology: Research and Practice*, *34*(2), 132–140.

Cotter, C. A., O'Neill, M. K., Stevens, M. N., Sanders, P. G., & Henninger, J. (2023). Counseling with male clients: The case for relational resilience approach. *American Journal of Men's Health*, *17*(3), 15579883231179328. https://doi.org/10.1177/15579883231179328

Danforth, L., & Wester, S. R. (2014). Gender-sensitive therapy with male servicemen: An integration of recent research and theory. *Professional Psychology: Research and Practice*, *45*(6), 443–451. https://doi.org/10.1037/a0036759

de Oliveira, P. P., dos Santos, W. J., Viegas, S. M. D. F., da Silveira, E. A. A., & Rodrigues, A. B. (2015). Experience of men in the context of Primary Health Care. *Investigacion y Educacion En Enfermeria*, *33*(2), 227–236. https://doi.org/10.17533/udea.iee.v33n2a05

Dielissen, P., Verdonk, P., Bottema, B., Kramer, A., & Lagro-Janssen, T. (2012). Expert consensus on gender criteria for assessment in medical communication education. *Patient Education and Counseling*, *88*(2), 189–195. https://doi.org/10.1016/j.pec.2012.01.013

Dienhart, A. (2001). Engaging men in family therapy: Does the gender of the therapist make a difference? *Journal of Family Therapy*, *23*(1), 21–45.

Dobson, R. (2006). Men are more likely than women to die early. *BMJ*, *333*(7561), Article 220. https://doi.org/10.1136/bmj.333.7561.220-c

Doherty, M., Conway, J., Clark, J., & Merritt, F. (2017). Should I stay or should I go? The impact of a sense of

control on young men's therapeutic engagement. *Counselling and Psychotherapy Research*, *17*(3), 209–217. https://doi.org/10.1002/capr.12126

Dvorkin, K. (2015). Working with men in therapy. *Group*, *39*, 241–250. https://api.semanticscholar.org/CorpusID:148714135

Englar-Carlson, M., & Kiselica, M. S. (2013). Affirming the strengths in men: A positive masculinity approach to assisting male clients. *Journal of Counseling & Development*, *91*, 399–409. https://doi.org/10.1002/j.1556-6676.2013.00111.x

Englar-Carlson, M., & Shepard, D. S. (2005). Engaging men in couples counseling: Strategies for overcoming ambivalence and inexpressiveness. *The Family Journal*, *13*(4), 383–391. https://doi.org/10.1177/1066480705278467

Farnbach, S., Fernando, J., Coyte, J., Simms, M., & Hackett, M. L. (2021). "It's hard for me to tell my story" the experiences of Aboriginal and Torres Strait Islander male clients at a residential drug and alcohol rehabilitation centre using primary health care. *Health Promotion Journal of Australia: Official Journal of Australian Association of Health Promotion Professionals*, 32(Suppl. 2), 87–94. https://doi.org/10.1002/hpja.452

Ferguson, N., Savic, M., McCann, T. V., Emond, K., Sandral, E., Smith, K., Roberts, L., Bosley, E., & Lubman, D. I. (2019). "I was worried if I don't have a broken leg they might not take it seriously": Experiences of men accessing ambulance services for mental health and/or alcohol and other drug problems. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, *22*(3), 565–574. https://doi.org/10.1111/hex.12886

Fisher, K., Seidler, Z. E., King, K., Oliffe, J. L., & Rice, S. M. (2021). Men's anxiety: A systematic review. *Journal of Affective Disorders*, *295*, 688–702. https://doi.org/10.1016/j.jad.2021.08.136

Galdas, P. M., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behaviour: Literature review. *Journal of Advanced Nursing*, *49*(6), 616–623. https://doi.org/10.1111/j.1365-2648.2004.03331.x

Galdas, P. M., Seidler, Z. E., & Oliffe, J. L. (2023). Designing men's health programs: The 5C framework. *American Journal of Men's Health*, *17*(4), 15579883231186463. https://doi.org/10.1177/15579883231186463

Garfield, C. F., Isacco, A., & Rogers, T. E. (2008). A review of men's health and masculinity. *American Journal of Lifestyle Medicine*, *2*(6), 474–487.

