How therapists work with men is related to their views on masculinity, patriarchy, and politics

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In recent years, guidelines have been issued encouraging therapists to see masculinity in relation to power, privilege, and other constructs related to patriarchy theory. An exploratory study took a snowball sample of psychological therapists (psychotherapists, clinical psychologists, etc) recruited through professional networks and social media platforms between September and November 2020. This anonymous online survey asked participants how they view masculinity in relation to therapy. A total of 107 therapists met the inclusion criteria, mean ± *SD* age 47.1 ± 12.5, 66% (71) male, and 12.1 ± 9.9 years in practice. Sixty therapists also described their approach to therapy with men, and content analysis found three categories: male-orientated (i.e., being aware of male-typical preferences for therapy; $n = 36$); gender-neutral (i.e., treating male and female clients in the same way; $n = 20$); and anti-patriarchy (i.e., viewing men's problems as a result of the influence of patriarchy on socialisation into masculinity; $n = 4$). Chi-square (χ^2) analysis with Fisher's exact correction found therapists with a male-friendly approach were significantly less likely than other therapists to believe that: the training they received was male-friendly ($\chi^2 = 17.804$, $p < .01$); patriarchy holds women back ($\chi^2 = 17.542$, $p < .05$); and masculinity is simply a social construct ($\chi^2 = 17.476$, $p < .05$). They also identified less as being feminist ($\chi^2 = 16.787$, $p <. 05$); and less as being left-wing politically ($\chi^2 = 15.347$, $p <. 05$). Therapists' views about masculinity and patriarchy are significantly related to how they report treating male clients.

Keywords: feminism; masculinity; men; patriarchy; therapist

It is a truism that there are 'more similarities than differences between men and women' (Hyde, 2005). Despite there being a relatively smaller number of differences, some of these differences are potentially important. For example, in general, men and women deal with stress in different ways (Tamres et al., 2002), have some different preferences for therapy (Liddon et al., 2017), and may even experience different outcomes from therapy (Wright & McLeod, 2016). These differences suggest that men might have different needs than women when it comes to therapy and because men are more likely than women to die by suicide, yet less likely to seek help from a therapist (Kung et al., 2003), there is a compelling case for making sure that men are not being put off seeking help, or drop out of therapy, because they feel their needs are not being met by the therapies that are available.

In this context, a welcome development was the publication of guidelines on therapy for men and boys (American Psychological Association, Boys and Men Guidelines Group, 2018). Some parts of the APA guidelines are evidence-based and of value, especially Guideline 9 which describes male-friendly approaches to therapy that have some degree of supporting evidence. However other parts of the APA guidelines have been widely criticised, especially Guidelines 1 and 3 (Barry et al., 2020). Guideline 1 makes the presumption that masculinity is just a social construct without any influence of biology, but this does not explain why many biologically based sexes' differences in behaviours and cognitions map closely onto notions of masculinity and femininity (Barry & Owens, 2019). Guideline 3 suggests that masculinity is problematic due to the influence of patriarchy, but this assumption does not explain research findings that masculinity can be good for men's mental health and relies on vague and unscientific definitions of patriarchy (Seager & Barry, 2019). Because the evidence base for APA Guidelines 1 and 3 is partial and weak, they are of questionable value in the therapeutic context where a sound evidence base for practice is considered important (Barry et al., 2020). Guidelines 1 and 3 appear to elevate gender politics over evidence-based therapy, and the following sections will explore what is already known about how socio-political views of gender shape our views of men, masculinity, and therapy for men.

Brooks (2001) made an astute observation regarding the impact of viewing masculinity as a social construct rather than something shaped by biological or evolutionary forces: 'When we approach men's mental health from an essentialist perspective, we are more likely to view the dark side of masculinity as an unfortunate, but the relatively inevitable, outcome of male heritage' (Brooks 2001, p. 292). It is no surprise then that this approach, like that of the APA guidelines, sees masculinity as a social construction that typically has a negative effect on men's mental health and other aspects of their lives. The term 'masculinity has been defined (or constructed) in increasingly negative ways in the social sciences, and the term 'toxic masculinity' has become popular in the media (Barry et al., 2020). However, there is evidence that this view is out of step with that of the general public. For example, a survey of 203 men and 52 women (mean + *SD* age 46 +13) found participants thought the term toxic masculinity insulting, probably harmful to boys, and unlikely to help men's behaviour. Although they were not asked about therapy, most participants said they would be unhappy if their masculinity or femininity were blamed for their work or relationship problems.

Views on patriarchy

'Patriarchy' means the 'rule of the father', describing communities of related families which have a male leader, or 'patriarch' (Oxford English Dictionary, 2020). Although arguably this social structure bears little resemblance to modern Western societies, the term is often used today in the social sciences and popular media to describe modern Western culture as a 'system of social structures and practices in which men dominate, oppress, and exploit women', and gives power and privilege to men (Walby, 1990). Referring to the US today, APA's guidelines suggest that 'males experience a greater degree of social and economic power than girls and women in a patriarchal society' (American Psychological Association, Boys and Men Guidelines Group 2018, p. 9). Although in many modern countries women have rights and privileges that men don't (e.g., preferential access to children and property after family breakdown) and experience some hardships less than men (e.g., most rough sleeping homeless people are male), belief in the systematic oppression of women in the modern West persists (van Creveld, 2013). The impact of these beliefs on therapists, and the consequences for male clients, has not been assessed.

