Masculinity Scripts, Presenting Concerns, and Help Seeking: Implications for Practice and Training

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Men are a unique population to work with in psychotherapy, but what does research indicate about how masculinity relates to therapeutic issues? Summarizing research on masculinity's relationship to a range of presenting issues, this article organizes and discusses the findings according to masculinity "scripts" that clinicians are likely to recognize when working with male clients. The article then addresses how masculinity is also associated with less help seeking and with negative attitudes toward psychological help seeking. This irony, that traditional masculinity scripts contribute to men's presenting concerns and act as barriers to help seeking, is then addressed through recommendations for training and practice that incorporate a sociocultural context into working with men.

Ask almost any practitioner and you will inevitably hear that working with men presents special challenges. A therapist may wonder, "How can I be effective with men when it seems many are reluctant to be in therapy, uncomfortable with the process of disclosure, and quick to avoid emotional exploration?" Others ask, "How do I work with presenting issues such as emotional restriction, interpersonal isolation and conflict, workaholism, or substance abuse that many men bring to therapy?" All seem to sense that masculinity plays a role in affecting men's experience of

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therapy, but they wonder how they can address these gender issues in their work with men.

In response to the need to work more effectively with men and integrate an important part of men's experiences (i.e., their masculine selves) into the therapeutic work, a great deal has been written and discussed recently regarding therapy with men (see Brooks & Good, 2001). This work addresses a broad range of therapeutic concerns, including group therapy with men (Andronico, 2001), working with boys and adolescent males (Horne & Kiselica, 1999), treatment strategies with traditional men (Brooks, 1998), new theoretical models for working with men (Good, Gilbert, & Scher, 1990), and integrating masculine socialization issues into existing theoretical frameworks (Mahalik, 1999a, 1999b).

Although research on therapeutic issues and masculinity has been limited to questions of how masculinity relates to presenting issues and attitudes toward therapy, findings from these studies identify a critical dynamic that must be addressed by psychologists—namely, elements of masculinity appear to contribute both to men's psychological distress and to their reluctance to get help for those stressors. The purpose of this article is to examine this research and make suggestions on ways in which men's gendered lives can be incorporated into therapeutic work with men.

Masculinity and Presenting Problems

To apply research findings from the masculinity literature to practice and training, one has to sort through a literature that seems to reach different conclusions. For example, some research reports that men are less likely than women to be diagnosed with anxiety- and depression-related disorders (e.g., Sachs-Ericsson & Ciarlo, 2000). We might thus conclude that masculinity is associated with greater psychological well-being. However, when we learn that women are more likely to recognize and label nonspecific feelings

of distress as an emotional problem (Kessler, Brown, & Boman, 1981) and that men have higher rates for the total prevalence of mental disorders when substance abuse and antisocial behaviors are considered (e.g., Bland, Orn, & Hewman, 1988), the earlier conclusion appears unfounded.

There is also a body of literature, mostly using the Bem Sex Role Inventory (BSRI), that reports "masculinity" to be related to better psychological functioning (e.g., Long, 1986; O'Heron & Orlofsky, 1990). However, these findings need to be reinterpreted given the evidence that masculinity, as measured by the BSRI, is an instrumental personality trait that shows "little or no relationship to global self-images of masculinity" (Spence & Helmreich, 1981, p. 365). Thus, it would be more correct to conclude that this body of research demonstrates that having an instrumental personality trait, rather than being masculine, is associated with greater psychological well-being.

It is also challenging to understand masculinity's relationship to presenting concerns when we recognize that certain masculine ideologies (i.e., culturally based scripts for males) should be associated with positive functioning. For example, men who enact more traditional masculine ideologies may have strengths in such areas as problem solving, logical thinking, appropriate risk taking, and assertive behavior (Levant, 1995). However, to date, research has not examined whether these psychological benefits are connected to masculine ideologies. Instead, research finds that the more men endorse traditional masculinity ideologies, the more they experience a host of presenting issues, including poorer self-esteem (Cournoyer & Mahalik, 1995), problems with interpersonal intimacy (Fischer & Good, 1997; Sharpe & Heppner, 1991), greater depression and anxiety (Cournoyer & Mahalik, 1995; Good & Mintz, 1990; Sharpe & Heppner, 1991), abuse of substances (Blazina & Watkins, 1996), problems with interpersonal violence (Franchina, Eisler, & Moore, 2001), greater biomedical concerns (Watkins, Eisler, Carpenter, Schechtman, & Fisher, 1991), as well as greater overall psychological distress (Good et al., 1995; Hayes & Mahalik, 2000). Thus, although our intention is not to be antimasculine, and many other psychological benefits may be identified that are associated with masculine ideologies, the current research literature is very consistent that men's endorsement of certain masculine ideologies is associated with a range of presenting problems.

