NO MAN LEFT BEHIND: TOWARDS NEW MODELS OF MALE ENGAGED THERAPY

by

Carson Alexander Kivari

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Abstract

Counselling literature often focuses on men’s limited help seeking behaviours. Less explored is how men engage or disengage when they actually do enter helping programs. Contrasting decades of quantitative research pairing masculine ideology with low help seeking (i.e., identifying the problem), this article looks qualitatively at the factors that help men to become engaged and committed to therapy (i.e., identifying solutions). This study examines a treatment program with high success rates and virtually no drop out—a unique occurrence in men’s psychotherapy. Enhanced Critical Incident Technique data suggest that helping men to feel competent, free from judgment, and in the company of down-to-earth and genuine practitioners are all instrumental in helping this sub-population engage in therapy. Further, it is suggested that while appealing to male gender roles may be critical at the outset of therapy, men transition to broader non-gendered (i.e., that might be shared by men and women alike) and universal human needs as therapy progresses.
Preface

This research study was approved by the University of British Columbia Behavioural Research Ethics Board on May 30, 2012 (H12-00799).
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Chapter 1: Introduction

The scope of psychotherapy has broadened considerably over the years. Historically criticized for its demographic biases (Jackson, 1995), pioneering feminist and multicultural therapists have helped counselling to meet the needs of diverse populations. Despite these advances, including the feminist response to therapies developed primarily from a male perspective (Brown, 2010), the needs of men are arguably not being met. Some background on the general mental health of men is first necessary.

While historically women are thought to suffer from depression at a rate twice that of men (Nolen-Hoeksema & Hilt, 2007), epidemiological studies reveal that these estimates are oversimplified. For instance, men often underreport depression (Hunt, Auriemma, & Cashaw, 2003). Correcting for this, comparable levels have been revealed between the sexes (Cochran, 2005). What is troubling, however, is that men often experience depression with higher rates of comorbid substance abuse (Fava, Abraham, Alpert, Nierenberg, & Rosenbaum, 1996; Kornstein, 2003), have higher incarceration rates (2.7% vs. 0.5% of United States population; Bonczar, 2003), and demonstrate completed suicide rates four to 15 times that of women (Moscicki, 1997).

1.1 Men and Help Seeking

While psychotherapy of course does not cause these disastrous outcomes, it is inadequately helping to solve them. Depression is treatable, substance abuse can be managed, and suicide is preventable through effective treatments (Gibbs & Grambrill, 2002). Men, however, are not seeking the help they need, instead suffering in silence (Addis & Mahalik, 2003; Mahalik & Rochlen, 2006; Mansfield, Addis, & Courtenay, 2005). In the United States, women account for two thirds of clients seeking mental health services
In the UK, 29% of women have sought treatment for mental health issues compared to 17% of men (Singleton & Lewis, 2003). How can this poor help seeking behaviour be explained?

The contemporary model for men’s low help seeking behaviour involves masculine gender socialization (Levant, 1996; Pleck, 1995) and stigmatizing attitudes towards receiving psychological assistance (Corrigan & Watson, 2007). Male socialization is both positive, in the sense of its virtuous qualities (e.g., male heroism and providing for one’s family; Kiselica & Englar-Carlson, 2010), and negative, whereby masculine gender roles place pressure on men (e.g., men must conceal weakness—“the sturdy oak”—and avoid appearing feminine—“no sissy stuff;” David and Brannon, 1976). The dissonance between maintaining male gender role at odds with one’s health or authenticity is the essence of what Pleck (1995) terms the gender role strain paradigm (GRSP).

Stigmatizing attitudes towards help seeking (i.e., negative views of accepting assistance) are related to GRSP in that male socialization is at odds with accepting the presence of a disorder or relying on others (e.g., I am weak if I can’t handle my shit). A stalemate occurs as highly treatable conditions such as depression are paired with an equally powerful reluctance to seek help (Corrigan & Watson, 2007). This is a cause of concern, as Livingston and Boyd’s (2010) meta-analysis revealed a strong negative relationship between mental illness-related self-stigma and several psychosocial variables including self-esteem, hope, and empowerment.

While it has been thought that we can increase men’s help seeking by addressing the issue of stigma alone, this is arguably a ‘band aid solution.’ Anti-stigma initiatives such as the National Institute of Mental Health’s (n.d.) “Real Men, Real Depression” campaign are
well intentioned but lack staying power if one core issue is not addressed: Men who do enter helping programs often feel alienated, mismatched, judged, and preemptively drop out (Powell, 2013). Thus, even if stigma is reduced, an impasse is reached if men do not engage in available therapies.