Genuchi, M. C., Hopper, B., & Morrison, C. R. (2017). Using metaphors to facilitate exploration of emotional content in counseling with college men. *The Journal of Men's Studies*, *25*(2), 133–149. https://doi.org/10.1177/1060826516661187

Gerteis, M., Edgman-Levitan, S., Daley, J., & Delbanco, T. L. (1993). *Through the patient's eyes: Understanding and promoting patient-centered care*. Jossey-Bass.

Gilliam, M. L., & Hernandez, M. (2007). Providing contraceptive care to low-income, African American teens: The experience of urban community health centers. *Journal of Community Health*, *32*(4), 231–244. https://doi.org/10.1007/s10900-007-9045-9

Gillon, E. (2008). Men, masculinity, and person-centered therapy / Männer, Männlichkeit und Personzentrierte Therapie / Hombres, masculinidad y terapia centrada en la persona / Les Hommes, la Masculinité, et la Thérapie Centrée sur la Personne / Homens, Masculinidade e Tera. *Person-Centered & Experiential Psychotherapies*, *7*(2), 120–134. https://doi.org/10.1080/14779757.2008.9688458

Global Burden of Disease 2017 Disability-Adjusted Life Years & Health-Adjusted Life Expectancy Collaborators. (2018). Global, regional, and national disability-adjusted life-years (DALYs) for 359 diseases and injuries and healthy life expectancy (HALE) for 195 countries and territories, 1990–2017: A systematic analysis for the Global Burden of Disease Study 2017. *Lancet*, *392*, 1859–1922.

González-Prendes, A. A. (2007). Cognitive-behavioral treatment of men and anger: Three single case studies. *Cognitive and Behavioral Practice*, *14*(2), 185–197. https://doi.org/10.1016/j.cbpra.2007.02.001

Good, G. E., & Robertson, J. M. (2010). To accept a pilot? Addressing men's ambivalence and altering their expectancies about therapy. *Psychotherapy*, *47*(3), 306–315. https://doi.org/10.1037/a0021162

Good, G. E., Thomson, D. A., & Brathwaite, A. D. (2005). Men and therapy: Critical concepts, theoretical frameworks, and research recommendations. *Journal of Clinical Psychology*, *61*(6), 699–711. https://doi.org/10.1002/jclp.20104

Gray, C. M., Anderson, A. S., Clarke, A. M., Dalziel, A., Hunt, K., Leishman, J., & Wyke, S. (2009). Addressing male obesity: An evaluation of a group-based weight management intervention for Scottish men. *Journal of Men's Health*, *6*(1), 70–81. https://doi.org/10.1016/j.jomh.2008.11.002

Greif, G. L. (2009). One dozen considerations when working with men in substance abuse groups. *Journal of Psychoactive Drugs*, *41*(4), 387–390. https://doi.org/10.1080/02791072.2009.10399777

Griffin, M., Krause, K. D., Kapadia, F., & Halkitis, P. N. (2018). A qualitative investigation of healthcare engagement among young adult gay men in New York City: A P18 cohort substudy. *LGBT Health*, *5*(6), 368–374. https://doi.org/10.1089/lgbt.2017.0015

Grove, D. L. (2012). Male midlife depression: Multidimensional contributing factors and renewed practice approaches. *Canadian Journal of Counseling and Psychotherapy*, *46*, 313–334.

Guilcher, S. J. T., Hamilton-Wright, S., Skinner, W., Woodhall-Melnik, J., Ferentzy, P., Wendaferew, A., Hwang, S. W., & Matheson, F. I. (2016). "Talk with me": Perspectives on services for men with problem gambling and housing instability. *BMC Health Services Research*, *16*(a), Article 340. https://doi.org/10.1186/s12913-016-1583-3

Hancock, T. U., & Siu, K. (2009). A culturally sensitive intervention with domestically violent Latino immigrant

men. *Journal of Family Violence*, *24*(2), 123–132. https://doi.org/10.1007/s10896-008-9217-0

Hawkes, S., Allotey, P., Elhadj, A. S., Clark, J., & Horton, R. (2020). The Lancet Commission on Gender and Global Health. *Lancet*, *396*(10250), 521–522. https://doi.org/10.1016/S0140-6736(20)31547-6