To organize our presentation and discussion of these findings, we think it important to translate the research into descriptions of masculine behaviors that clinicians might better recognize when working with men. To do so, we describe an array of masculine "scripts" that are tied to presenting issues likely to show up when working clinically with men. In doing so, we recognize that some scripts may be important for some men but not for others. We also believe, consistent with interpersonal theory (e.g., Kiesler, 1983), that all of the scripts may be adaptive for men if they are flexibly enacted. However, our purpose in discussing each script is to help clinicians make connections between how masculinity may be connected to the issues that men present when coming to counseling and therapy. To further the exploration of these scripts, we also provide brief case examples to highlight how these masculinity scripts may appear in clinical settings.

Strong-and-Silent Script

Being viewed as unemotional is central to the "strong-and-silent" masculine script (e.g., Brannon, 1976). Enacting this script helps boys and men to live up to masculine role expectations through being stoic and in control of one's feelings; however, the longer term adverse consequences of emotional restriction for men are becoming increasingly apparent. For example, Levant (1998) initiated the theoretical discussion of the problem of "alexithymia" (meaning "without words for emotions") as a potential result of masculine socialization. And although alexithymia has not been found to demonstrate a consistent sex-based pattern (Mallinckrodt, King, & Coble, 1998), men's restricted emotionality has been consistently connected to greater levels of alexithymia (Fischer & Good, 1997; Shepard, 1994), as well as to increased paranoia and psychoticism (Good, Robertson, Fitzgerald, Stevens, & Bartels, 1996), fear of intimacy (Cournoyer & Mahalik, 1995; Fischer & Good, 1997; Good et al., 1995), higher levels of depression (Cournoyer & Mahalik, 1995; Good & Mintz, 1990; Good et al., 1996), greater hostile–submissive personality styles (Mahalik, 2000), and higher levels of anxiety, anger, and personality styles similar to those of substance abusers (Blazina & Watkins, 1996).

> "Raymond," a 70-year-old retired engineer, came to therapy only to accompany his wife, who was suffering from depression compounded by the recent diagnosis of a progressive debilitating disease. During the collection of background information, his wife indicated that their only child had been killed in a tragic accident at age 7. At that point in their lives, Raymond had said, "I don't want to talk about it!" and spent the next 3 decades of his life trying to "be strong and not talk"—eventually avoiding discussion of any important aspect of his life with anyone. Not surprisingly, he too was deeply depressed, isolated, and afraid to feel anything.

Tough-Guy Script

Closely related to the strong-and-silent masculine gender role script are those messages associated with being a "tough guy." For example, when boys learn to be tough, they too frequently do so by suppressing emotions potentially associated with vulnerability. These coping styles often "have dysfunctional health consequences for many men and for those with whom they come into contact" (Eisler, 1995, p. 208). For example, if a man is unable to express openly his honest emotions of sadness and grief, he is likely to turn to alternate (and less healthy) coping mechanisms, such as substance abuse. Indeed, men are three times more likely than women to die from alcohol-related ailments (Doyle, 1996); 39% of men have some level of psychological dependency on alcohol in their lifetime (Lemle & Mishkind, 1989).

Other tough-guy messages that relate to presenting issues include prescriptions that men must be aggressive, fearless, and invulnerable. As with repression of emotions, aggressiveness and attempts to be fearless can contribute to health problems and premature death. Often, the extent to which a man is considered masculine is defined by his willingness to engage in extreme behaviors that attest to his supposed indestructibility. In this vein, men are far more likely than women to take risks while driving motor vehicles—for example, men are involved in fatal crashes three times more often than women (Li, 1998).