1.2 Going Deeper–A Mismatch of Men and Therapy

Current training models of counselling often rest on what Westwood and Black (2012) termed a feminine nurturance model—a style of therapy that centers on corrective emotional support and empathic response (Powell, 2013). This may be partially explained by women attaining 70-80% of all doctoral degrees in clinical and counselling psychology (Willyard, 2011). It may also involve the translation of Carl Rogers’ (1951) Person-Centered Therapy, which is thought to cultivate a full and rich understanding of a clients worldview, into isolated core skills and interventions. One example is responding ‘empathically’ to clients by using feeling words (e.g., ‘you must have felt very frustrated when your father said that’). Followers of Rogers (e.g., Carkhuff & Anthony, 1979; Egan, 1994) played a role in translating these ‘person-centered’ skills into the mainstream curricula of therapy training programs.

Problematically, a front-end to therapy based on feeling words and nurturance often clashes with socialized masculinities, leaving men in a double bind of requiring help yet feeling shame at receiving it (Englar-Carlson, 2006). Further, men are often expected to ‘pick up the tools’ of communicating emotional experiences. Because this may seem foreign they may feel alienated and incompetent (Powell, 2013).

Awareness of a mismatch between counselling and men has been steadily growing for decades. Levant’s (1996) “New Psychology of Men” championed a social science focused
on men and issues of masculinity in the same way that feminist therapies arose to meet the needs of women. One result was an interest in quantifying masculine ideology (e.g., the Conformity to Masculine Norms Inventory, Mahalik et al., 2003; the Male Role Norms Inventory-Revised, Levant et al., 2007). Correlation-based research emerged between masculine ideology and negative outcomes such as poor help seeking attitudes (Mansfield et al., 2005).

These troubling relationships, paired with the GRSP, led some to call for a ‘new’ masculinity (e.g., Levant, 1995). That is, with good intentions men were encouraged to step outside the confines of restrictive gender roles and redefine what it means to be a man. Just as it was in feminism, moving beyond the status quo of gendered expectations is an important aspect of social change for men. The issue, however, is that it may generate a subtext asking that men change to meet the structure of therapy rather than practitioners working to meet the needs of men.

1.2.1 Working with traditionally socialized men, not against them.

Kiselica and Englar-Carlson (2010) termed the above approach a ‘deficit model’ in that it conceptualized traditional male socialization as a negative construct that required change. Fitting with theorists who have recognized the need to embrace positive aspects of male socialization (e.g., Wong & Rochlen, 2008; Wong, 2009), their approach instead reframed masculine constructs as strengths, postulating that if we better understand how to work with these ideologies we can develop male friendly interventions. They proposed a list of 10 positive aspects of traditional masculinity (e.g., male self-resilience and the worker/provider tradition of men) that will be referred to subsequently throughout this article. The big distinction between previous models of effectively helping men is the
manner in which a strength-based approach aims to meet men’s needs as opposed to asking that men change to meet therapy.

An important consideration in meeting the needs of men is their readiness to address presenting concerns. This is well illustrated by Prochaska’s Transtheoretical Model (TTM) of Behavior Change (Prochaska & Velicer, 1997). It may be the case that men are often in the *precontemplation* stage which is marked by downplaying the benefits of change, uninformed opinions of therapy, and a demoralized sense that improvement is possible (Powell, 2013). While men are historically seen as resistant, reluctant, or in a state that requires interventions to move them towards cooperation (e.g., Brooks, 1996), it may instead be that the program is failing to meet men’s precontemplative needs. Powell (2013) illustrates how a male client with a drinking problem feels judged and alienated as this precontemplative stage of readiness and unique male socialized needs are neglected. Ultimately he reacts with, “Get me out of here” before dropping out of the program and explaining to his wife, “I have to do this on my own” (96).

Fortunately, there is a small but growing body of literature helping to guide therapists to meet the needs of men (Englar-Carlson, 2006; Good & Brooks, 2005; Pollack & Levant, 1998). Englar-Carlson (2006) stresses that practitioners strive to avoid labeling and stereotyping men as they enter therapy while Robertson (2006) encourages a space that cultivates familiarity (e.g., are there magazines men would like in the waiting room?) and confidentiality. Lynch and Kilmartin (1999) consider it important to speak with men in a comfortable manner (e.g., let men refer to actual events versus feelings at the outset of therapy). Stevens (2007) considers an education about the process of therapy important for men both because they are often unfamiliar with counselling and because this helps to stress
transparency with no ulterior agenda. Kiselica (2008) encourages moving past traditional therapy, himself at times walking, having a meal, or throwing a ball with a client.