Hawkes, S., & Buse, K. (2013). Gender and global health: Evidence, policy, and inconvenient truths. *Lancet*, *381*(9879), 1783–1787. https://doi.org/10.1016/S0140-6736(13)60253-6

Hay, K., McDougal, L., Percival, V., Henry, S., Klugman, J., Wurie, H., Raven, J., Shabalala, F., Fielding-Miller, R., Dey, A., Dehingia, N., Morgan, R., Atmavilas, Y., Saggurti, N., Yore, J., Blokhina, E., Huque, R., Barasa, E., & Bhan, N., . . . Gender Equality, Norms, and Health Steering Committee. (2019). Disrupting gender norms in health systems: Making the case for change. *Lancet (London, England)*, *393*(10190), 2535–2549. https://doi.org/10.1016/S0140-6736(19)30648-8

Hinton, L., Sciolla, A. F., Unützer, J., Elizarraras, E., Kravitz, R. L., & Apesoa-Varano, E. C. (2017). Family-centered depression treatment for older men in primary care: A qualitative study of stakeholder perspectives. *BMC Family Practice*, *18*(1), Article 88. https://doi.org/10.1186/s12875-017-0659-4

Jansen, S. (2020). Men are emotionally competent: Considerations on group therapy with men. *South African Journal of Psychology*, *50*(2), 154–157. https://doi.org/10.1177/0081246319854360

Johansson, A., & Olsson, M. (2013). Boys don't cry: Therapeutic encounters with depressed boys and factors contributing to success. *Social Work in Mental Health*, *11*(6), 530–541. https://doi.org/10.1080/15332985.2013.812539

Johnston, L., Huggard, P., & Goodyear-Smith, F. (2008). Men's health and the health of the nation. *The New Zealand Medical Journal*, *121*(1287), 69–76.

Kahn, J. S. (2010). Feminist therapy for men: Challenging assumptions and moving forward. *Women & Therapy*, *34*(1–2), 59–76. https://doi.org/10.1080/02703149.2011.532458

Kealy, D., Seidler, Z. E., Rice, S. M., Oliffe, J. L., Ogrodniczuk, J. S., & Kim, D. (2021). Challenging assumptions about what men want: Examining preferences for psychotherapy among men attending outpatient mental health clinics. *Professional Psychology: Research and Practice*, *52*(1), 28–33. https://doi.org/10.1037/pro0000321

Kierski, W., & Blazina, C. (2010). The male fear of the feminine and its effects on counseling and psychotherapy. *The Journal of Men's Studies*, *17*(2), 155–172. https://doi.org/10.3149/jms.1702.155

Kilmartin, C. (2005). Depression in men: Communication, diagnosis and therapy. *Journal of Men's Health & Gender*, *2*(1), 95–99. https://doi.org/10.1016/j.jmhg.2004.10.010

Kiselica, M. S. (2003). Transforming psychotherapy in order to succeed with adolescent boys: Male-friendly practices. *Journal of Clinical Psychology*, *59*(11), 1225–1236. https://doi.org/10.1002/jclp.10213

Kiselica, M. S., & Englar-Carlson, M. (2010). Identifying, affirming, and building upon male strengths: The positive psychology/positive masculinity model of psychotherapy with boys and men. *Psychotherapy*, *47*(3), 276–287. https://doi.org/10.1037/a0021159

Kivari, C. A., Oliffe, J. L., Borgen, W. A., & Westwood, M. J. (2018). No man left behind: Effectively engaging male military veterans in counseling. *American Journal of Men's Health*, *12*(2), 241–251. https://doi.org/10.1177/1557988316630538

Kwon, M., Lawn, S., & Kaine, C. (2023). Understanding men's engagement and disengagement when seeking support for mental health. *American Journal of Men's Health*, *17*(2), 15579883231157972. https://doi.org/10.1177/15579883231157971

Lømo, B., Haavind, H., & Tjersland, O. A. (2021). Finding a common ground: Therapist responsiveness to male clients who have acted violently against their female partner. *Journal of Interpersonal Violence*, *36*(17–18), NP9930–NP9958. https://doi.org/10.1177/0886260519862271

Laanani, M., Imbaud, C., Tuppin, P., Poulalhon, C., Jollant, F., Coste, J., & Rey, G. (2020). Contacts with health services during the year prior to suicide death and prevalent conditions a nationwide study. *Journal of Affective Disorders*, *274*, 174–182. https://doi.org/10.1016/j.jad.2020.05.071

The Lancet. (2019). Raising the profile of men's health. *Lancet*, *393*, 1779.

