

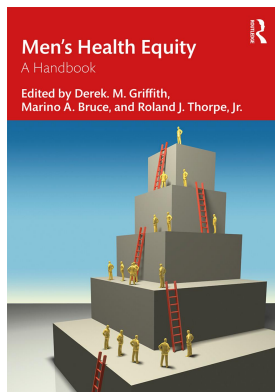
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Men's Health Equity A Handbook

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Considerations in Men's Mental Health Promotion and Treatment

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CONSIDERATIONS IN MEN'S MENTAL HEALTH PROMOTION AND TREATMENT

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Introduction

The field of men's mental health is gaining momentum as clinicians and researchers from an array of healthcare disciplines attempt to better understand and address many men's reticence to seek professional help (Galdas, Cheater, & Marshall, 2005). The economic and social burden of men's psychiatric illness and suicide (Swanson, 2002), substance overuse (Whiteford et al., 2013), and physical violence (Hester et al., 2015) points to a need to advance prevention efforts and drastically improve service engagement among men. Moreover, the refinement of men's mental health promotion and treatment should be informed—and ultimately evaluated—using empirical research. This chapter provides a sketch of the current landscape regarding initiatives aimed at enhancing men's engagement in mental health services and interventions tailored to men's needs. The chapter is based on the understanding that men's mental health is an interdisciplinary healthcare issue, requiring attention and action from researchers and clinicians of diverse backgrounds in order to bring about meaningful change.

Less than one third of men with a need for services will seek help when experiencing mental health concerns, and those who do are likely to present when experiencing physical symptoms or a major mental health crisis (Möller-Leimkühler, 2002; Susukida, Mojtabai, & Mendelson, 2015). A population estimate for those in the age range of 16 to 24 years old predicts that only 13.2% of young men with a need for mental health care actually access existing services (Slade, Johnston, Browne, Andrews, & Whiteford, 2009). These patterns are cause for concern, given the societal effects of untreated or undertreated mental illness. Clinical services designed to assess, diagnose, and/or treat men need to be improved upon if this problematic state of play is to be altered in the future. The reasons suggested for men's underuse of and attrition from mental health services are diverse, but consistently implicated is the effect of dominant masculine ideals (e.g., stoicism, control) that serve as barriers to care, in addition to clinicians' poor recognition of illness presentation among some men and a lack of men-centered services (Seidler, Dawes, Rice, Oliffe, & Dhillon, 2016; see Table 17.1). Societal and self-stigma, perceived weakness associated with having a mental illness that requires professional help, as well as poor mental health literacy impair many men's understanding and communication with clinicians (Ogrodniczuk, Oliffe, & Black, 2016; Oliffe & Phillips, 2008). An additional challenge is the observation that some men may express psychological distress in a manner that is not readily recognized as concordant with mental illness. For example,

Table 17.1 Reasons for Men's Underuse and Attrition From Mental Health Services

<i>Theme</i>	<i>Description</i>
Impact of dominant masculine ideals	Contradiction between seeking help and masculine ideals of stoicism, strength, independence, success, and power (e.g., Oliffe et al., 2010).
Poor mental health literacy	Difficulty recognizing, communicating, and understanding mental health conditions (e.g., Rochlen et al., 2010).
Societal and self-stigma	Shame regarding perceptions of weakness or failure, discomfort with emotional disclosure, potential issues of trust with practitioner, and problem minimization or avoidance both before and within help-seeking settings (e.g., Latalova, Kamaradova, & Prasko, 2014).
Atypical symptom expression	Poor fit between existing diagnostic criteria and common male symptom patterns (i.e., anger, substance misuse, violence; Rice et al., 2015; Cavanagh et al., 2017).
Clinician biases, stereotypes, and discomfort	Difficulty working with men due to rigid gendered assumptions regarding common male behaviors and responses (e.g., Mahalik et al., 2012).
Lack of men-centered services	Poor acceptability of clinical environment and promotion of or reliance upon treatment options that do not match men's needs, nor what they find engaging (i.e., medication and vulnerability-focused psychotherapy; Seidler, Rice, Oliffe, Fogarty & Dhillon, 2017).

depression in some men may manifest as primarily externalizing behaviors that do not correspond to existing diagnostic criteria or screening measures for depression (Genuchi & Mitsunaga, 2015; Rice, Fallon, Aucote & Möller-Leimkühler, 2013; Martin, Neighbors, & Griffith, 2013). This may limit identification of mental illness and reduce opportunities for men to fully engage clinical care.