Patriarchy as a subtext in therapy

Although patriarchy is not always mentioned specifically when it comes to therapy, sometimes assumptions about power imbalances in relationships are seen as a manifestation of patriarchy. For example, in a book chapter entitled *When Therapy Challenges Patriarchy,* it is suggested that: 'People, including therapists,

often believe that women and men are equal now and may not recognize how communication patterns tend to remain gendered such that men are less likely to tune into, notice, and accommodate to female partners. Or if they do, masculine gender norms tell them they have given up too much' (Knudson-Martin 2015, p.16). The definition of power given in this chapter assumes it is male: Among intimate partners, power 'refers to the ability of one person to influence a relationship toward his own goals, interests, and well-being' (Mahoney & Knudson-Martin 2009, p. 10). This concept of power would not be shared by many men, especially when the victim of domestic violence from a female partner (Powney & Graham-Kevan, 2019), or when dealing with relationship breakdown (Barry & Liddon, 2020). The idea of patriarchy in relationships is popular, and interventions based on this idea are widely used, invoking a pattern of power and control by men over women (Powney & Graham-Kevan, 2019), despite the fact that they are relatively ineffective compared to more psychology-based interventions, such relationship enhancement (Babcock et al., 2004).

Feminist and anti-patriarchy views

A survey found that identifying as a feminist, and especially having anti-patriarchy views, were correlated with more approval of the 'toxic masculinity' narrative (Barry et al., 2020). In contrast, supporting equality of opportunity views was not related to approval of the 'toxic masculinity' narrative. This contrast emphasises a qualitative difference between 'equal opportunities' feminism and 'anti-patriarchy feminism, and indeed the two constructs were not correlated.

Applying feminist therapy to men

Various forms of feminist therapies for men exist, such as gender-aware therapy (Good et al., 1990) and gender role journey therapy (O'Neil, 2015). These models are derived from other models of feminist therapy, such as gender-role analysis (Worell & Remer, 2002). A more recent model, Feminist Multicultural Therapy (FMCT) was devised originally for women and ethnic minorities, but it is suggested by (Wolf et al., 2018) to be more flexible than other feminist approaches. It is claimed that it can be used not only with men who identify as gay or non-White, but also men struggling with gender role conflict and toxic masculinity (phenomena that are 'so evident in U.S. culture'), and even men who are not aware of their how their power and privilege and how the pressures of hegemonic masculinity and patriarchy create mental health problems for them and others around them (Wolf et al., 2018). FMCT is psychotherapy that emphasises context – mainly power, privilege, and oppression – as contributors to psychological distress. This approach thus introduces politics and ideology into therapeutic environments, though feminists might justify this by recourse to the idea that 'the personal is political' (see the section on politics below). FMCT explains men's mental health problems and lack of help-seeking in therapy as linked to the rigid constraints of masculinity. For example, men seek therapy less because of the masculine rule that seeking help is unacceptably weak (Yousaf et al., 2015).

How much does feminism impact the views of men

Various research suggests that women who identify more as feminists than they identify with women as a group are 'chronically motivated' to confront what they see as gender stereotypes (van Breen et al., 2018). This includes showing an increased willingness in experiments on moral decision-making to sacrifice men rather than women (van Breen et al., 2018). The impact of this mindset on male clients of feminist therapists has not, to date, been assessed.

Political views

Various demographic factors are related to political views. An axiomatic example is that people become more conservative as they grow older (Tilley & Evans, 2014). Left-wing parties tend to be more in favour of women's issues and less in favour of masculinity (Winter, 2010), and psychologists tend to lean to the left politically (Langbert & Stevens, 2020). Although it is well known that discussing politics risks confrontation, around two-thirds of therapy clients discuss politics with their therapist (Langbert & Stevens, 2020). When political views are congruent between client and therapist this might be expected to improve the therapeutic alliance, which is, in turn, beneficial to the outcome of therapy (Solomonov & Barber, 2018). In therapy, the chances of congruence of political views are good because most psychologists (Langbert & Stevens, 2020) and most therapy clients (Kung et al., 2003) are women. However, the impact on clients whose politics are not to the left is not known. It could be that the lack of congruence might be an impediment to the success of therapy and might lead to dropout and subsequently not taking up therapy in the future.

The present paper aims to find out how much a therapist's view on gender politics and politics more generally is related to how they conduct their therapy.

METHODS

The setting was online, and the questionnaire was designed for the present study. The study was reviewed by an independent expert and followed the BPS code of human research ethics (British Psychological Society, 2014). The survey collection was done via PsyToolkit platform Version 3.3.0 (Stoet, 2010, 2017).

Participants

From early October to early December 2020, attitudes towards masculinity were surveyed in a snowball sample of therapists (clinical psychologists, psychotherapists, etc). Recruitment came through various sites at various times during the recruitment period, including various therapy networks and sharing on social media with various psychology organisations internationally. The snowball sample started with the *Male Psychology Network* and then spread by word of mouth and social media to other research networks e.g., *Therapists Connect* and other groups via Twitter and Facebook. Although we were unable to identify all of the networks accumulated in the increasingly diverse and complex snowball sample, the researchers made efforts to include views from a spectrum of perspectives by, for example, tagging the APA's Division 51 (Psychology of Men and Masculinities) who had created the Guidelines discussed above, the Division of Clinical Psychology of the British Psychological Society and the equivalent in Ireland. In some tweets, we specifically sought to recruit feminist therapists to the study. Participants were excluded if they were under 18 years old, did not complete the consent form, or did not give key information (e.g., age, gender, or attitudes to masculinity). Participants indicated their informed consent to take part by ticking a box that followed an information sheet. The survey was anonymous and confidential, and done in accordance with the ethical guidelines of the British Psychological Society (2014).