Lefkowich, M., Richardson, N., & Robertson, S. (2017). "If we want to get men in, then we need to ask men what they want": Pathways to effective health programing for men. *American Journal of Men's Health*, *11*(5), 1512–1524. https://doi.org/10.1177/1557988315617825

Leone, J. E., Rovito, M. J., Gray, K. A., & Mallo, R. (2021). Practical strategies for improving men's health: Maximizing the patient-provider encounter. *International Journal of Men's Social and Community Health*, *4*(1), e1–e16. https://doi.org/10.22374/ijmsch.v4i1.17

Lorber, W., & Garcia, H. A. (2010). Not supposed to feel this: Traditional masculinity in psychotherapy with male veterans returning from Afghanistan and Iraq. *Psychotherapy: Theory, Research, Practice, Training*, *47*(3), 296–305.

Lovett, D., Rasmussen, B., Holden, C., & Livingston, P. M. (2017). Are nurses meeting the needs of men in primary care? *Australian Journal of Primary Health*, *23*(4), 319–322. https://doi.org/10.1071/PY16106

Macdonald, J. A., Mansour, K. A., Wynter, K., Francis, L. M., Rogers, A., Angeles, M. R., Pennell, M., Biden, E., Harrison, T., & Smith, I. (2022). *Men's and boys' barriers to health system access. A literature review*. Australian Government Department of Health and Aged Care.

Madsen, S. A. (2015). Men as patients: Understanding and communicating with men. *Trends in Urology & Men's Health*, *6*(3), 22–26. https://doi.org/10.1002/tre.458

Mahalik, J. R., Good, G. E., & Englar-Carlson, M. (2003). Masculinity scripts, presenting concerns, and help seeking: Implications for practice and training. *Professional*

Psychology: Research and Practice, *34*(2), 123–131. https://doi.org/10.1037/0735-7028.34.2.123

Mahalik, J. R., Good, G. E., Tager, D., Levant, R. F., & Mackowiak, C. (2012). Developing a taxonomy of helpful and harmful practices for clinical work with boys and men. *Journal of Counseling Psychology*, *59*(4), 591–603. https://doi.org/10.1037/a0030130

Malcher, G. (2009). Engaging men in health care. *Australian Family Physician*, *38*(3), 92–95.

Manandhar, M., Hawkes, S., Buse, K., Nosrati, E., & Magar, V. (2018). Gender, health and the 2030 agenda for sustainable development. *Bulletin of the World Health Organization*, *96*(9), 644–653. https://doi.org/10.2471/BLT.18.211607

Marasco, V. M. (2018). Addressing hegemonic masculinity with adolescent boys within the counseling relationship. *Journal of Child and Adolescent Counseling*, *4*(3), 226–238. https://doi.org/10.1080/23727810.2017.1422647

Marcell, A. V., & Monasterio, E. B. (2003). Providing anticipatory guidance and counseling to the adolescent male. *Adolescent Medicine*, *14*(3), 565–582, v–vi. https://doi.org/10.1016/S1041349903500457

Marotti, J., Thackeray, L., & Midgley, N. (2020). Teenage boys in therapy: A qualitative study of male adolescents' experiences of short-term psychoanalytic psychotherapy. *Journal of Infant, Child, and Adolescent Psychotherapy*, *19*(4), 403–416. https://doi.org/10.1080/15289168.2020.1832836

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *68*(3), 438–450.

Martin, S., Zajac, I., Vincent, A., Adams, R. J., Appleton, S., & Wittert, G. A. (2021). Effect of depression on health service utilisation in men: A prospective cohort study of Australian men aged 35 to 80 years. *BMJ Open*, *11*(3), Article e044893. https://doi.org/10.1136/bmjopen-2020-044893

McGregor, A. J., Chin, E. L., Rojek, M. K., Digre, K. B., Lopez, A. M., Jenkins, K., Johnston, L., & Jenkins, M. (2019). Sex and gender health education summit: Advancing curricula through a multidisciplinary lens. *Journal of Women's Health*, *28*(12), 1728–1736.