Concerted efforts have been made to shift this trend of poor help-seeking. These have included the development and dissemination of community-led help-seeking and antistigma campaigns (Ogrodniczuk, Oliffe, Kuhl, & Gross, 2016). Central to this messaging has been an emphasis on transforming how men think about their mental health, illness, and help-seeking. One aim of these campaigns has been to mobilize men through targeted education (Ogrodniczuk, Oliffe, Kuhl, & Gross, 2016; Rochlen, Whilde, & Hoyer, 2005). Upon seeking mental health services, men are then faced with the issue of whether the clinical service will accord with their presentation, expectations, and needs. Some researchers (e.g., Westwood & Black, 2012) suggest that, given men's socialization experiences, some men may struggle to effectively engage with psychotherapies focused on expression and communication of emotion and vulnerability. This core element of many psychotherapy approaches may strike some men as transgressing masculine ideals that valorize strength and stoicism (Johnson et al., 2012; Seidler et al., 2016; Westwood & Black, 2012). Attempts have been made to explore elements of psychotherapy that are most efficacious and engaging for men (Kivari, Oliffe, Borgen, & Westwood, 2016; Richards & Bedi, 2015; Seidler, Rice, Oliffe, Fogarty, & Dhillon, 2017). Thus far, however, such work is in its infancy.

The Help-Seeking Dilemma—Getting Men Through the Door

Whereas some men do seek and engage in clinical care for mental illness, many actively deny illness and are reticent to seek professional help. Dominant masculine ideals, including strength, self-reliance, and competitiveness, have been highlighted as contributing to men's reticence to obtain professional help (Seidler et al., 2016). Some men may interpret these cultural mores as indicating that emotional or psychological distress is unmanly or that needing outside help for mental illness

is a sign of weakness. For these men, the notion of seeking help may be equivalent to relinquishing an aspect of one's masculinity—one's very sense of what it means to be a man. Such a constricted sense of masculinity—where there is little room for emotionality and vulnerability—stigmatizes men's mental illness and the act of seeking help. Campaigns to promote mental health literacy and services uptake among men have thus sought to counter such dominant masculine ideals and to destigmatize mental illness. The hope with such efforts is for men to incorporate the notions of mental illness and help-seeking within a sense of what it means to be a man—that is, acknowledging their mental health challenges and working to improve their well-being for themselves, their families, and friends. Fortunately, men-focused public health initiatives parallel shifts within some segments of Western societies that allow and even facilitate more flexible and expansive gender roles for men (Addis & Cohane, 2005; Ogradniczuk Ogradniczuk, Oliffe, Kuhl, & Gross, 2016).

Destigmatizing Mental Illness Among Men

A prevailing and potent driver for destigmatizing men's mental illness has been to lobby for authentic talk about ordinarily taboo issues. For example, the Canadian Man-Up Against Suicide Project offered safe spaces and places to discuss male suicide. The discussions were facilitated by men and women who had lost a male to suicide and by men who previously had experienced suicidality; the facilitators shared their related photographs and narratives. At in-person photographic exhibitions and through online videos and photographs, the project has raised awareness about male suicide while lobbying for discussion about targeted male suicide prevention strategies (Creighton et al., 2017; Man-Up Against Suicide, n.d.). Similarly, in the United Kingdom, the Campaign Against Living Miserably (CALM) promotes social media movements that aim to defy negative male stereotypes and widely disseminates print magazines with interviews and articles that normalize male mental illness amid promoting effective self-management strategies (The Calm Zone, 2014). In Australia, the Man Up (2016) project includes a national television series depicting the impact of masculine socialization on men's emotional communication and overall mental health, debunking some of the limits that constrain boys and men who adhere to risky dominant masculine ideals. Finally, the Australian-based Young Men's Project (n.d.) involves peer-led group workshops in which young men discuss, create, and model ways that men can better understand, and the project responds to mental health issues with the aim of generating innovative community-based projects and campaigns for the future. Common across these initiatives are efforts for destigmatizing mental illness among men through norming and affirming boys and men as strong and courageous in speaking up and out.