> "Jake," a 28-year-old ex-marine employed in a blue-collar profession, lifted weights, drank excessively, and got violent when drunk. He very

reluctantly accompanied his wife into marital therapy. In the course of marital therapy, it became apparent that Jake's tough-guy facade was his attempt to cover the deep insecurity he felt about several aspects of his life. He was especially fearful that his wife would leave him for another man who made more money or was a better lover.

"Give-'em-Hell" Script

Research finds that men disproportionately perpetrate, and are the victims of, most forms of violence (Uniform Crime Report, 1997). Violence becomes part of the socialization of men early in life when they are encouraged to fight in order to "build character" and keep from being bullied (Levant & Pollack, 1995). Later on, men may belong to groups that are primarily male (e.g., the military, college fraternities) in which a certain amount of violent peer hazing is considered an acceptable way of initiating men into an exclusive "club."

Violence also plays an especially prominent role in the world of organized sports, which is an important socialization environment for many males. Sports such as boxing and wrestling directly encourage male violence against other males. Additionally, coaches' support of violence in practices and games may lead to an admiration of violence (Pollack, 1998). For example, in their study of hockey games, Weinstein, Smith, and Weisenthal (1995) found that fist fights, more than playing or skating skills, were seen as indicating greater competence by both teammates and coaches. Thus, boys and men may learn that violence is, at least to some extent, a socially acceptable way to behave and work out problems, and they may not learn to separate aggression and violence that occur within the context of a sporting event from aggression and violence against others outside of the sports arena. Violence and aggression may also be avenues through which some boys and men compensate for uncomfortable feelings such as shame and hurt (Bergman, 1995). Therefore, instead of recognizing, understanding, and coping with their hurt or scared feelings, males may externalize their distress by "taking it out on others."

Research finds that men who conform to violence norms are more likely to experience greater psychological distress in the form of somatic complaints and irritability (Mahalik et al., 2003). This study also found that men's conformity to violence norms was associated with being in trouble with the law, having "blackouts" while drinking, and preferring inequitable social relationships (e.g., where men have power over women).

Research also documents that men's endorsement of traditional masculinity has been related to violence against their partners. Specifically, findings indicate that men who endorsed traditional masculine roles were more likely to have committed actual physical abuse against their female dating partners or wives (Bernard, Bernard, & Bernard, 1985; Prince & Arias, 1984; Telch & Lindquist, 1984; Vass & Gold, 1995), to have attitudes supportive of husbands' violence against their wives (Finn, 1986), as well as to respond with greater anger to women's negative feedback (Vass & Gold, 1995).

An explanation for these research findings is that some men may be very averse to losing power or control to a woman (Dutton & Browning, 1988). Abusive behavior may therefore become one way for these men to restore their sense of power and control. Thus, violence may be a way in which men try to gain a sense of control when interpersonal experiences (e.g., conflict with partner, loss of a job, parenting difficulties) threaten their control and sense of power.

"PJ," a 22-year-old who was in court-mandated counseling following an assault conviction, told the counselor, "Nobody 'disses' [disrespects] me or my brothers [members of his gang] and gets away with it! I don't start fights, but I'm not afraid to finish them!" He said his older brothers taught him to fight so that others would not view him as a "punk" who gets pushed around. In addition to being in and out of trouble with the law from age 12, he described experiencing a lot of pent-up emotions and a chronically upset stomach.

Playboy Script

Sexuality is a normal component of human development. However, a variety of societal messages and traumatic experiences can deflect young men's sexual development onto problematic trajectories. Boys often learn to suppress the extent to which they allow themselves to care for and connect with others. This suppression may lead to nonrelational sex, which is a tendency to experience sex primarily as lust, without any requirements for relational intimacy or emotional attachment. Hence, when sexuality enters their lives, it is often of an unconnected and nonrelational nature (Good & Sherrod, 1997; Levant, 1997). Many observers have pointed out the various ways in which playboy attitudes are harmful to others. For example, in conforming to playboy norms, men tend to be more hostile, to prefer inequitable social relationships (Mahalik et al., 2003), as well as to support rape myths (Locke, 2001). However, an important trend in research is finding that this value system is also quite harmful to men themselves. For example, although for some men engaging in nonrelational sex may be a useful stage of exploration during their life's journey, for others it becomes a problematic, self-perpetuating stage from which they have difficulty progressing (e.g., Brooks, 1998; Good & Sherrod, 1997). Men's fear of vulnerability and shame lead to a fear of intimacy in sexual relations. Thus, men may come to believe that the "slam-bam-thank-you-ma'am" form of sexuality is safer for them (Brooks, 1998) even though little communication or caring is shared and the risk of exposure to a variety of sexually transmitted diseases is high.