Mitchell, J., Williams, E.-D. G., Perry, R., & Lobo, K. (2019). "You have to be part of the process": A qualitative analysis of older African American men's primary care communication and participation. *American Journal of Men's Health*, *13*(4), 1557988319861569. https://doi.org/10.1177/1557988319861569

Morgan, H. (2001). Depression in men. *Australian Family Physician*, *30*(3), 206–*211*, 214–217.

Mróz, L. W., Oliffe, J. L., & Davison, B. J. (2013). Masculinities and patient perspectives of communication about active surveillance for prostate cancer. *Health Psychology: Official Journal of the Division of Health Psychology, American Psychological Association*, *32*(1), 83–90. https://doi.org/10.1037/a0029934

Nahon, D., & Lander, N. R. (2014). Working with men in individual psychotherapy from an integrity model perspective: The unsung heroes. *The Journal of Men's Studies*, *22*(3), 194–206. https://doi.org/10.3149/jms.2203.194

Noone, J. H., & Stephens, C. (2008). Men, masculine identities, and health care utilisation. *Sociology of Health & Illness*, *30*(5), 711–725. https://doi.org/10.1111/j.1467-9566.2008.01095.x

Novak, J. R., Peak, T., Gast, J., & Arnell, M. (2019). Associations between masculine norms and health-care utilization in highly religious, heterosexual men. *American Journal of Men's Health*, *13*(3), 1557988319856739. https://doi.org/10.1177/1557988319856739

Obst, K. L., Oxlad, M., Turnbull, D., & McPherson, N. O. (2023). "No one asked me if I'm alright": A mixed-methods study exploring information/support needs and challenges engaging men diagnosed with male-factor infertility. *American Journal of Men's Health*, *17*(6), 15579883231209210. https://doi.org/10.1177/15579883231209210

Ogrodniczuk, J. S., & Oliffe, J. L. (2009). Grief and groups: Considerations for the treatment of depressed men. *Journal of Men's Health*, *6*(4), 295–298. https://doi.org/10.1016/j.jomh.2009.07.005

O'Loughlin, J. I., Cox, D. W., Ogrodniczuk, J. S., & Castro, C. A. (2022). Traditional masculinity ideology and psychotherapy treatment outcome for military service veteran men. *Psychology of Men & Masculinities*, *24*(1), 16–25. https://doi.org/10.1037/men0000415

Osborne, A., Carroll, P., Richardson, N., Doheny, M., Brennan, L., & Lambe, B. (2018). From training to practice: The impact of ENGAGE, Ireland's national men's health training programme. *Health Promotion International*, *33*(3), 458–467. https://doi.org/10.1093/heapro/daw100

Patel, P. S., & Barnett, C. W. (2011). Counseling techniques to address male communication characteristics: An application of the extended parallel process model. *Journal of Pharmacy Practice*, *24*(4), 386–390. https://doi.org/10.1177/0897190010397720

Peters, M. D. J., Marnie, C., Tricco, A. C., Pollock, D., Munn, Z., Alexander, L., McInerney, P., Godfrey, C. M., & Khalil, H. (2020). Updated methodological guidance for the conduct of scoping reviews. *JBI Evidence Synthesis*, *18*(10), 2119–2126. https://doi.org/10.11124/JBIES-20-00167

Phillips, S. P., O'Connor, M., & Vafaei, A. (2023). Women suffer but men die: Survey data exploring whether this self-reported health paradox is real or an artefact of gender stereotypes. *BMC Public Health*, *23*(1), Article 94. https://doi.org/10.1186/s12889-023-15011-4

Primack, J. M., Addis, M. E., Syzdek, M., & Miller, I. W. (2010). The Men's Stress Workshop: A gender-sensitive treatment for depressed men. *Cognitive and Behavioral Practice*, *17*, 77–87. https://doi.org/10.1016/j.cbpra.2009.07.002

Rabinowitz, F. E., & Cochran, S. V. (2007). Men and depression: Implications for counselors. *Counseling and Human Development*, *40*(1), 1–10.