Norming Men's Help-Seeking

Efforts toward norming men's help-seeking have built upon the destigmatizing initiatives mentioned in the previous paragraph. Among these have been online services, offering anonymity to men interested in self-evaluating and managing their mental health challenges. For example, Canada's HeadsUpGuys (n.d.) website (<http://headsupguys.org>) specifically counters many men's socialized views of accessing health services as a sign of failure or flawed dependence. The site offers psychoeducation, practical tips, and help-seeking guidance to men recovering from and managing depression. The site attracted more than a quarter of a million visitors in its first year, with 45,000 men completing the depression self-check tool that is included on the site. In addition, Australia's Beyond Blue (2018) website (<https://www.beyondblue.org.au>) offers self-management strategies and information about access to mental health services; the website also includes a section that is specific to men's mental health. These online resources frame help-seeking as a strength that is consonant with dominant masculine ideals.

Such large-scale initiatives may partially account for some recent findings of increased mental health service utilization among men (Harris et al., 2015). However, given their infancy, these

campaigns and resources require formal evaluation regarding their reach, efficacy, and relatability for men in order to be iteratively improved upon. Moreover, expanding the scope of such campaigns to target a broad range of masculinities (i.e., based on sexuality, class, and ethnic diversity) is needed. This may occur through appropriate imagery, form, content, and integration of well-known advocates, sending a clear message that providers who offer mental illness treatment can engage with and embrace diversity, rather than assume homogeneity in male clients. It is clear that with online mental health resources being developed using a gender lens, men can be provided a gateway to access professional services that can either augment existing treatments or exist as a stand-alone option.

Embracing Diversity

Certain social determinants of health place men at greater risk of experiencing mental illness. Younger (12–25 years old) and older men (70 years old or more), sexually diverse men, and racial or ethnic minorities are some at-risk groups requiring specific focus when it comes to treatment promotion and service provision (Griffith, 2012). In addition, a strong socioeconomic rationale exists for addressing inequities among men to improve their engagement in mental health care (Rice, Purcell, & McGorry, 2018). These clear, practical ramifications for addressing diversity have a strong theoretical underpinning, with Connell (2005) theorizing that a plurality of masculinities exists for men. These expressions of masculinity, while dynamic, tend to be stratified as complicit (conforming to dominant masculine norms), subordinate (lacking authority or status which is replaced with dependency), or marginalized (excluded based on difference). Compared with dominant (i.e., white, middle class, heterosexual) complicit masculinity, subordinate and marginalized masculinities gain little to no attention in either help-seeking campaigns or service design and delivery. Furthermore, the combination and intersectionality between these sociocultural factors must be considered. For instance, the ways in which a marginalized African American gay man is left with role-related stressors after unemployment are not well understood. This and other examples problematize the promotion of mental health help-seeking for certain men. The following sections outline selected groups of men across age groups, ethnicity, and sexuality that have been found to struggle most with mental illness and suicide because of role stressors and their masculine identity.

Young Men

Young men under the age of 25 years who experience mental illness are the most unlikely demographic group to engage with mental health care services (Slade et al., 2009). This developmental stage is often coupled with an environment in which hormonal changes, masculine identity formation, and social conformity clash, discouraging boys from feelings of vulnerability or weakness and promoting risk-taking (Evans, Frank, Oliffe, & Gregory, 2011). For those with mental health concerns, male adolescence often signifies the beginning of a long clinical trajectory of broken periods of engagement characterized by unique symptom presentation, inadequate clinical responsiveness, and having to overcome self- and societal stigma as barriers to prolonged service access (Rice et al., 2018). Current responses to engage this critical demographic of young men repeatedly miss the mark. Developmentally appropriate solutions are needed to understand and accept the unique difficulties these men may face (e.g., problematic substance use, interpersonal violence, emotion regulation difficulties, economic hardship). Developing solutions to reach this group will require tapping into existing domains of interest through appropriate new media and technology (e.g., social media and e-interventions), incorporating—for example—sports, gaming, music, or adventure therapy (Rice, Telford, Rickwood, & Parker, 2017). Moreover, school-based programs have been found to be a useful, large-scale approach to engaging young men in early interventions

to gain their trust and rapport while building among them mental health literacy and motivation. Also, given the critical role of fathers as male role models to adolescent men in shaping their son's sense of masculinity and counteracting negative stereotypes and barriers to treatment, more concerted effort is needed to improve fathers' engagement in mental health interventions (Frank, Keown, & Sanders, 2015).