"Ted's" mother provided comfort but was ineffective in protecting him and his brother from his physically abusive father, who suffered from combat-related posttraumatic stress disorder. Ted learned early in school that other males respected him more when he was "successful" in having sexual relations with women. Ted grasped onto a sense of power, control, and mastery that he had not experienced during his childhood by seducing numerous women. Not until his second marriage began to crumble in his 40s did he begin to question the formula that "sexual conquest = self-esteem."

Homophobic Script

For the majority of people who have a dualistic way of viewing the world (Perry, 1970), the corollary of being traditionally masculine is to avoid any features associated with femininity or homosexuality. In this vein, characteristics that are potentially associated with homosexuality, such as any intimate connection with other men, must be avoided in oneself and disdained in others.

Research supports that this script is related to men's well-being in various ways. For example, men who restrict affectionate behavior with other men tend to employ more immature psychological defenses, such as projection and turning against the object (Mahalik, Cournoyer, DeFranc, Cherry, & Napolitano, 1998), and report greater paranoia, psychoticism, and feelings of personal inadequacy (Good et al., 1996). Indeed, recent research reports that heterosexual men react more negatively to homosexual men when the former feel less masculine (Gramzow, 2002). These notions of paranoia, turning against the (threatening) object, and regaining a sense of being masculine appear to be exemplified by the murderers of Matthew Shepard (an unimposing gay man in Wyoming).

This type of violence may be an example of the difficulty men have coping with feelings of same-sex attraction when homophobia is so prevalent in U.S. society. For example, recent research reports that men who had higher levels of homophobia experienced greater sexual arousal when watching homosexual pornography compared with men who had lower levels of homophobia (Adams, Wright, & Lohr, 1996). Thus, homophobia may be a way in which men try to gain a sense of control when feelings of attraction to other men create anxiety for them.

> "Richard," a successful 50-year-old car salesman, was a "man's man." He had a clear sense of right and wrong and was "in charge" of his family. When Tom, Richard's bright, handsome, popular, musical, and athletic 18-year-old son, informed Richard that he was dating other guys, Richard erupted in rage, disowned him, and put him out of the house.

Winner Script

An extremely important masculine script in American culture is that of being competitive and successful (David & Brannon, 1976). Although competition is often fun and an important aspect of sports activities, competition in the workplace is thought to be a significant source of stress that contributes to elevated blood pressure and other cardiovascular health problems for men (Good, Sherrod, & Dillon, 2000). For example, men have twice the age-adjusted death rate from heart disease as women (National Center for Health Statistics, 1992), with 48% of men who die suddenly of coronary heart disease having had no previous symptoms (American Heart Association, 1998).

"Type A" behavior, which has been consistently linked to coronary health problems, includes characteristics such as impatience, high drive for achievement, hostility, high need for control, competitiveness, and inability or unwillingness to express oneself. Many of these qualities are valued as ideals of American masculinity having to do with success and being a "winner" (O'Neil, Good, & Holmes, 1995). Supporting this connection to masculinity is the finding that Type A behavior has been associated directly with masculine gender role stress in working adults (Watkins, Eisler, Carpenter, Schechtman, & Fisher, 1991), which has been linked to serious health problems in men (Eisler, 1995).

In terms of psychosocial implications, men who endorse success, power, and competition display more controlling and rigid interpersonal behavior (Mahalik, 2000), more immature psychological defenses (Mahalik, Cournoyer, DeFranc, Cherry, & Napolitano, 1998), and more paranoia (Good et al., 1996). Also, research examining men's conformity to winning norms finds that

it is related to greater hostility and being socially uncomfortable (Mahalik et al., 2003).

> "Paul," an 18-year-old high school senior and athlete, described his conflictual relationship with his parents as a win–lose competition. He said, "If I am going to lose a [verbal] fight with them, then I want to make sure that they lose something and hurt too!" Instead of viewing relationship problems as being worked out through compromise, Paul viewed his relationships with his parents, teammates, and girlfriend as power struggles that have clear winners and losers.