Reed, E. E. (2014). Man up: Young men's lived experiences and reflections on counseling. *Journal of Counseling & Development*, *92*(4), 428–437.

Reigeluth, C. S., & Johnson, B. II. (2022). Pragmatic applications for therapeutic engagement with marginalized men: An intersectional exploration of two emerging adult African American male clients. *Journal of Psychotherapy Integration*, *32*(3), 342–362. https://doi.org/10.1037/int0000280

Rice, S. M., Kealy, D., Seidler, Z. E., Oliffe, J. L., Levant, R. F., & Ogrodniczuk, J. S. (2020). Male-type and prototypal depression trajectories for men experiencing mental health problems. *International Journal of Environmental Research and Public Health*, *17*(19), 7322. https://doi.org/10.3390/ijerph17197322

Richards, M., & Bedi, R. P. (2015). Gaining perspective: How men describe incidents damaging the therapeutic alliance. *Psychology of Men & Masculinities*, *16*(2), 170–182. https://doi.org/10.1037/a0036924

Richmond, K., & Levant, R. (2003). Clinical application of the gender role strain paradigm: Group treatment for adolescent boys. *Journal of Clinical Psychology*, *59*(11), 1237–1245. https://doi.org/10.1002/jclp.10214

Robertson, S., Gough, B., Hanna, E., Raine, G., Robinson, M., Seims, A., & White, A. (2016). Successful mental health promotion with men: The evidence from "tacit knowledge."*Health Promotion International*, *33*(2), 334–344. https://doi.org/10.1093/heapro/daw067

Robertson, S., Witty, K., Zwolinsky, S., & Day, R. (2013). Men's health promotion interventions: What have we learned from previous programmes. *Community Practitioner: The Journal of the Community Practitioners & Health Visitors Association*, *86*(11), 38–41.

Rosu, M. B., Oliffe, J. L., & Kelly, M. T. (2017). Nurse practitioners and men's primary health care. *American Journal of Men's Health*, *11*(5), 1501–1511. https://doi.org/10.1177/1557988315617721

Rubin, S. E., McKee, M. D., Campos, G., & O'Sullivan, L. F. (2010). Delivery of confidential care to adolescent males. *Journal of the American Board of Family Medicine*, *23*(6), 728–735. https://doi.org/10.3122/jabfm.2010.06.100072

Sagar-Ouriaghli, I., Brown, J. S. L., Tailor, V., & Godfrey, E. (2020). Engaging male students with mental health support: A qualitative focus group study. *BMC Public Health*, *20*(1), Article 1159. https://doi.org/10.1186/s12889-020-09269-1

Scrandis, D. A., & Arnow, D. (2023). Suicide among men: Risk assessment and mitigation in primary care. *The Nurse Practitioner*, *48*(8), 13–19. https://doi.org/10.1097/01.NPR.0000000000000080

Seidler, Z. E., Rice, S. M., Kealy, D., Oliffe, J. L., & Ogrodniczuk, J. S. (2020). Once bitten, twice shy: Dissatisfaction with previous therapy and its implication for future help-seeking among men. *The International Journal of Psychiatry in Medicine*, *55*(4), 255–263. https://doi.org/10.1177/0091217420905182

Seidler, Z. E., Rice, S. M., Ogrodniczuk, J. S., Oliffe, J. L., & Dhillon, H. M. (2018). Engaging men in psychological treatment: A scoping review. *American Journal of Men's Health*, *12*(6), 1882–1900. https://doi.org/10.1177/1557988318792157

Seidler, Z. E., Rice, S. M., Ogrodniczuk, J. S., Oliffe, J. L., Shaw, J. M., & Dhillon, H. M. (2019). Men, masculinities, depression: Implications for mental health services from a Delphi expert consensus study. *Professional Psychology: Research and Practice*, *50*, 51–61. https://doi.org/10.1037/pro0000220

Seidler, Z. E., Rice, S. M., Oliffe, J. L., Fogarty, A. S., & Dhillon, H. M. (2018). Men in and out of treatment for depression: Strategies for improved engagement. *Australian Psychologist*, *53*(5), 405–415. https://doi.org/10.1111/ap.12331