Middle-Aged Men

It should be noted that middle age (45–60 years old) also brings specific environmental role stressors for men that can impact their mental health and are worthy of consideration. These include career demands, fatherhood, family responsibilities, caring for older parents, and the potential onset of significant physical ill health or chronic conditions. Many men in this stage of life are cementing long-held masculine beliefs and practices regarding their physical and mental health, which subsequently play a profound role in decreased life expectancy rates. Stoicism and fatherhood often become synonymous, and maintaining an image of physical competence and an ability to provide income for one's family overpowers any impetus to seek help (Evans et al., 2011). Despite this period often being a time of identity shift or the more popular "mid-life crisis"—which triggers the potential for substance misuse and depression—denial and avoidance are employed in an attempt to overcome these changes, which challenge hegemonic ideals (Olliffe, Robertson, Kelly, Roy, & Ogrodniczuk, 2010). This challenge to dominant masculinity may be more salient for men of this age given the sharp 43% increase in suicide deaths among this age group between 1997 and 2014, reinforcing the need for targeted intervention (Centers for Disease Control and Prevention, 2018).

Older Men

Older men (70 years old or more) share many of the characteristics of younger men (see section on "Younger Men") but have specific age-related concerns that help-seeking campaigns and clinicians need to take into account. These include loss of role, status, and income through retirement, which can adversely affect older men's self-concept. Older men typically try to avoid a transition from autonomy and self-reliance to any form of subordinate dependence, thus explaining their long delays seeking help for mental health concerns (Griffith, Cornish, Bergner, Bruce, & Beech, 2017; McVittie & Willock, 2006). The underdiagnosis and undertreatment of mental illness in older men, combined with often problematic physical health, means that an integration of medical and psychological care in a single physical setting may be most useful in increasing uptake of services (Guilcher et al., 2016). Given the fear of weakness and loss of status in older men, services should aim to accommodate for any self-stigma by employing strength-based interventions that promote self-management, support work-related transitions (e.g., job uncertainty, retirement), and affirm multiple masculine identities (Olliffe et al., 2013). This can be done by engaging families and support networks in care, by providing convenient and unobtrusive treatment (e.g., teletherapy), and by both normalizing and encouraging social connectedness through the offering of men's groups (Kosberg, 2005).

Racial or Ethnic Minority Men

Mental health treatment has often been described as Eurocentric in its construction, representative of a "white institution," thus distancing racial minority men and often being inappropriate for engaging them (McCarthy & Holliday, 2004). Minority men conform to many of the same dominant masculine ideals as White men (e.g., *machismo* in Latino men; Arciniega, Anderson, Tovar-Blank, & Tracey, 2008; Griffith, 2015). However, the existing problematic barriers that White men

face when contemplating treatment are only amplified among minority men because of a mistrust of a system that often marginalizes them and neither seeks to understand nor respect their culture or experience (Whaley, 2001, 2004). Importantly, a difference exists between knowing certain cultural factors that are relevant to immigrant or refugee men, for instance, and applying a culturally responsive clinical treatment (Carr & West, 2013). Seeking knowledge and input in a client-led treatment style that promotes authenticity and transparency (e.g., using first names, self-disclosing) over pathology and shame is especially key when engaging these men. Given the higher likelihood of comorbid physical health, substance misuse, and economic concerns in this male subpopulation, campaigns promoting help-seeking should strive to address this group through messages of connectedness, openness, and visibility (e.g., we see you, we hear you) to counter notions of invisibility, stigma, and disconnection. As with younger men, gender-based motivational interviewing to address and overcome ambivalence may be especially useful in engaging minority men, but first, clinicians must consider their own perceptions and stereotypes regarding certain cultural groups so as not to worsen any pre-existing acculturation stress (Zayas & Torres, 2009). To increase feelings of trust while honoring certain cultural practices, Gross and colleagues (2016) recommend that community-based organizations form minority-specific support groups that are designed and coordinated by members.