Materials

Given that this topic has been so little researched, options for research instruments are very limited. For this reason, the team opted to create a questionnaire specifically for this study. Some parts of the questionnaire (the questions regarding feminism) were used previously (Barry et al., 2020). The main part of the questionnaire was developed through discussion within the research team over several months. The research team included expertise in questionnaire design and development (JB), and clinical psychology (MS is a consultant clinical psychologist) and involved consultation with another consultant clinical psychologist not otherwise involved with the study.

Background variables

Variables include: age, ethnicity (14 options, plus 'other'), gender (male, female, or other), occupational status, marital status, sexuality, and country of birth.

Sociopolitical beliefs

Participants were asked how much they agreed that the following described their views: liberal, conservative, left-wing, or right-wing. The response options were on a six-point Likert scale from 'very much agree' to 'very much disagree'.

Feminist attitudes

There were three items: (a) *I am a feminist*; (b) *Women should have equal opportunities to men*, and (c) *Patriarchy holds women back*. The response options were on a six-point Likert scale from 'very much agree' to 'very much disagree'.

Professional variables

Questions about the type of therapy practised, qualifications, experience (years of post-qualification practice), and male-female ratio of clients were assessed with text boxes. There were five trainees, and their 'years of practice' were coded as zero.

The questions below had response options on a six-point Likert scale from 'extremely accurately' to 'extremely inaccurately', or 'very helpful' to 'very unhelpful', or 'very much agree' to 'very much disagree'.

Masculinity as a social construct

Some people say that that: 'Masculinity is a social construct, with no contribution from biology (e.g., evolution, genetics, testosterone, etc). In other words, masculinity is created by social, cultural, and contextual norms and expectations, and can be reshaped or changed through therapy if needed.'

- How much do you believe this idea is an accurate assessment of masculinity?
- How much does it represent the views of most therapists you know e.g., in the organisation you work for or the professional body you are associated with?

Helpfulness to therapy of the social constructionist view of masculinity

'Masculinity is a social construct, with no contribution from biology (e.g., evolution, genetics, testosterone, etc). In other words, masculinity is created by social, cultural, and contextual norms and expectations, and can be reshaped or changed through therapy if needed.'

To what extent would you find the above idea (masculinity as purely a social construct) helpful in your clinical work in the following scenarios? In reality, these scenarios would involve many variables, but please try to give an approximate answer based on a very generic situation:

There followed several scenarios to be rated on a six-point Likert scale from 'very helpful' to 'very unhelpful'.

- Therapy with men who are having work-related problems
- Therapy with men who are experiencing domestic violence from a female partner
- Helping adult male victims of child sex abuse from a female perpetrator
- Helping boys who have autism
- Helping boys excluded from school for disruptive behaviour
- Working with traumatised military veterans
- Working with suicidal men
- Working with male rough sleepers
- Building an empathic and collaborative relationship with male clients
- Helping you to improve the self-esteem of vulnerable male clients
- Working with parents of boys with behavioural problems
- Working with fathers who are angry and depressed due to legal problems regarding access to their children
- Male clients accused of domestic violence
- Male clients with a history of harassing women online
- Male clients who feel guilty about having sexist views of women
- Male clients who feel angry that men are portrayed negatively in the media

These 16 items were combined into the variable *Masc_useful_clinically.*

To what extent do you think the idea that masculinity is purely a social construction helps support the following:

- A bio-psycho-social approach to the human condition
- Ethical and legal principle of non-discrimination on grounds of sex or gender
- Evolutionary theory
- Humanistic principles of empathy, warmth, and genuineness
- Evidence-based training for psychological therapists
- Encouraging men to seek therapy
- Improving therapeutic outcomes
- Understanding older male clients

These eight items were combined into the variable *Masculinity_supports_therapeutic_values.*

Patriarchy theory is useful in therapy

Some people say that we live in a patriarchal society where, on average, males experience a greater degree of social and economic power and privilege than females and that psychologists need to keep this in mind when treating male clients

- How much do you think this idea accurately describes the real-world experience of the average male?
- How much do you think your colleagues think this idea accurately describes the real-world experience of the average male?