Independent Script

Recent advances in relational psychology theories have promoted the notion that young boys typically experience "forced disidentification" from their mothers too early in their development (Bergman, 1995; Pollack, 1998), which can create problems with attachment relationships (Chodorow, 1978). Although research finds that males are no more likely than females to develop maladaptive attachment styles (Kiselica, 2001b), research does demonstrate a connection between traditional masculine gender roles and parental attachment and separation. Specifically, as males were more rigid in enacting masculine ideologies (i.e., had greater gender role conflict) and more stressed from failing to live up to masculine ideals (i.e., had greater gender role stress), they reported less attachment to, and more psychological separation from, parental relationships (Blazina & Watkins, 2000; DeFranc & Mahalik, 2002; Fischer & Good, 1998). Thus, because poorer parental attachment interferes with affective self-regulation, leaving the individual vulnerable to stress and at risk for compulsive self-sufficiency (Ainsworth, 1989; Bowlby, 1969), hyperindependence in men may signal being uncomfortable with "attaching" to others or with needing assistance from others, including their partners, health care professionals, or when seriously injured or ill. Supportive of this is research that finds men's conformity to self-reliance norms related both to greater psychological distress (specifically to greater depression, anxiety, irritability, intrusive thoughts, and social discomfort) as well as to less willingness to seek psychological help (Mahalik et al., 2003).

> "John," a 44-year-old computer programmer, experienced intense periods of anxiety and loneliness. Heterosexual, but never married, he wondered why he has always found something wrong with the women he has dated. His most common complaint was that the women he has become involved with get "too clingy after awhile." He began almost every session by saying, "I don't know if I really need to be here," and then talked about how he would only need one or two more sessions and he would be ready to quit therapy and set out on his own.

Responding to Men's Masculinity Scripts

It seems clear that living out certain masculinity scripts can be tied to many stressors for men and the important others in their lives. Even armed with this knowledge, however, clinicians are still likely to be wondering how they should address masculinity issues effectively in their work with men. We suggest the following strategies as potentially useful. First, determine what the salient masculinity scripts are for a particular client. For one client, being emotionally controlled (i.e., "strong and silent") may feel central to his masculine self, but for another it may be that being successful and competitive (i.e., "winner") or not taking any

"crap" (i.e., "give 'em hell") is most important. Although these scripts may be related to each other, we believe it is a mistake to focus on masculinity in a global way when working with clients, as men's individual constructions of masculinity are likely to focus on some normative messages but not on others (Mahalik et al., 2003).

Second, identify the positive functions these scripts serve for the client. For example, being strong and silent may be an effective strategy for a man at work, as others view him as steady in a crisis. Being a tough risk-taker may have helped him advance in his career or gain peer acceptance. Being aggressive or even violent may help him feel he can keep himself from being taken advantage of, or bullied, by others. Being sexually promiscuous may be exciting and a way to make himself feel desirable. Being homophobic might help him feel less anxious about peer rejection. His accomplishments through competition are likely to help him feel a sense of worth. And being self-reliant is likely to help him feel capable and not dependent on others for what he needs.

Beyond the specific benefits that a particular masculinity script may have for the client, conforming to traditional masculinity scripts also offers clear guidance about how one is supposed to act in society (Mahalik et al., 2003). This is no small benefit, as the process of identity development is often a difficult one. As such, conformity to gender role norms helps establish an identity for the individual who is wrestling with this stage of development. For example, being a tough guy or a "big wheel" are ready-made identities for men, and they provide individuals with clear priorities and ways of being that are likely to be useful.

After the client has had the opportunity to explore how these masculinity scripts have value for him, the client can be moved to examine some of the costs in relation to his presenting concerns that were highlighted in the review of the research discussed earlier. For example, the strong-and-silent script may disconnect the client from important others and contribute to his feelings of isolation. Being a tough guy may lead him to neglect himself or push himself in ways that hurt his health. Giving others "hell" may lead to trouble with the law or to family members' leaving him. Being a playboy may prevent him from real intimacy in his life and may hurt a partner to whom he is committed. Ensuring that others do not think he is homosexual may prevent any real connection to other men, whether family members or male friends, and may lead to self-loathing if he feels any same-sex attraction. Being a winner may cause physical stress as well as interpersonal alienation from always having to compete and beat others; and standing alone may lead to interpersonal isolation and feelings of hopelessness if one is unable to handle things by oneself.