Gay & Bisexual Men

Gay and bisexual men are another at-risk, socially marginalized community with poor mental health outcomes (Hatzenbuehler, 2009; Meyer, 2003). Men in this subpopulation often conceal their sexual identity to keep up dominant masculine appearances and to avoid discrimination, violence, and interpersonal rejection (Cook & Calebs, 2016). This fear of alienation and societal stigma leads to higher rates of suicidality and substance misuse in this population, with healthcare services repeatedly found to lack the specialization to respond to their unique concerns, for instance around relationships and identity formation (Lee, Gamarel, Bryant, Zaller, & Operario, 2016). Gay and bisexual men often encounter stereotypes and generalizations in care that are similar to those encountered by ethnic minority men because of providers' lack of education and awareness of significant issues, resulting in the men's disengagement and cultivation of feelings of mistrust (Knight et al., 2012). These men must also be represented in help-seeking campaigns in content that highlights the depth of their experience in a nonstereotypical manner. It is essential that both health promotion efforts and treating clinicians use appropriate language and communicative styles in portraying an environment free of judgment where men can confide (Ferlatte et al., 2017).

In what follows, we turn our attention to some specific community-based and clinically based programs that target men's mental health promotion and mental illness treatments.

Clinical Services for Men—What's Been Done and What We Know

Given the attention and effort devoted to improving men's use of mental health care services, it is important to consider whether available treatments appropriately serve men's needs. Evidence shows that men have a strong preference for psychotherapy over psychopharmaceutical interventions (Berger, Addis, Reilly, Syzdek, & Green, 2012; Sierra Hernandez, Oliffe, Joyce, Söchting, & Ogrodniczuk, 2014). This research challenges the widespread belief that men are opposed to psychotherapy as a treatment option for their mental health concerns, and it questions the supposed need for alternative mental health services for men (McGale, McArdle, & Gaffney, 2011). It remains a distinct possibility that some men may not wish to partake in the activities associated with psychotherapeutic treatment, which might lend to their reluctance to seek help. Yet, regarding help-seeking men, studies have provided evidence to suggest that psychotherapy should not only be considered a reasonable treatment option for men, but that it is likely to be particularly favored by a vast majority of such men (Oliffe et al., 2010; Tang, Oliffe, Galdas, Phinney, & Han, 2014).

Most of the literature concerning men-centered treatment refers to psychotherapy. The existing body of work typically takes the form of literature reviews, commentaries, or qualitative case reports rather than large empirical studies. In a recent review, Strokoff, Halford, and Owen (2016) found 15 psychotherapy studies that used either all-male samples or male-specific outcomes. These authors found a range of populations, treatments, and outcomes among the 15 reports, making it difficult to draw conclusions about the effectiveness of male-centered treatment from this pool of studies. Moreover, they identified only one study (Syzdek, Addis, Green, Whorley, & Berger, 2014) in which a treatment was specifically geared toward male clients. Researchers of this study investigated the briefly used alliance-building intervention gender-based motivational interviewing. This intervention was undertaken in a small sample of 23 men who had symptoms of anxiety and depression. The intervention was designed to promote treatment engagement and to reduce internalizing symptoms, all by adopting an interpersonal style characterized by transparency, curiosity, and respect to lessen masculine posturing and competition in the room (Syzdek et al., 2014). Although no statistically significant effects were found in the Syzdek et al. (2014) study, in a subsequent trial of gender-based motivational interviewing in a sample of 35 college men, a statistically significant increase was documented for seeking help from parents (Syzdek, Green, Lindgren, & Addis, 2016).

Adding to this nascent literature, a recent cohort study was conducted of a male-sensitive program for stressed or distressed men attending primary care (Cheshire, Peters, & Ridge, 2016). Known as the Atlas Program, it was designed to be sensitive to men's concerns by offering a male-only service, by offering a choice between psychological counseling or acupuncture, and by modifying language and promotional material (e.g., well-being rather than mental health). Preliminary findings suggest improvements in symptoms and well-being for program completers. Similarly promising findings have emerged from a Canadian study (Cox et al., 2014) in which the researchers examined a group treatment for male veterans who experienced combat-related psychological trauma. The Veterans Transition Program was designed to reduce hierarchy among clinicians and group members, to engage participants using male- and veteran-specific language, and to involve men helping each other by using action- and group-based processing of traumatic events with professional facilitation by psychologists. Contributing to the emerging trend of developing male-specific interventions is a small pilot study of a cognitive behavioral group intervention called the Men's Stress Workshop, which focused on depressed men and emphasized psychoeducation around male gender role norms to promote insight into and challenging of the positive and negative impacts of men's conformity or adherence to these norms (Primack, Addis, Syzdek, & Miller, 2010). The developers of the Men's Stress Workshop argue that purposefully addressing masculinities and gender dynamics in a collaborative, structured manner may be an efficacious point for psychotherapeutic intervention, although supporting evidence for such adaptations remains to be demonstrated. Because of the emergent nature of the field, these efforts lack comparison conditions or randomization. Most use very small samples, and, so far, follow-up assessment has been absent. Moreover, the disparate nature of the populations studied prevents generalization to men more broadly.