Powell (2013) argues that men may best demonstrate engagement and improvement in groups. This fits with research demonstrating that from as early as age five that males spend more time than women do engaged in group activities (Benenson, Apostoleris, & Parnass, 1997) and tend to connect with each other on the basis of achieving a common goal (Maccoby, 2002). Powell (2013) also suggested the groups should be gender-specific (i.e., male exclusive) to avoid distraction and interpersonal translational difficulties (e.g., the divide of gender-based experiences). He also proposed that an integrative variety of interventions be used, particularly avoiding those that are emotionally oriented early on in counselling.

A more recent trend is the move towards online, interactive flash media such as with the Man Therapy (2013) web-campaign. This style of program borrows from pop-culture, social memes, and relies heavily on humour. It is possible that the casual and contemporary presentation of media-based mental health initiatives helps to diminish stigma and re-conceptualize what it means to seek therapy. The Man Therapy campaign is one example of engaging men that considers linguistics highly important. Terms like ‘therapy’ or ‘mental illness’ are downplayed in favour of ‘coaching’ or ‘injury.’ In this sense, depression is no different than a broken leg that requires the appropriate treatment.

1.3 Military Veterans

One sub-population composed heavily of traditionally socialized men who are often reluctant and estranged from therapy (or perhaps better viewed as in the precontemplation stage of readiness) is that of military veterans (Hinojosa, 2010; Iversen et al., 2005). In this
sense, veterans may illustrate the therapeutic challenges of many civilian men in an inflated
or hypermasculinized sense. What is unique, however, is that our lab runs a therapeutic
mental health and transition program for Canadian military personnel that consistently
demonstrates high participant engagement and rapid diminishment in stigmatizing attitudes
(Westwood et al., 2010). A recent study conducted on the Veterans Transition Program
(VTP) reported a zero percent rate of attrition in 56 veterans who entered the program
(Westwood et al., in press). Taken together, for one of the most reluctant sub-populations to
demonstrate high levels of commitment, engagement, and improvement indicates a valuable
opportunity to look closely at what works for men.

1.4 The Present Study

The following article addresses a gap in our understanding of how to best help
traditionally socialized men to engage psychotherapy and other helping programs. These
findings can inform both future academic research and practitioners to better assist men
everywhere who might otherwise be ‘slipping through the cracks.’ A broader hope is that if
clinicians adhere to best practices for men’s counselling stigma will be reduced as men
experience help outside of expected stereotypes.

This study utilized veterans who completed the VTP. In contrast to previous
quantitative studies examining a negative relationship between traditional masculine
ideology and help seeking (e.g., Addis & Mahalik, 2003), and therapeutic commitment (e.g.,
Robertson, 2005), this article took a qualitative look at factors associated with engaged male
therapy. Having found men who successfully and enthusiastically ‘bought in’ to a helping
program the research question was, “What factors helped and hindered men in becoming
engaged in the VTP?”
Chapter 2: Method

This study is interpretivist and constructionist, emphasizing the socially inscribed nature of knowledge. While this view does not actively deny a tangible, knowable universe, it assumes that our consciousness filters all world-perceptions and thus scientific knowledge is fluid and subject to the ‘socially constructed lens’ of human experience (Crotty, 1998).

Qualitative methodologies are chosen on the basis of the research questions they aim to answer. For instance, phenomenology deals with questions of participants’ experiences (Groenewald, 2004), while grounded theory involves questions regarding the process of something (Charmaz, 2005). This study aims to identify factors associated with therapeutic engagement. Thus, Critical Incident Technique (CIT; Flanagan 1954; Butterfield, Borgen, Amundson, & Maglio, 2005) was chosen, as this methodology examines what aspects of a particular activity or experience helped or hindered its success.

Additionally, the open-ended and exploratory nature of CIT is thought to parallel core principles of counselling psychology (Woolsey, 1986). More accurately, this article used the enhanced CIT (ECIT). Butterfield et al.’s (2005) amendment to Flanagan’s (1954) classic CIT involved more rigour in checking credibility, more contextual questioning to ground interviews, and the inclusion of ‘wish list’ items that did not surface as explicit incidents.