'Psychologists need to take into account the impact of patriarchy, power, and privilege on boys and men and their relationships with others.'
To what extent would you find the above idea helpful in your clinical work in the following scenarios? In reality, these scenarios would involve many variables, but please try to give an approximate answer based on a very generic situation:

- Therapy with men who are having work-related problems
- Therapy with men who are experiencing domestic violence from a female partner
- Helping adult male victims of child sex abuse from a female perpetrator
- Helping boys who have autism
- Helping boys excluded from school for disruptive behaviour
- Working with traumatised military veterans
- Working with suicidal men
- Working with male rough sleepers
- Building an empathic and collaborative relationship with male clients
- Helping you to improve the self-esteem of vulnerable male clients
- Working with parents of boys with behavioural problems
- Working with fathers who are angry and depressed due to legal problems regarding access to their children
- Male clients accused of domestic violence
- Male clients with a history of harassing women online
- Male clients who feel guilty about having sexist views of women
- Male clients who feel angry that men are portrayed negatively in the media

These 16 items were combined into the variable *Patriarchy_useful_clinically*

To what extent do you think the idea of patriarchy, power, and privilege in shaping the development of boys and men helps support the following:

- A bio-psycho-social approach to the human condition
- Ethical and legal principle of non-discrimination on grounds of sex or gender
- Evolutionary theory
- Humanistic principles of empathy, warmth, and genuineness
- Evidence-based training for psychological therapists
- Encouraging men to seek therapy
- Improving therapeutic outcomes
- Understanding older male clients

These eight items were combined into the variable *Patriarchy_supports_therapeutic_values*.

Male-friendly therapy training

How much do you agree that your training:

- Placed more importance on the suffering of males than females [reverse-scored]
- Was equally empathic to the problems of men and women [reverse-scored]
- Blamed men for their problems
- Blamed masculinity for men's problems
- Blamed masculinity for women's problems
- Blamed patriarchy for problems experienced by men and women

The six items were combined into the variable *Feminist_training*.

The therapist's own experiences and views of best practice

Based on Mahalik et al (2012), the following questions were asked: From your own clinical experience, can you give one or more examples of:

- Good ways for working with men or boys
- Unhelpful ways of working with men or boys

From what you have heard from other sources (colleague, peer-reviewed journal, professional training, the media, etc), can you give one or more example of:

- Good ways for working with men or boys (and identify the source if possible)
- Unhelpful ways of working with men or boys (and identify the source if possible)

Statistical analyses

Data were analysed using χ^2 with Fisher's Exact correction, Spearman's correlations (r_s), and ANOVA. The views of therapists were presented as percentages. ANOVA analysis had a sufficiently large sample size ($N > 50$) to use parametric tests regardless of the shape of the distribution (Hinkle et al., 2003), based on the central limit theorem (Pek et al., 2018). To detect a moderate effect size with 80% statistical power, a minimum of 100 participants was needed for Pearson's correlations (Cohen, 1988). Effect sizes of Spearman's rho (r_s) correlations followed the convention of .1 = weak, .3 = moderate, .5 = strong.

Free text responses were reviewed and coded using content analysis (Graneheim & Lundman, 2004). The free-text responses were reviewed by the researchers, mainly RW and JB, and recurring themes were tallied and given an appropriate label.

RESULTS

142 therapists responded to the survey. Of these, 35 dropped out before completing enough information to be included, or omitted key information such as their age. 107 filled in minimal information for inclusion (completing as far as the questions on masculinity being a social construct), and 60 participants completed all parts of the questionnaire. The final item (other people's views on best practice) was omitted from the analysis as too few participants answered.

Demographic and professional characteristics

The characteristics of the therapists were: mean $\pm$ *SD* age 47.1 $\pm$ 12.5; 90% ($n = 96$) Caucasian; 66% (71) male; 64% (66) in stable relationship, 83% (89) heterosexual, and 54% (58) based in the UK. The types of therapies were psychotherapy 34% (36), clinical or counselling psychology 33% (35), counselling 24% (26), other psychological therapy 8% (8), and two trainees (2%). They had a mean $\pm$ *SD* of 12.1 $\pm$ 9.9 years in practice (post-qualification), and the ratio of male to female clients was approximately 49:51.

Correlations between politics, gender views, and masculinity in therapy

Table 1 shows correlations between the questions on views on politics, feminism, masculinity, patriarchy, and training. For the sake of space, three questions on politics were omitted (Liberal, Conservative, and Right-Wing views) because of the politics variables the left-wing item was the most strongly correlated with other items in the questionnaire.

Table 1 shows that apart from an almost unanimous agreement with equal opportunities, in general, there was little agreement with ideas such as 'masculinity is a social construct' and 'anti-patriarchy is useful clinically'. On the other hand, correlations between the various views tended to be quite strong. For example, having left-wing views was moderate to strongly associated with feminist views ($r_s = .606$), patriarchy theory ($r_s = .538$), and the idea that masculinity being viewed as a social construct, and patriarchy theory, are good in clinical terms ($r_s = .372$ and .445 respectively). Also being more feminist and believing in patriarchy theory were moderate to strongly correlated with the idea that masculinity being viewed as a social construct, and patriarchy theory, are good in clinical terms ($r_s = .600$ and .652 respectively). This was in

contrast to the view that men and women should have equal opportunities, which was not at all correlated with any of those views (r_s < .1 in all cases). Those who felt they had feminist training were less likely to be left-wing (r_s = –.391) or identify as feminist (r_s = –.511) or believe patriarchy harms women (r_s = –.507).