Seidler, Z. E., Rice, S. M., River, J., Oliffe, J. L., & Dhillon, H. M. (2018). Men's mental health services: The case for a masculinities model. *The Journal of Men's Studies*, *26*(1), 92–104. https://doi.org/10.1177/1060826517729406

Seidler, Z. E., Sheldrake, M., Benakovic, R., Wilson, M. J., Hall, N., Wittert, G. A., & McGee, M. A. (2024). *What does men's health education look like in Australian university health curricula? A formative evaluation and future enhancement opportunities* [Manuscript submitted for publication]. Centre for Youth Mental Health, The University of Melbourne.

Seidler, Z. E., Wilson, M. J., Benakovic, R., Mackinnon, A., Oliffe, J. L., Ogrodniczuk, J. S., Kealy, D., Owen, J., Pirkis, J., Mihalopoulos, C., Le, L. K.-D., & Rice, S. M. (2023). A randomized wait-list controlled trial of Men in Mind: Enhancing mental health practitioners' self-rated clinical competencies to work with men. *American Psychologist*. Advance online publication. https://doi.org/10.1037/amp0001242

Seidler, Z. E., Wilson, M. J., Kealy, D., Oliffe, J. L., Ogrodniczuk, J. S., & Rice, S. M. (2021). Men's dropout from mental health services: Results from a survey of Australian men across the life span. *American Journal of Men's Health*, *15*(3), 15579883211014776. https://doi.org/10.1177/15579883211014776

Seidler, Z. E., Wilson, M. J., Toogood, N., Oliffe, J. L., Kealy, D., Ogrodniczuk, J. S., Owen, J., Lee, G., & Rice, S. M. (2022). Pilot evaluation of the men in mind training program for mental health practitioners. *Psychology of Men & Masculinities*, *23*(2), 257–264. https://doi.org/10.1037/men0000383

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), 2781–2797. https://doi.org/10.1002/jclp.23257

Serefoglu, E. C., Gratzke, C., & Verze, P., & Young Academic Urologists Working Party Men's Health Group. (2014). What can be done to maintain men's health: Perspectives from the EAU Young Academic Urologists Working Party Men's Health Group. *European Urology*, *66*(4), 605–608. https://doi.org/10.1016/j.eururo.2014.04.002

Sharp, P., Ogrodniczuk, J. S., Sha, M., Kelly, M. T., Montaner, G. G., Kealy, D., Seidler, Z. E., Rice, S. M., & Oliffe, J. L. (2023). Working with men in the context of distressed and disrupted intimate partner relationships: A

qualitative study. *Patient Education and Counseling*, *115*, 107873. https://doi.org/10.1016/j.pec.2023.107873

Shen-Miller, D. S., Isacco, A., Davies, J. A., St. Jean, M., & Phan, J. L. (2013). The men's center approach: Ecological interventions for college men's health. *Journal of Counseling & Development*, *91*(4), 499–507. https://doi.org/10.1002/j.1556-6676.2013.00123.x

Simons, K., Bradfield, O., Spittal, M. J., & King, T. (2023). Age and gender patterns in health service utilisation: Age-Period-Cohort modelling of linked health service usage records. *BMC Health Services Research*, *23*(1), Article 480. https://doi.org/10.1186/s12913-023-09456-x

Smith, J. A., Adams, M., & Bonson, J. (2018). Investing in men's health in Australia. *The Medical Journal of Australia*, *208*(1), 67. https://doi.org/10.5694/mja17.00173

Smith, J. A., Braunack-Mayer, A. J., Wittert, G. A., & Warin, M. J. (2008). Qualities men value when communicating with general practitioners: Implications for primary care settings. *The Medical Journal of Australia*, *189*(11–12), 618–621. https://doi.org/10.5694/j.1326-5377.2008.tb02214.x

Smith, J. A., Watkins, D. C., & Griffith, D. M. (2020). Equity, gender and health: New directions for global men's health promotion. *Health Promotion Journal of Australia*, *31*(2), 161–165. https://doi.org/10.1002/hpja.337

Spandler, H., Roy, A., & Mckeown, M. (2013). Using football metaphor to engage men in therapeutic support. *Journal of Social Work Practice*, *28*(2), 229–245. https://doi.org/10.1080/02650533.2013.853286

Spendelow, J. S. (2015). Cognitive-behavioral treatment of depression in men: Tailoring treatment and directions for future research. *American Journal of Men's Health*, *9*(2), 94–102.