2.1 Participants

Participants were seven Caucasian men who ranged in age from 28 to 60 years ($M = 47.71$ years). Six participants (86%) were born in Canada, while the remaining individual was born in Germany. In terms of highest level of education, four participants (57%) had undergraduate degrees, one (14%) had a high school diploma with some post-secondary
education, one had a high school diploma, and one had two master’s degrees. Four participants (57%) were married, two (28%) divorced, and one (14%) single.

All participants completed the VTP. Each participant was asked about his sense of therapeutic engagement as characterized by having (a) felt comfortable, safe, and included throughout VTP sessions, (b) felt a genuine sense of wanting to be there from start to finish, and (c) felt motivated to be involved and to contribute throughout the sessions. Three VTP facilitators from respective programs were asked if their experiences of each VTP graduate matched what these participants reported. Each of these informal interviews took about 10 minutes. All participants had graduated from the VTP within the last 12 months.

Upon attaining approval from the Behavioural Research Ethics Board, University of British Columbia, participants were contacted and asked if they would like to participate in this study. All VTP participants had consented to be contacted following the program for research purposes.

2.2 Measurement

Male gender role socialization is an important construct in understanding men’s therapeutic engagement, thus it was measured using the *Male Roles Norms Inventory-Revised* (MRNI-R; Levant et al., 2007), which is found in Appendix A. While this is not a quantitative or mixed-methods study, measuring traditional masculine ideology provided interesting descriptive data and ideas for future research (see Discussion).

The MRNI-R is a 53-item measure of traditional masculine gender role ideology. It is composed of seven subscales (e.g., extreme self-reliance) whose internal consistency ranges from .78 to .91 (as reflected by Cronbach’s alphas; see Levant et al., 2007). For the purposes of this study, however, only the total general masculine ideology index (e.g., a
broad measure of male gender role endorsement as one construct) was used. Participants indicated their degree of agreement or disagreement to statements about male socialization (e.g., “A man should be allowed to openly show affection for another man.”) using a 7-point Likert-type scale (i.e., 1 = Strongly Disagree; 7 = Strongly Agree). Note that item two was modified from “President of the United States” to “Prime Minister of Canada.”

2.3 Procedures

Seven participants who had completed the VTP within the last year and who met inclusion criteria were contacted and interviewed twice (Butterfield et al., 2009). Five participants were interviewed via phone call and two in person. The first interview was the actual critical incident (CI) component. This session was divided into (a) contextual questions to ground participants in the purpose of the study (i.e., to investigate what helped and hindered therapeutic engagement), (b) helping incidents, (c) hindering incidents, (d) wish list (WL) items (i.e., what was missing that would have further helped their engagement?), and (e) demographic information. Participants were asked both for critical incidents and the personal meaning each incident had along with specific examples.

An interview protocol (see Appendix B) aided consistency across each session. The second interview involved follow-up questions and is further explained in the Data Analysis section. Participants were given code numbers to maintain anonymity. All interviews were digitally recorded and transcribed verbatim by an independent research assistant. Exhaustion (i.e., redundancy of incidents) occurred after six interviews but a seventh interview was conducted given that arrangements had already been made.
2.4 Data Analysis

First, each transcribed interview was loaded into the qualitative research program HyperRESEARCH. The software was used to code helping and hindering CIs as well as WL items. Each incident had three components: (a) the incident itself and its meaning to the participant, (b) how it affected their experience in the therapeutic setting, and (c) a specific example of how this took place (see Appendix B). In five instances across three participants the interview did not provide a specific example to support an incident and in these cases the participant was contacted for further clarification.

Next, categories of CIs and WL items were created (Butterfield et al., 2009; Flanagan, 1954). This process was guided by the future-oriented goal of identifying practical ‘male friendly’ interventions. Electronic text documents were created for each participant. Within these documents, CIs and WL items were inductively organized into categories by examining similarities and differences. This process was repeated with each subsequent transcript as new categories emerged. Meanwhile, a log was kept (see Appendix C) to track the global emergence of new categories so that it was clear when exhaustiveness was reached. Categories were continually revised and updated. As per Borgen and Amundson’s (1984) standard, 25% of participants must have identified incidents that fit into a category for it to be viable.

2.4.1 Credibility/trustworthiness checks.

ECIT involves nine credibility checks to support the trustworthiness of findings—a valuable step in any qualitative study that lacks the scientific precision of statistical research (Alfonso, 1997; Butterfield et al., 2005; Butterfield et al., 2009). Two of these checks have already been discussed in that (a) all interviews were audiorecorded and transcribed verbatim
and that (b) the emergence of new incident categories was logged (see Appendix C) until exhaustion was reached.