Views on best practice of working with men

Participants were asked to describe what, in their experience, good practice with men and bad practice with men. Sixty therapists answered this question. The demographic and other characteristics of this subsample were almost identical to those of the parent sample. Their suggestions are grouped by content analysis into types of therapy. Three main groups emerged: male-orientated (e.g., being aware of male-typical preferences for therapy such as being more solution-focused than feelings-focused; n = 36), gender-neutral (e.g., treating male and female clients in the same way; n = 20), and anti-patriarchy (i.e., viewing men's problems as a result of socialisation into masculinity; n = 4). One-way ANOVA found that age was significantly different in the groups (F = 6.484; df = 2, 59; p < .003), with the mean ± SD age of the anti-patriarchy group being younger (28.00 ± 4.32) than the gender-neutral (52.85 ± 13.13) or male-friendly group (49.03 ± 12.95). Likewise, one-way ANOVA found that years of experience as a therapist was significantly different in the groups (F = 2.269; df = 2, 59; p < .113), with the mean ± SD years of experience of the anti-patriarchy group was far less (2.25 ± 2.06) than the gender-neutral (14.53 ± 9.16) or male-friendly group (13.00 ± 11.65). One of each therapist in the anti-patriarchy group was from each of the four main therapy groups (psychotherapy, clinical or counselling psychology, counselling, and other psychological therapy).

There was no significant difference in the number of men and women who practiced male-friendly therapy (Fisher's exact test = 3.355, p < .207). Around 60% of men and women opted for male-friendly therapy, and around a third of male therapists and a quarter of female therapists opted for a gender-neutral approach. Although proportionally more female therapists (15.8%, or 3) than male (2.5%, or 1) took an anti-patriarchy approach, the numbers were too small to reach statistical significance, or indeed to be generalised in any meaningful way. There was only one transgender participant and they were included in most analyses, but excluded in analyses by gender, because one participant is too small to analyse as a group, and they did not state whether they were trans male or female.

Sex difference in views of gender and politics

Table 2 compares the opinions of male therapists to female therapists.

Table 2. Descriptive statistics and comparison by gender of the views of the 107 therapists in the study. Values are shown as percentages (and the number of therapists) of those who 'very much' or 'moderately' agreed. Sex differences on the Likert-scaled responses were analysed using χ^2 with Fisher's Exact correction.

Table 2 shows there were two statistically significant differences in how male and female therapists' opinions. Men were significantly more likely than women to agree that Others think masculinity is a social construct' (41% vs 31%; p < .01) and that being 'anti-patriarchy supports therapeutic values' (19% vs 11%; p < .05). It also shows that a minority of male and female therapists agreed that patriarchy holds women back (32% vs 34%) and less than 20% thought it was useful clinically or supported therapeutic values. In contrast, fewer men and women themselves thought masculinity is a social construct (16% vs 6%). A minority of male and female therapists agreed that seeing masculinity as a social construct is useful clinically (27% vs 24%) and supports therapeutic values (20% vs 15%).

Therapeutic approach and differences in views of gender and politics

Table 3 shows the opinions of therapists based on their therapeutic approach in relation to being male-friendly or not.

Table 3. Views of the 60 therapists who described their style of therapy. Values are shown as percentages (and a number of therapists) of those who 'very much' or 'moderately' agreed. The number of participants varies according to how many answered the questions. Sex differences on the Likert-scaled responses were analysed using χ^2 with Fisher's Exact correction.

Table 1
Median and Range Scores, and Spearman's Correlations (r_s) Between the Various Views on Masculinity and Other Gender-Related Issues for Whole Sample (N = 107)

Views	*n*	*M*	Range	1	2	3	4	5	6	7	8	9	10	11
Left wing	107	4	1–6	–	–									
I am a feminist	107	4	1–6	.606***	–									
Support for equal opportunities	107	6	1–6	.189	.053	–								
Patriarchy holds women back	107	3	1–6	.538***	.738***	.054	–							
Masculinity is a social construct	107	2	1–6	.344**	.531***	.001	.519***	–						
Others think masculinity is a social construct	107	4	1–6	–.241*	–.265**	–.058	–.289**	–.034	–					
'Masc. is social construct' useful clinically	93	2	1–6	.372**	.600***	.042	.581***	.828***	–.079	–				
'Masc. is social construct' supports therapeutic values	88	2	1–6	.309**	.552***	.010	.537***	.834***	–.134	.913***	–			
Anti-patriarchy is useful clinically	86	2	1–6	.445***	.652***	.070	.631***	.626***	–.295**	.683***	.695***	–		
Anti-patriarchy supports therapeutic values	85	2	1–6	.449***	.594***	–.006	.630***	.551***	–.276*	.604***	.670***	.847***	–	
Feminist training	84	4	1–6	–.391***	.511***	–.025	–.507***	–.265*	.308**	–.331**	–.371***	–.407***	–.366***	–

Note: *p < .05, **p < .01, ***p < .001. The n is lower in the later questions due to attrition. Responses were on a six-point Likert scale from 6 (very much agree), 5 (moderately agree), 4 (slightly agree), 3 (slightly disagree), 2 (moderately disagree), 1 (very much disagree).