Clinician Considerations—The Need for Gender Sensitivity

Research on men's experiences with psychotherapy processes has provided important direction for clinicians across disciplines that work with men. In a study of 37 men (Bedi & Richards, 2011), several key alliance-building themes were found for men receiving psychotherapy, including *nonverbal psychotherapist actions* (e.g., handshake, greeting style) and *emotional support* (e.g., clinician reflected the client's feelings), with the strongest being a focus on the psychotherapist's skill in *bringing out the issues* (e.g., normalizing help-seeking, offering suggestions, discussing goals). In a sample of 86 male therapy attenders, the same authors (Richards & Bedi, 2015) found a number of themes

that men endorsed as being potentially damaging to a therapeutic alliance. These included a mismatched approach, timing problems, lack of trust, and a therapist acting on assumptions or pressuring the patient. Men also felt that their own uncertainty or lack of effort would be detrimental to the alliance. After studying a sample of 25 young men, Rice and colleagues (2017) reported that the therapy process, including an emphasis on emotional disclosure, was unfamiliar and at times uncomfortable for young men. Mahalik, Good, Tager, Levant, and Mackowiak (2012) developed a taxonomy of useful clinical considerations regarding the treatment of male clients, based on the responses of 475 psychologists working with men. These included awareness of gender role issues and male development, use of male-oriented language, and avoidance of stigmatizing labels and attitudes toward men and masculinity. Also important were openness to discussing sexuality, willingness to discuss exposure to trauma, and exploration of the influence of gender socialization on emotions, intimate relationships, and other identity domains.

Many of these themes have been echoed throughout the books and articles that are available to help clinicians tailor their approaches to treat men (e.g., Brooks, 2010; Good & Robertson, 2010; Rabinowitz & Cochran, 2008; Rochlen & Rabinowitz, 2014). Such recommendations emphasize the challenges presented by dominant masculine ideals that disavow vulnerability and emotional expression (Rochlen et al., 2010; Seidler, Rice, Ogrodniczuk, Oliffe & Dhillon, 2018). A key message in this literature is the suggestion that many men may need assistance in acclimatizing to psychotherapy processes, which can feel unfamiliar and uncomfortable, as noted previously (Rice et al., 2017). Such assistance may involve transparently explaining the *how* and *why* of treatment processes (Kivari et al., 2016; Stevens, 2007) and providing tangible information to improve mental health literacy (Seidler, Rice, Oliffe, et al., 2017). Fostering a relationship based on respect, shared control, and decision-making may also counteract feelings of dependence and vulnerability that hinder some men's engagement in mental health treatment (Good & Robertson, 2010; River, 2016). Some authors recommend action-oriented rather than emotion-laden language to appeal to men who identify with dominant masculinity norms (Westwood & Black, 2012).

The aforementioned suggestions are likely to be useful for working with some, but not necessarily all men. Some researchers (Owen, Wong, & Rodolfa, 2010) have found that men who conform to masculine norms tend to perceive interpersonal and emotion-related processes as key drivers of therapeutic success. Thus, interpretive therapy—reflecting on intrapsychic, interpersonal, and emotion-focused themes—has been found to benefit men more than a supportive, problem-solving approach (Ogrodniczuk, 2006). Hence, working with men is likely best facilitated by having an appreciation of myriad permutations of masculinity and individual preference.