To assess interview fidelity and adherence to both protocol and methodology (c) every third recorded interview and transcript (i.e., the third and sixth interview) was submitted to an ECIT expert. This individual, who helped to develop ECIT, stated that interviews had adhered well to protocol and methodology. In the fourth check, (d) an independent researcher reviewed two randomly selected transcripts and using the same coding scheme, extracted helping and hindering CIs as well as WL items. In the first interview we had an 86% agreement rate. After discussing why our coding differed, we agreed that two incidents related to *shared military understanding* and *the company of men* were cited as meaningful and exemplified incidents which brought us to a 100% agreement rate. For the second interview we reached 100% agreement rate on first extraction.

The fifth check involved (e) calculating participation rates (i.e., percentage of participants who had at least one incident in a category), which supports the importance of each category (Borgen & Amundson, 1984). For instance, *establishment of safety* is among the most important categories as all participants cited it (i.e., a 100% participation rate). For the sixth check, (f) a second independent researcher placed 25% of all incidents (chosen using a random number generator) into the now established categories. This bared a 100% match rate which is above Borgen and Amundson’s (1984) criteria of at least 80%.

The seventh step involved (g) cross-checking by participants (i.e., the second interview). Each participant was emailed a compilation of his incidents in each category along with several clarifying questions. It was asked whether these incidents seemed accurate, whether they reflected their experiences, and if they would have added or have
changed anything. The same questions were asked in regards to the categories, again giving participants a chance to provide feedback or make changes. Finally, participants were offered a chance to address any general concerns or make suggestions or revisions across any aspect of what had so far been covered. All seven participants responded in agreement with incidents and categories. One participant, however, wanted to address a transcription error in one incident where he corrected, “I thought only I could do that” to, “I thought only I would do that.” Additionally, one participant requested a phone-call to discuss and clarify the incident breakdown though he did not wish to make any changes.

For the eighth check, (h) categories were submitted to two experts in the area of men’s health. While both experts agreed that the categories were both relevant and useful in regards to men’s therapeutic engagement, one expert had further feedback. He was surprised that the ‘importance of practical action’ had not emerged as a category. Given the theoretical emphasis on action-oriented therapies for men, this was a shared surprise (see Discussion for further consideration). He also perceived a redundancy between the naming of two categories (understanding from members and caring from leaders and members). We agreed on this redundancy and so these categories were renamed more accurately and distinctly to understanding and normalizing from members and affection from members and leaders.

In the final check, (i) theoretical agreement was assessed by first reflecting on the assumptions of this study. That is, that men are often reluctant to become engaged in helping programs. Reviewing the literature, this is a well-supported assumption (Addis & Mahalik, 2003; Kiselica & Englar-Carlson, 2010; Mahalik & Rochlen, 2006). The second step involved referencing the emergent categories through a literature search. While all categories were supported in the relevant scholarly literature (e.g., Englar-Carlson, 2006;
Kiselica & Englar-Carlson), there were surprises and complexities that certain incidents were not cited in interviews. A deeper exploration of this can be found in the Discussion section. All credibility checks considered, it was concluded that the data are sound.

Chapter 3: Results

In terms of endorsing traditional masculine ideology as measured by the MRNI-R, before completing the VTP men scored $M = 3.16$ ($SD = 0.79$). This is essentially the same as Levant et al.’s (2007) normative sample ($M = 3.14$, $SD = 0.21$). It is noteworthy that after completing the program men’s scores dropped slightly to a mean of 2.93 ($SD = 0.63$). While these data are only presented descriptively it would be interesting to look at change of masculine ideology endorsement with a larger sample. See Table 1 for the MRNI-R general masculine ideology scores for all participants aside from one whose participation in the VTP had predated our lab’s measurement of this construct.

Table 1

<table>
<thead>
<tr>
<th>MRNI-R Before and After Scores for Each Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before</td>
</tr>
<tr>
<td>Participant 1</td>
</tr>
<tr>
<td>Participant 2</td>
</tr>
<tr>
<td>Participant 3</td>
</tr>
<tr>
<td>Participant 4</td>
</tr>
<tr>
<td>Participant 5</td>
</tr>
<tr>
<td>Participant 7</td>
</tr>
<tr>
<td>Mean (SD)</td>
</tr>
</tbody>
</table>

Note. Items scored on a 1-7 response scale; 1 = Strongly Disagree, 7 = Strongly Agree. Participant 6 did not complete the MRNI-R as his enrollment in the VTP predated the measurement of this construct.
A total of 66 helping CIs ($N = 50$), hindering CIs ($N = 11$), and WL items ($N = 5$) emerged in regards to men’s therapeutic engagement within the VTP (see Table 2 for a summary of incidents and categories). Following careful analysis and rigorous assessment of credibility, it was concluded that incidents were best represented by 10 categories. Seven of these represented helping CIs, two hindering, and one WL item. As elaborated below, four of the helping categories used subcategories to better account for the specifics of what helped engagement. Based on participation rates and relative importance, the top five helping categories (and their subcategories) are discussed. As together there are only three, all hindering and WL categories are discussed. Categories are contextualized with quotations.