Table 2
Descriptive Statistics and Comparison by Gender of the Views of the 107 Therapists in the Study

Variable	Men	Women	χ^2
Left wing politics	30% (21)	40% (14)	3.202
'I am a feminist'	28% (20)	37% (13)	6.470
Support for equal opportunities	95% (67)	95% (33)	3.089
Patriarchy holds women back	32% (23)	34% (12)	7.244
Masculinity is a social construct	16% (11)	6% (2)	3.336
Others think masculinity is a social construct	41% (28)	31% (11)	17.228**
'Masc is social construct' useful_clinically	27% (17)	24% (7)	5.699
'Masc is social construct' supports therapeutic values	20% (12)	15% (4)	5.992
Anti-patriarchy is useful clinically	17% (10)	19% (5)	4.516
Anti-patriarchy supports therapeutic values	19% (11)	11% (3)	12.112*
Training not male-friendly	55% (31)	30% (8)	8.551

*$p < .05$; ** $p < .01$; *** $p < .001$ (two-sided)
Note: Responses were on a six-point Likert scale from 6 (very much agree) to 1 (very much disagree). Only responses 5 and 6 are shown here. Values are shown as percentages (and number of therapists) of those who 'very much' or 'moderately' agreed. Sex differences on the Likert-scaled responses were analysed using χ^2 with Fisher's Exact correction.

Table 3
Views of the 60 Therapists Who Described Their Style of Therapy

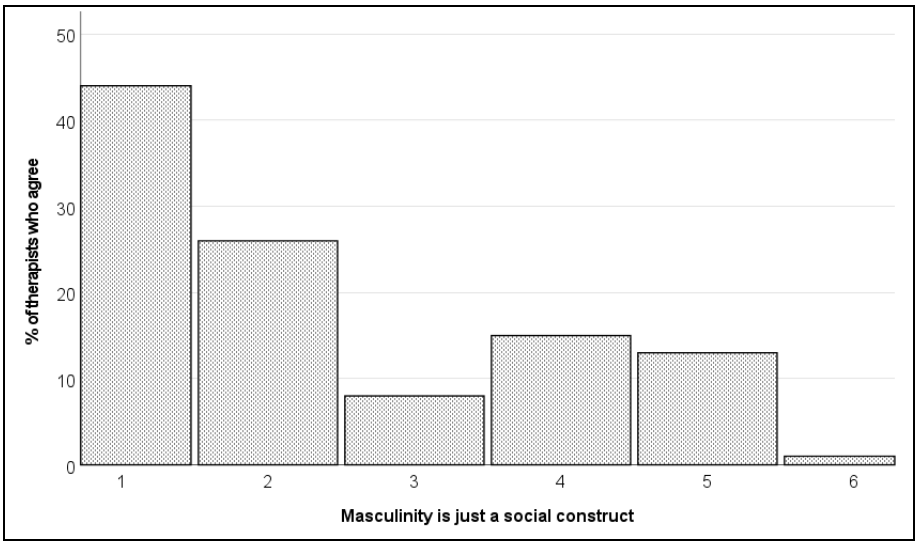
Variable	Anti-	Gender	Male-	χ^2
Left wing politics	75% (3)	58% (11)	22% (8)	15.347*
'I am a feminist'	100% (4)	37% (7)	22% (8)	16.787*
Support for equal opportunities	100% (4)	95% (18)	92% (33)	6.751
Patriarchy holds women back	100% (4)	42% (8)	17% (6)	17.542*
Masculinity is a social construct	100% (4)	26% (5)	17% (6)	17.476*
Others think masculinity is a social constuct	75% (3)	26% (5)	45% (16)	7.179
'Masc is social construct' useful_clinically	50% (2)	32% (6)	22% (8)	11.511
'Masc is social construct' supports therapeutic	25% (1)	21% (4)	19% (7)	14.515
Anti-patriarchy is useful clinically	25% (1)	16% (3)	19% (7)	13.050
Anti-patriarchy supports therapeutic values	50% (2)	16% (3)	19% (7)	11.948
Training not male-friendly	0% (0)	26% (5)	64% (26)	17.804**

*$p < .05$; ** $p < .01$; *** $p < .001$ (two-sided)
Note: Responses were on a six-point Likert scale from 6 (very much agree) to 1 (very much disagree). Only responses 5 and 6 are shown here.

Values on Table 3 are shown as percentages (and number of therapists) of those who 'very much' or 'moderately' agreed. The number of participants varies according to how many answered the questions. Sex differences on the Likert-scaled responses were analysed using χ^2 with Fisher's exact correction.

Therapists who had a male-friendly approach were significantly less likely to believe that their training was male-friendly ($\chi 2 = 17.804$, $p < .01$), patriarchy holds women back ($\chi 2 = 17.542$, $p < .05$); masculinity is a social construct ($\chi 2 = 17.476$, $p < .05$); identify as being a feminist ($\chi 2 = 16.787$, $p < .05$); and identify as being left-wing politically ($\chi 2 = 15.347$, $p < .05$).

Figure 1
Scores on the Question About Whether Masculinity Is Just a Social Construct



Scores (N = 107) on the question about whether masculinity is just a social construct, showing polarisation of views. Responses were on a six-point Likert scale from 6 (very much agree), 5 (moderately agree), 4 (slightly agree), 3 (slightly disagree), 2 (moderately disagree), 1 (very much disagree).

DISCUSSION

This online survey of 107 therapists found opinions about feminism, patriarchy, and the social construction of masculinity were correlated with opinions on therapy for men.

Views on masculinity

Most people appear to have a favourable view of masculinity (Barry et al., 2020). Table 1 shows that, overall, therapists disagreed that masculinity is simply a social construct. Although the median score was 2 in most cases (i.e., 'moderately disagree') the wide range of scores (e.g., Figure 1), shows opinion was somewhat divided, and 13% thought it was accurate or extremely accurate to say masculinity is a social construct. This implies that most of the present sample had a favourable view of men if it is true that seeing masculinity as a social construct makes people see bad behaviour by men as less acceptable (Brooks, 2001).