Although our review and examples may be a place for therapists to start when anticipating the costs that such masculinity scripts may incur for their male clients, we are really suggesting that therapists help male clients identify costs by exploring their emotional and physical health in all of their work, family, and leisure relationships. For example, a client may talk about feeling competitive at work, but does he also compete with family members, and how does all of this affect his experiences of stress? The client is aware of being emotionally disconnected from his partner or children and wants to improve these relationships, but does he view these as the only potentially intimate relationships he can have? Although he has discussed blowing up and "giving hell" to

coworkers, are his wife and children also afraid of him, and do other important people in his life steer clear of him?

Having gone through these previous steps, the therapist can now help the client become more flexible in the enactment of masculine scripts that are causing distress for him. For example, maybe the strong-and-silent script is effective at work, but it makes family members feel disconnected from the client. More flexibility in this script might include leaving his workplace relationships as they are but trying to open up more with his partner, family, and/or close friends. For another client, more flexibility with the winner script might mean simply competing with a fewer number of people. For another, it might mean learning new interpersonal skills beyond "kicking butt" or "blowing up" at people. As these more flexible outcomes would be specific to individual clients, identifying all of them is beyond the scope of this article. However, by identifying the salient masculinity scripts, understanding the positive role they play, and comprehensively documenting their costs, therapists and their male clients are more likely to understand what changes need to be made, and clients are more likely to be motivated to make those changes.

Masculinity and Psychological Help Seeking

In addition to identifying strategies for working with men in therapy, clinicians need to be aware of how masculinity scripts may affect men's help seeking. From a socialization perspective, many of the tasks associated with help seeking, such as relying on others, admitting that one needs help, or recognizing and labeling an emotional problem, are at odds with the masculinity scripts identified and discussed above. Supportive of this thinking, research indicates that masculine gender role conflict is consistently inversely related to men's willingness to seek psychological help. Examining specific elements of gender role conflict, Good, Dell, and Mintz (1989) reported that men who endorse restrictive emotionality and affectionate behavior between men were reluctant to seek psychological help. Similarly, Robertson and Fitzgerald (1992) reported that success/power/competition and restrictive emotionality were correlated with negative attitudes toward psychological help seeking. If these findings are interpreted through the lens of our review, their results indicate that the strong-and-silent, winner, and homophobic scripts are connected to less willingness to seek psychological help.

These results suggest that internalized gender roles may create barriers to help seeking for men, particularly if help seeking involves violating important masculine gender roles. For example, seeking help often implies dependence, vulnerability, or even submission to someone with more power (such as a physician), and if men succumb to illnesses, they may be threatened by feelings of helplessness and loss of power—feelings that directly contradict societal pressures demanding their independence and invulnerability (Pollack, 1998; Sutkin & Good, 1987).

Of particular importance to beginning the therapeutic process are male clients' reactions to emotional expression. Specifically, male clients may expect that they will be encouraged, or even demanded, to use affective language and explore the emotional context of their life experiences. Because of the inhibition against strong emotional expression valued in North American culture (Bronstein, 1984), men may believe that feelings are unnecessary and better left unexplored, particularly if they feel comfortable and

more skilled in rational problem solving. Thus, men who are ambivalent about experiencing or expressing emotions may be more likely to avoid or terminate counseling as the work becomes focused on feelings.

As treatment fears appear to be different from negative attitudes toward seeking help (Englar-Carlson, Vandiver, & Keat, 2002), we believe it is also helpful to understand treatment fearfulness in men. Specifically, Kushner and Sher (1991) considered the decision to seek help to be motivated in part by a conflict between approach tendencies (e.g., mental distress, transition in life, pressures from others) and avoidance tendencies (e.g., fear of stigma, cost, time commitments, access to services). From this perspective, although men experience mental distress, they may also experience specific treatment fears around image concerns (i.e., fears of being judged negatively by oneself or others for seeking treatment; Deane & Chamberlain, 1994; Komiya, Good, & Sherrod, 2000) and coercion concerns (i.e., fears about being pushed to think, do, or say things related to their problems in a new way).