Springer, K. L., & Bedi, R. P. (2021). Why do men drop out of counseling/psychotherapy? An enhanced critical incident technique analysis of male clients' experiences. *Psychology of Men & Masculinities*, *22*(4), 776–786. https://doi.org/10.1037/men0000350

Strange, P., & Tenni, M. (2012). Bendigo CHS Men's Health Clinic: Improving access to primary care. *Australian Family Physician*, *41*(9), 731–733.

Swetlitz, N., Hinton, L., Rivera, M., Liu, M., Fernandez, A. C., & Garcia, M. E. (2024). Barriers and facilitators to depression care among Latino men in a primary care setting: A qualitative study. *BMC Primary Care*, *25*(1), Article 30. https://doi.org/10.1186/s12875-024-02275-x

Syzdek, M. R., Addis, M. E., Green, J. D., Whorley, M. R., & Berger, J. L. (2014). A pilot trial of gender-based motivational interviewing for help-seeking and internalizing symptoms in men. *Psychology of Men & Masculinities*, *15*(1), 90–94.

Todd, N., Weaver-Dunlop, G., & Ogden, C. (2014). Approaching the subject of violence: A response-based approach to working with men who have abused others. *Violence Against Women*, *20*(9), 1117–1137. https://doi.org/10.1177/1077801214549638

Tong, S. F., Low, W. Y., Ismail, S. B., Trevena, L., & Willcock, S. (2011). Physician's intention to initiate health check-up discussions with men: A qualitative study. *Family Practice*, *28*(3), 307–316. https://doi.org/10.1093/fampra/cmq101

Tremblay, G., & L'Heureux, P. (2005). Psychosocial intervention with men. *International Journal of Men's Health*, *4*, 55–71. https://doi.org/10.3149/jmh.0401.55

Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K. K., Colquhoun, H., Levac, D., Moher, D., Peters, M. D. J., Horsley, T., Weeks, L., Hempel, S., Akl, E. A., Chang, C., McGowan, J., Stewart, L., Hartling, L., Aldcroft, A., Wilson, M. G., Garritty, C., & . . .Straus, S. E. (2018). PRISMA extension for scoping reviews (PRISMA-ScR): Checklist and explanation. *Annals of Internal Medicine*, *169*(7), 467–473. https://doi.org/10.7326/M18-0850

Westwood, M. J., & Black, T. G. (2012). Introduction to the special issue of the Canadian Journal of Counselling and Psychotherapy. *Canadian Journal of Counseling and Psychotherapy*, *46*(4), 285–291. https://cjc-rcc.ucalgary.ca/article/view/60922

Wischmann, T. (2013). "Your count is zero"—Counselling the infertile man. *Human Fertility*, *16*(1), 35–39. https://doi.org/10.3109/14647273.2013.776179

World Health Organization. (2016). *Technical series on safer primary care: Patient engagement*. https://www.who.int/publications/i/item/9789241511629

World Health Organization. (2023). *Primary health care* [Fact sheet]. https://www.who.int/news-room/fact-sheets/detail/primary-health-care

Yeazel, M. R. (2015). Your millennial toolbox: Developing culturally competent strategies for psychotherapy with men. *The Journal of Men's Studies*, *23*(2), 226–237. https://doi.org/10.1177/1060826515582522

Zajac, I. T., Rice, S., Proeve, M., Kealy, D., Oliffe, J. L., & Ogrodniczuk, J. S. (2022). Suicide risk, psychological distress and treatment preferences in men presenting with prototypical, externalising and mixed depressive symptomology. *Journal of Mental Health*, *31*(3), 309–316. https://doi.org/10.1080/09638237.2020.1755026

Zielke, J., Batram-Zantvoort, S., Razum, O., & Miani, C. (2023). Operationalising masculinities in theories and practices of gender-transformative health interventions: A scoping review. *International Journal for Equity in Health*, *22*(1), 139. https://doi.org/10.1186/s12939-023-01955-x