### 3.1 Helping CI Categories ($N = 50$)

*Establishment of Safety (12 incidents, 100% participation)* pertains to group rules, guidelines, physical location, structuring, atmosphere, and the subsequent feeling that it is safe to disclose experiences, vulnerabilities, and personal authenticities with the group.

Herman (1997) provides an operational definition of safety based on (a) a sense of control through understanding symptoms and interventions, (b) the construction of trusting attachment with others, and (c) diminishment of alienation through interpersonal support—factors that fit with the program design of the VTP and participant experiences.

As a result of safe conditions, participants expressed feelings of belonging, being respected, trust, and protection from judgment. Two participants discussed lovingness within the men’s group—a surprise given traditional male avoidance of this type of emotional expression (Levant et al., 2007). Incident count and participation rate suggests that this was the most important category of helping factors in therapeutic engagement for this sample.

Following are several examples:
<table>
<thead>
<tr>
<th>Category</th>
<th>Helping Critical Incidents (N = 50)</th>
<th>Hindering Critical Incidents (N = 11)</th>
<th>Wish List Items (N = 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participants (N = 7)</td>
<td>Incidents (n)</td>
<td>Participants (N = 7)</td>
</tr>
<tr>
<td>Establishment of Safety</td>
<td>7</td>
<td>100</td>
<td>12</td>
</tr>
<tr>
<td>No Longer Alone</td>
<td>6</td>
<td>86</td>
<td>11</td>
</tr>
<tr>
<td>Affection From Members and Leaders</td>
<td>6</td>
<td>86</td>
<td>6</td>
</tr>
<tr>
<td>Effectiveness of Leaders</td>
<td>5</td>
<td>71</td>
<td>9</td>
</tr>
<tr>
<td>Collaboration and Team Orientation</td>
<td>4</td>
<td>57</td>
<td>6</td>
</tr>
<tr>
<td>Knowledge of Program Competence</td>
<td>2</td>
<td>29</td>
<td>3</td>
</tr>
<tr>
<td>Spartan Practicality</td>
<td>2</td>
<td>29</td>
<td>3</td>
</tr>
<tr>
<td>Detracting Group Members</td>
<td>-</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Overworking</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Additional Integrative Work</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Table 2

Critical Incident and Wish List Items
The guy wouldn't hesitate to say it because this whole atmosphere of comfort and non-judgment told him that it didn't matter what he said, we still loved him, we still supported him, giving him all of the support that [he] would probably need down the road sometime. (Participant 3)

Just in conversation with people in general, their biggest fear is judgment. Period. And to have that explicitly talked about, even in the veterans circle, the judgment, to just have that absent is key. (Participant 2)

I'm sorry, but I can't keep a stiff upper lip forever. Maybe some people can, but count me out. (Interviewer: Right, maybe you got a sense that you didn't have to at this program?) No, not at all. The worst thing I remember was wearing our masks when we got there. We eventually got beyond that and learned about each other really intimately on the emotional level. (Participant 1)

Two subcategories emerged that characterize special instances of what contributed to participant safety. Crawl, Walk, Run (3 incidents, 43% participation) suggested that men felt relieved to find out that when the program became difficult or ‘went deep’ they would not be left behind. Similar to the broad category of safety, this generally helped participants to engage in the process and feel a deeper sense of belonging. An example of how this pacing affected a member is:
We were taking the time to do each piece, there was no rush through it… If it took extra time then it took extra time, so those are the things that really made me believe right off the bat that, "OK, this is a legitimate program." This isn't just cookie cutter shit…the guys are getting the time they need. It seemed to be really focused towards the vets versus focused towards the clock. (Participant 6)

*The Company of Men (2 incidents, 29% participation)* pertains to safety to engage unguardedly as a result of a non-gender mixed group. It came as a surprise that this was not mentioned more given the theoretical emphasis on men’s groups (Powell, 2013). It may be the case that this was supported on such an implicit level that participants did not consciously experience it, as is elaborated in Discussion. One example:

You place a female in that room and just the basic instinctive dynamics would change. [It] would have shut down aspects of what they had to say or how they felt about things. One of the big bonding things was, "Fuck I feel the same way. I've had the same experience." And if I didn't hear that out loud, which you wouldn't have in front of a woman…I would not have connected with that person. If I'm not connecting with that person I'm not connecting with that group. (Participant 5)

*No Longer Alone (11 incidents, 86% participation)* was the second most important category to members based on the number of incidents and representative participation in interviews. This category pertained to the sense of *finally* being understood, gaining a sense of being heard or seen, and feeling normal within the group. The men at times sighed with
relief while recanting the feeling of suddenly realizing their commonalities with others.

Below are two examples:

Everyone in the group was able to reflect on the story that was told and say, "Your story was impactful on me because I had a similar experience when such and such a thing happened to me." We said, "Wow we had the same childhood." That's a positive thing. Even if your childhood was horrible, suddenly you’re in a room with four or five different guys saying, "Hey man, I'm just like you," or "You're just like me." That goes a long way towards not feeling so alone anymore. (Participant 4)

The personal things they had to deal with. Not sleeping, the anger, the different things they described…over the last year or the last decades. How it's changed their lives. The core issues are very similar. So right away that created for me an understanding, "Hey I get that," "Fuck, I thought I was the only guy that would do that." I’m an oddball in any group but I felt, “OK, I'm not an oddball in this group." (Participant 5)

*Shared Military Background (4 incidents, 57% participant)* was a subcategory that accounted for a specific sense that members shared an “effortless understanding.” This involved the shorthand associated with shared military jargon, but more importantly that the feelings associated with military experiences could be shared amongst the group in a way the men had become exhausted trying to explain to others. One example:
The fact that everyone there has a common denominator of the military is also another factor. There's no having to explain the chain in command or the feelings that go with it. (Participant 5)

_Affection from Members and Leaders (6 incidents, 86% participation)_ pertains to the sense of being valued or cared for in response to others who communicated this type of warmth through words and actions. It seemed to have a ripple effect as men felt cared for to spontaneously communicate affection towards others. It is interesting the manner in which men communicated caring, such as in the examples below through a theme of fatherhood and becoming angry on another man’s behalf:

It was the sharing and the non-program sharing, just as human beings. We actually bought into it quite quickly. I kept calling [Participant 2] son and he kept calling me dad. A bit of a joke. We were able to talk about things very easily and we still do. (Participant 1)

I got to really understand how I viewed myself as that of being a monster because of the things I had to do. Coming into this, feeling that I didn’t deserve to be here. To be told (by another member), “You deserve to be here. It’s bullshit that you don’t think you deserve to be here. I’m angry that you feel that way” is a big deal. It’s huge. So to be told that…is really the beginning of self-compassion. (Participant 2)
Effectiveness of Leaders (9 incidents, 71% participation) involves how participants bought-in after seeing the leaders adequately carry out their roles, convey themselves respectably, and respond to challenges. For two participants, it was particularly important that leaders respected their competence without pitying or looking down upon them. In the third example, a participant appreciates that the leaders can present the theoretical backbone of the treatment in a straightforward manner:

It didn't feel like I was going to talk to doctors. It wasn't like I was being pitied. Or just, "Ohhh, we need to help you because there's something wrong with you" (patronizing tone). If there was any of that I would have shut off. I didn’t want to be ‘helped.’ They talk to you like you’re a person. Your input is valued and given airtime. (Participant 2)

Sometimes we have a problem explaining ourselves and it can be a little bit frustrating. They would understand the feelings you were projecting. The leaders knew the right questions in order to bring it out appropriately. (Participant 3)

They presented fairly complex perspectives and issues in a very simplistic, easy, straightforward way. We’d ask, "Guys what does that mean?" and they could define it as opposed to some people, when you call them on a word, lack the ability to define it. Sort of like how Stephen Hawking understands complex concepts so well that he can easily make others understand. (Participant 5)
Genuineness of the Leaders (3 incidents, 29% participation) stood out as a subcategory as it was a special type of leader effectiveness. In this case, men placed a high value on the human aspect of the leaders not ‘hiding behind’ the role of a therapist:

When I met them at the VTP…I didn't see psychologists or whatever sort of title they would have had. I saw them as people. The entire notion of airy-fairy just isn't there. There's no question about what the intention is. They communicated no ulterior motive. For me to go to speak to somebody about these things is a really fucking big deal. (Participant 2)