Related to men's image concerns is a perceived "gender-specific" stigma that men may associate with breaching the dictates of the masculine gender role that goes beyond the general negative societal reaction toward those who seek psychological help (Sibicky & Dovidio, 1986). In this case, the stigma of not living up to a masculine image likely interferes with asking for psychological help, particularly when asking for help is related to a salient (i.e., ego-central) masculine script (see Addis & Mahalik, 2003). For example, men who live out the winner script likely fear the stigma associated with being a "loser" that seeking therapy might bring. Men who live out the strong-and-silent, tough-guy, and give-'em-hell scripts likely fear the stigma associated with weakness; and men who live out the independent script are likely to fear the stigma associated with being dependent.

When considering men's fear of treatment, we think this same analysis may be applied to a fear of coercion. For example, men who live out the strong-and-silent script may fear being coerced into being weak and emotional in therapy. Men who live out the homophobic script may fear appearing passive; and if working with a male therapist or in group therapy with other men, such men may fear being coerced into intimacy with other men. Men who endorse the independent script may fear being coerced into being dependent in therapy, or in their lives, as a result of therapy.

Given these issues, we recommend that clinicians first work to identify the expectations that male clients have of the therapeutic process and either correct those that are erroneous or change the structure of therapy to be more congruent for a given male client. For example, if the client believes that the therapist is going to make him talk about things he does not want to talk about, the therapist can provide more accurate information about the therapeutic process (e.g., reassuring him that he is the one who is ultimately in charge of what gets talked about in therapy).

Second, psychologists might find ways to change the context of the help-seeking environment for men. To this end, Addis and Mahalik (2003) propose a model of men's help seeking that uses social psychological theory to integrate the masculinity research with social constructionist and feminist analyses of masculinity. They recommend contextual changes to help-seeking environments, such as providing greater opportunities for reciprocity (e.g., with other group members), increasing the perception of normativeness for particular problems (e.g., depression), training profes-

sional helpers to recognize the ego-centrality of certain problems (e.g., unemployment for men who view their family role primarily as "provider"), and creating alternative, nontraditional forums more congruent with masculine socialization (e.g., psychoeducational classes in work settings; see also Kiselica's, 2001a, suggestions for making the therapeutic environment more male-friendly by using shorter sessions or doing therapy outside of the office, for example).

In these ways, clinicians can anticipate stigma and treatment fearfulness, and then take concrete steps to help male clients feel more comfortable. By doing so, clinicians have a greater chance to work on difficult issues with male clients who may be ambivalent toward the traditional therapeutic process than if they do not do so and the male client takes control of the therapeutic process by leaving it.

Implications for Training

Because men's socialization into masculine roles contributes both to clients' presenting problems as well as to their negative attitudes and fears about counseling, we believe that the guidelines developed for multicultural counseling proficiency (American Psychological Association, 1990) and principles concerning psychotherapy with women (see Fitzgerald & Nutt, 1986) offer important considerations regarding training psychologists to work with men. Specifically, the principles developed for multicultural counseling proficiency and psychotherapy with women incorporate a sociocultural context into recommendations for training and practice that we believe are equally important to include when training psychologists to work with men. Using this same sociocultural perspective, we suggest that training address a number of issues when preparing psychologists to work with men:

1. It is important that psychologists be knowledgeable about masculine socialization. Specifically, we recommend that psychologists have knowledge about the cultural, racial, political, historical, and economic contexts that influence masculine socialization experiences. Given the research findings reviewed previously, psychologists who develop awareness of how these socialization experiences may constrain men's lives and affect their well-being are likely to be more effective in working clinically with men. Training programs could also design curricula to increase students' knowledge about the way in which masculine socialization contributes to personality formation, vocational choices, and the manifestation of psychological stressors.

2. Psychologists should strive to recognize the interface between an individual's experiences of masculine socialization and his thoughts, behaviors, and feelings regarding getting help. Therapists would do well to assess and understand the help-seeking process that male clients experience in terms of their masculine selves and their expectations and concerns about seeking psychological help. Greater understanding and anticipation of how masculinity issues, including help-seeking norms in the client's male peer groups, interact with experiences of seeking help can lead to initial therapeutic encounters that respect the experiences of men while exploring what may be unrealistic fears and expectations male clients may be holding (e.g., that a client may lose control of himself or that the therapist will try to turn him into a "sensitive male"). Asking such questions as "What parts about talking to a therapist or coming for therapy make you feel uneasy or skepti-

cal?" can identify reactions to help seeking that are tied to fear of stigma, coercion, emotional expression, or other issues that may interact with the client's masculine identity. By giving corrective information about the realities of the therapeutic process (e.g., "you are the one who decides what to talk about" or "you decide what changes to make or not make in your life"), male clients are less likely to have unrealistic fears of the therapeutic process.