Table 2 shows that 16% of men and 6% of women 'very much' or 'moderately' agreed that masculinity is a social construct. Interestingly, proportionally more men thought this was the case. Significantly more men than women thought that others see masculinity as a social construct (41% vs 31%, $p < .01$). Similar proportions of men and women (~22%) thought masculinity as a social construct is a useful concept for therapy and supports therapeutic values.

Interestingly, more therapists thought a social constructionist concept of masculinity is useful for therapy (n = 24, or 22%) than agreed that the concept was accurate (n = 13, or 12%). This might reflect the view that an approach can be useful in therapy even if there is no scientific basis for it. Table 1 shows that more agreement that masculinity is a social construct was very strongly correlated with thinking this concept is useful clinically (r_s = .828) and supports therapeutic values (r_s = .834). However, Table 3 shows that even among the four anti-patriarchy therapists, only two thought the concept supports clinical values, and only one thought it clinically useful.

Table 3 shows that the social constructionist view of masculinity was strongest among the anti-patriarchy therapists, and weakest among male-friendly therapists. The same trend was seen regarding the clinical usefulness of the idea, and how much it supports therapeutic values. Less than 20% of male-friendly therapists agreed with these views.

Overall these findings suggest limited support for APA Guideline 1, though male-friendly therapists are adhering to Guideline 9 well.

Views on patriarchy

A survey found 15.6% of men and 42.9% of women agreed to some degree that patriarchy holds women back (Barry et al., 2020) and that feminism and belief in patriarchy were strongly correlated (r = .589). Similarly, the present study found that feminism and belief in patriarchy were positively correlated (r_s = .738). Some therapists believe that in couples there is typically a power imbalance favouring man (e.g. men not listening sufficiently), which demonstrates patriarchy (Knudson-Martin 2015). However, patriarchy theory might not be the best approach to resolving relationship issues, as suggested by a meta-analysis which found that interventions for domestic violence based on the concept of patriarchy are about half as effective as interventions based on relationship enhancement (Babcock et al., 2004).

Table 1 shows that on average the therapists slightly disagreed that patriarchy holds women back (median = 3, range 1–6). When it came to therapy, there was a moderate disagreement that anti-patriarchy views could help in therapy or supported therapeutic values (in both cases median = 2, range 1–6). Table 2 shows a minority of male and female therapists agreed that patriarchy holds women back (32% vs 34%) and less than a fifth thought it was useful clinically or supported therapeutic values. Women were significantly less likely than men to agree that the anti-patriarchy concept supports clinical values (19% vs 11%; p < .05). The more male-friendly the therapist, the less they agreed that patriarchy holds women back (p < .05), though 17% of male-friendly therapists agreed that patriarchy holds women back. The agreement that the patriarchy concept is clinically useful and supportive of therapeutic values was strongly correlated with identifying as a feminist (r_s = .652 and .594, respectively). These findings regarding views of patriarchy in therapy suggest limited support for APA Guideline 3.

The explanation for anti-patriarchy findings

The findings regarding therapy types can't be explained by differences in characteristics in the subsample of 60 compared to the full sample of 107, because the characteristics were almost identical. For example, the years in practice (post qualification) in the total sample was mean $\pm$ *SD* of 12.1 $\pm$ 9.9 and in the subsample was 12.6 $\pm$ 10.7, the ages were 47.1 $\pm$ 12.5 and 48.5 $\pm$ 13.6 respectively, and the ratio of male to female clients was approximately 49:51 in the larger sample and 51:49 in the smaller sample.

However, there were differences between the therapists when grouped on their approach to therapy, which unfortunately could not be controlled for statistically (Miller & Chapman, 2001). Age was significantly different (p<.003), with the mean $\pm$ *SD* age of the anti-patriarchy group being younger (28.00 $\pm$ 4.32) than the gender-neutral (52.85 $\pm$ 13.13) or male-friendly group (49.03 $\pm$ 12.95). The experience was substantially less though non-significantly so in the patriarchy group. It could be they made no difference, though with less experience there might less first-hand experience of the therapeutic needs of men, and perhaps a more idealistic expectation of how much change is possible in therapy. The school of therapy (counselling, psychotherapy, etc) does not explain differences, because all four anti-patriarchy therapists were spread across all four schools.

Views on politics

Overall the sample leaned slightly towards left-wing views (median 4, range 1-6) which is unsurprisingly for a sample with so many psychologists (Langbert & Stevens, 2020). In the present study, left-wing views were moderately or strongly associated with the full range of feminist views, patriarchy, and the social construction of masculinity. Table 2 shows that men endorsed left-wing views slightly less than women did. Table 3 shows that regardless of gender, the more male-friendly the therapy was, the less left-wing the views were. The main relevance of these findings is the impact they might have on the therapeutic alliance, where some clients with right-leaning views might feel uncomfortable raising them with a left-leaning therapist.