As Spector Person (2006) notes, the differences among men regarding gender and gender role identities are often vast. The experience of being male and embodying masculine identities is diverse and complex, intersecting with ethnicity, culture, and sexual orientation (Griffith, 2016). Thus, rather than adopting any specific male-centered approach, we encourage clinicians to maintain an openness to the nuanced ways in which each man experiences, identifies with, and constructs masculine identity themes (Johnson et al., 2012) and to tailor engagement and treatment accordingly (Seidler, Rice, River, Oliffe & Dhillon, 2017). For example, Strokoff and colleagues (2016) advocate for cultural competence in clinical work with men and suggest using a multi-cultural orientation framework to guide assessment of the salience of masculinities—and other identities—for each man's mental health challenges and treatment needs. Research evaluating and extending these types of frameworks is urgently needed. Although not a clinical intervention per se, the Men's Sheds movement from Australia has been successful in engaging men in psychosocial supports (Milligan et al., 2016). Men's sheds are effective in engaging older men as they literally meet men where they are by creating member-led groups founded on building social connections through shared activities. The success of this model provides clues for how to design innovative programs in the men's mental health space.

Future Directions—The Next Generation of Men’s Mental Health Services

Our review has highlighted some of the ways in which the field of men’s mental health continues to gain traction within research and clinical spheres. Several examples highlighted here demonstrate the innovative ways in which men might be helped to feel less stigmatized regarding mental health concerns and become more engaged in clinical, community-based, and online mental health care. In addition, early research regarding the refinement of mental health interventions for men—particularly psychotherapy—appears promising. There is, however, considerable room for development, requiring a concerted effort for interdisciplinary collaboration that takes into account intersectionality. Participatory models are more likely to be effective where men themselves, representing diverse communities and masculinities, are actively engaged in the design, implementation, and evaluation process.

As gender norms are increasingly questioned and expanded—aided by feminist critique and queer theory—the hegemony of dominant masculinity ideals may start to bear down less ominously upon men’s emotional and psychological health. Vulnerability and interdependence—already incorporated into many men’s sense of what it means to be a man—may become increasingly compatible with emerging masculine ideals. In tandem, continued efforts to promote mental health literacy and engagement among men are requisite to advancing the mental health of men and their families. Online and social media initiatives should feature prominently in this regard, because of their potential to reach mass audiences with engaging and accessible information. Given the role of technological advancement on health and well-being, incorporating new media (e.g., Twitter and Instagram) makes sense to entice hard-to-reach young men. This population—adolescent and emerging adult men—should be targeted by mental health promotion efforts, given their increased vulnerability for risk-taking and suicide and their strong resistance towards traditional help-seeking (Brown, Rice, Rickwood, & Parker, 2015). In turn, determining the unique mental health needs and service preferences of young men should be a research priority.

With regard to treatment, the extant literature provides little in the way of clear, evidence-based recommendations for male-specific intervention. More rigorous designs for treatment studies, using larger and more representative samples of men positioned from an array of mental health professional lenses, would certainly advance the field. Consideration should also be given to research that investigates men’s motivations, expectations, preferences, and actual experiences of clinical care. If conducted across diverse and large samples of men, such research could complement Mahalik and colleagues’ (2012) taxonomy of clinical considerations—informed by a range of men and masculinities. As for clinicians, undergraduate and graduate training in the helping professions such as psychology, psychiatry, nursing, and social work should include a core curriculum focused on men’s mental health. Currently, only 25% of U.S. doctorate programs in psychology include training in men’s gender issues (Mahalik et al., 2012), and Canadian and Australian medical programs also have a paucity of men’s health curricula (Muller, Ramsden, & White, 2013; Seidler, Rice, Dhillon & Herrman, 2018).

Conclusions

Study findings have highlighted that men can seek help and remain engaged with treatment in the right circumstances (Johnson et al., 2012; Seidler, Rice, Oliffe, et al., 2017; Sierra Hernandez et al., 2014). The long-standing negative focus on masculinity as a barrier to help-seeking has perhaps inadvertently characterized men as reluctant “problem” clients, impeding consideration of currently available psychotherapy services—typically depicted as antimasculine—as relevant and appropriate for men (Englar-Carlson, 2006; Kiselica & Englar-Carlson, 2010). Suggesting that men’s underutilization and problematic engagement with mental health services only reflect their own or society’s shortcomings disregards the necessity for all clinicians, across mental health disciplines, to also

consider how they can maximize engagement with their male patients by maintaining an openness to the nuanced ways in which each individual man constructs his own masculine identity. As an emergent field, men's mental health requires generational and cultural shifts in order to explore the full complement of approaches to men's mental health promotion and treatment in ways that are cognizant and inclusive of the diversity and patterns within and across men.

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