3. Psychologists should incorporate a gender role analysis into their work with men. This would help clinicians and clients to better understand the contribution that masculine socialization may be making to men's presenting issues. This could be done by exploring the experiences that contributed to their masculine socialization. For example, the clinician can explore with the client by saying, "You talk about believing that men aren't supposed to show feelings. What are some of the experiences you've had that taught you that lesson?" In a similar way, clinicians could help clients connect earlier socialization experiences with current stressors. For example, "Given what you say about your father's emphasis on winning, I wonder how you felt when you didn't get that promotion?" Such exploration with male clients can help them better understand the connection between their masculine socialization and current psychological stressors. Such insight should lead to therapeutic goals coming from the client to loosen some of the constraints associated with those experiences and messages.

4. Psychologists should become aware of, and continually review, their own values and biases and the effects these have on their male clients. At the heart of the clinical bias literature is the idea that psychotherapists' clinical judgments, and their in-session behavior with clients, are influenced by the stereotypes that clinicians hold about specific populations to which clients may belong. Describing how this may occur for both male and female therapists, Mintz and O'Neil (1990) emphasized that because therapists undergo the same gender role socialization as do their clients, therapists' attitudes and behaviors related to gender role are likely to influence the process of assessing, diagnosing, and treating clients who enact traditional or nontraditional gender roles. Supportive of this thinking is research that has found that experienced male therapists who were traditional in their gender roles rated a nontraditional male client as having a poorer prognosis than a traditional male client (Wisch & Mahalik, 1999). Also, these therapists reported that they liked the nontraditional male client less, were less comfortable with him, had less empathy for him, and were less willing to see him. Conversely, nontraditional male therapists rated the traditional male as having a poorer prognosis than the nontraditional male and reported that they liked him less, were less comfortable with him, had less empathy for him, and were less willing to see him. Although female therapists were not examined in this study, it is not unreasonable to expect that their own values and biases connected to their traditional or nontraditional gender roles will likely interact with their male clients' gender roles.

Caveats and Conclusions

Although the body of research that we have reviewed documents the linkages between traditional masculinity scripts, psychological distress, and negative attitudes toward getting psychological treatment, a number of positive features associated with traditional conceptions of masculinity bear repeating from the first section of this article. Specifically, men holding more traditional conceptions of masculinity may have strengths in such areas as problem solving, logical thinking, risk taking, expressing anger, and assertiveness that are important skills for living and may be especially beneficial in times of crisis (Levant, 1995). Examples of how these positive aspects of more traditional masculinity ideologies may be manifested include the ability to remain calm and problem-focused in times of crisis, to subsume personal needs to the greater duty of protecting, and to provide for one's family or country through personal sacrifice.

These same skills may also be strengths that men who hold more traditional conceptions of masculinity bring to therapy. For example, problem-solving skills and a willingness to take risks in one's interpersonal life (e.g., to make changes in one's life or to try new behaviors—such as sharing feelings—that might be uncomfortable or awkward at first) are likely to affect positively the counseling process and the client's well-being. However, research on masculinity and therapy has not yet examined strengths that men who conform to traditional masculine norms may bring to therapy, nor has it evaluated the effectiveness of any of these clinical strategies or models proposed as effective in working with men.

Nevertheless, research on masculinity and therapy has identified an important irony associated with how elements of masculinity contribute to men's psychological distress as well as to their reluctance to seek help for psychological problems. These findings highlight the need for clinicians to better understand masculine socialization, to make efforts to explore the linkages between masculine scripts and men's presenting problems in their work with men, and to anticipate men's possible ambivalence to seeking help by finding ways to make the therapeutic experience more comfortable and effective. Our suggestion to the field is that programs begin training psychologists to attend to the sociocultural context of men in the same way in which we have already recognized how the sociocultural context shapes the experiences of persons of color and women.

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