Views of training

Men were more likely than women to think their training was not male-friendly (55% vs 30%). Interestingly, Table 2 shows there was a significant negative trend between how male-friendly a therapist's approach was and how male-friendly a therapist thought their training was (χ^2 = 17.804; p < .01), and a significant positive

trend between how much a therapist identified as being feminist and how male-friendly a therapist thought their training was (χ^2 = 16.787; p < .05). One explanation is that these correlations reflect perceptions of training rather than differences in training and that all training shows a similar attitude to men, which is acceptable to feminists but not to male-friendly therapists. This topic needs further research.

Prevalence of feminism in this sample

28% of male and 37% of female therapists strongly or moderately agreed they were feminists. This is similar to women in the UK general population (34%) but higher for men (18%) (YouGov, 2018), suggesting that male therapists are more feminist than men in the general population. Szymanski et al. (2002) suggest that male feminist therapists may be particularly helpful with male clients because 'they can use their male privilege to enact change' (Wolf et al., 2017, p.448). Mintz and Tager (2012) suggest that feminist therapy is necessary for male clients to reach their full potential. On the other hand, Wolf et al. (2017) acknowledge that many people have a problem with feminism and realise that identifying the therapy as feminist could put men off. This is probably why none of the eight feminist therapists interviewed in Wolf et al (2017) stated explicitly (e.g., in advertising) that they are feminists. Four said they would use CBT with a man who was not receptive to feminism rather than overtly feminist therapy, though three of the four said they would continue 'conceptualizing the client from a feminist multicultural worldview' throughout therapy (Wolf et al 2017, p.449). The definition of feminism is relevant to this issue, as shown in Table 1 (columns headed '2' and '3') by the contrast between identification as feminist and agreement with equal opportunities, similar to (Barry et al., 2020).

Impact on the therapeutic alliance

Research has found that regardless of the therapeutic approach taken, the therapeutic alliance is moderately correlated (Pearson's r = ~.3) with the success of therapy (Del Re et al., 2012). Given that men are less likely to seek psychological help than are women, it makes sense to avoid adopting practices that will undermine the therapeutic alliance. For example, unless a man explicitly rejects traditional masculinity and sees patriarchy as a problem, it is difficult to see how an anti-patriarchy therapy might appeal to him. Psychologically vulnerable men might be distressed at the suggestion that their problems are caused by their gender or privilege. Most therapies in some way help clients by helping them to have more control over their thoughts and feelings. Asking the client to focus on the source of their problems as things that are outside their control – their sex, or the culture they were raised in, or their gender identity as a man are questionable departures from this model.

Implications for co-existence of APA Guidelines 1, 3, and 9

The present study suggests that therapists who take a male-friendly approach have different views about masculinity and patriarchy than those who take an anti-patriarchy approach. The APA guidelines appear to see no contradiction in advocating these opposite approaches (Guidelines 1 and 3 vs 9), and they might consider this anomaly when reviewing their guidelines. In the meantime, therapists should note that the APA says "these guidelines are not definitive and are designed to respect the decision-making judgment of individual professional psychologists" (American Psychological Association, Boys and Men Guidelines Group 2018, p.2).

Are male-friendly therapies better for men?

Research on this key question is needed. However, the male-friendly approach seems more likely to appeal to male clients than ones influenced by patriarchy theory, such as in the US (APA), UK (PTMF), and Australia (APS).

Limitations

Although there was sufficient power in most tests, for the comparisons in Table 3 (n = 60) statistical power was slightly low, meaning that some relevant findings might not have been detected as significant. Also, the group of four anti-patriarchy therapists was too small to power statistical analyses. These relatively small sample sizes mean that the results of this study should be seen as provisional.

Because of snowball sampling, this study probably over-represents therapists of a male-friendly orientation. Proportionally more therapists likely take a gender-neutral approach to therapy,

though it is unknown how many take an anti-patriarchy approach. However, the relatively young age of the four anti-patriarchy participants could indicate that there is a new generation of therapists coming through, inspired by the APA and similar guidelines.

Future research

Future studies should recruit more therapists, especially those who practice anti-patriarchy therapy. Given the exploratory nature of this research, future research teams must replicate this study. Except for the questions about feminism (which replicated fairly well the findings of Barry et al., 2020), the survey has not been used previously. Future replications could be done in various ways, for example, using similar methods and measures to test for the reliability or using different sampling methods e.g. recruiting different types of participants (e.g., specifically feminist therapists to specifically non-feminist therapists) to test for known groups validity. Future directions for research might include comparing the appeal of different therapeutic approaches to men and women, and the safety, efficacy, and dropout from these therapies. The actual techniques and behaviours of the therapist, as well as therapists' self-reports of their techniques and behaviours, might also be measured to test the correspondence between the two. Perhaps most importantly, future research should test the degree to which the views of the therapist are related to the outcomes of therapy. This will help ensure that future teaching and training of psychologists, counsellors, and therapists can be based on a scientific foundation. A challenge to researching the contentious issue of bias is to do so while minimising the impact of one's own biases. Awareness of this should be an ongoing effort, with the overarching goal of improving the quality of therapy delivered.

CONCLUSION

Guidelines on therapy should be evidence-based rather than ideology-based. The present survey raises questions about key assumptions about therapy for men. Given that men die by suicide more than women do yet seek help from psychological therapists less than women do, there is an urgent need for the provision of safe and effective help for men. Also, service providers should make it possible for men to choose therapies that do not conflict with their beliefs or their sense of themselves as a man.

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