Do the helping interview with me for more than five minutes and I'm going to shut off. I prefer we discuss and if you think, "Wow, that's fucking weird," I expect you to tell me that sounds weird and then we'll go in that direction. I'm very direct. I like to be dealt with directly and I don't like being shined. (Participant 5)

Collaboration and Team Orientation (6 incidents, 57% participation) involved a sense of comfort, familiarity, and engagement that resulted from the roles and responsibilities with working as a group. Also important was the sense of men simply being with men, modeling of others, and recognizing that this was a collaborative process where their input was valued. An example:

It's just the boys back together again, it's not going to be complicated, and it’s not going to be difficult. Any team based fire fighters, COPs, anything along those lines
where you’re always working in a team with a bunch of guys it seems like a pretty simple move. The relative simplicity made it easy for me. (Participant 7)

*Feeling Valued Within Group (3 incidents, 43%) and Giving to Receive (2 incidents, 29% participation)* emerged as subcategories. The former refers to a sense of feeling one’s input was respected and critical to keep the process moving forward. The latter involves the awareness that one makes gains in proportion to how much they give to the group and that if one does not contribute, others may progress slower. Here are some supporting quotations from the former and latter, respectively:

I have to commit otherwise they're not going to commit. That kept me going. I wanted them to know that I was committed to them as much as they were committed to me and that goes back to the way that the program is structured. We're all here to do our own work but at the same time we are here to support and help each other. I formed some strong attachments and I want to see them be successful. (Participant 4)

Somebody always takes the lead in sharing something really personal or sacred about their injury and their youth. Somebody takes the lead and then sets the standard and then everyone tends to follow suit. (Participant 6)

### 3.2 Hindering CI (N = 11) and WL Item Categories (N = 5)

There were relatively few cited hindering CIs and WL items. In the case of factors that hindered men’s therapeutic engagement two categories formed.
Detracting Group Members (7 incidents, 86% participation) involved any way in which other group members restricted men’s engagement. This most often involved other men remaining disengaged, reflecting above how members cited that their participation was necessary for other members to make therapeutic gains. Some members also cited disingenuousness of other members as hindering. Some examples:

I rely on my sort of intuition. How I read people and body language and that sort of thing. If I felt like [other members] were being fake I feel myself closing off. Not completely, but it's more like I've put a layer up there because they had a layer up. (Participant 2)

If I've got five or six guys in a room and one guy is sort of half-hearted in it that definitely takes away from my experience. I'm not saying that he shouldn't have been there but I'm just saying it was distracting for me. It's just like, "Aw man, one guy's working his ass off and dude is just sitting in the corner." (Participant 4)

Overworking (4 incidents, 57% participation) took place when members felt the conditions of the program prevented gains. Note that this stands in mild contradiction to incidents in which members previously cited the ‘Spartan’ conditions (e.g., austerity, hard-work, freedom from distraction, etc.) of the program as helpful. Some examples:
We had some long, long days. Emotionally draining, thirteen hours, fourteen hours. And it was literally on a break I would fall back in my chair. Not so much that it was uncomfortable as it was phenomenally draining. (Participant 5)

Sitting in chairs for eight, nine hours a day is physically very hard to do. It's painful and that does become a bit of a distraction. (Participant 6)

The WL item portion of interviews produced so few incidents it was best organized into one broad category of *Additional Integrative Work (5 incidents, 43% participation)*. Some examples:

I would like to have seen individuals paired off one to one and telling their stories to each other first before they did an enactment. I think without the preview of the one-on-one kind of thing it took some people by shock. Then when that happens and you get that full extra openness…you can glimpse into the distance and see, "Ah, that's how it was. I understand a little bit better now.” (Participant 3)

For me, after the re-enactments, my re-enactment…was very emotional. It brought up a lot of stuff. I was very messed up. I described it as scrambled eggs brains. I felt that had [the last few days of the program] had a bit more work in there as opposed to having a large focus on administrative stuff and saying goodbye…it would have been more effective. I was thinking maybe if we just push a little harder, go a bit deeper. (Participant 5)
Chapter 4: Discussion

This study was an investigation of factors that helped and hindered men’s therapeutic engagement in a mental health program for returning military veterans. The overarching goal was to extract effective interventions to aid practitioners in meeting the needs of traditionally socialized male clients. Participants were interviewed twice, after which the data met nine credibility checks to ensure trustworthiness. Examining interviews produced an abundance of helping critical incidents that suggest that the VTP met what men needed to become therapeutically engaged.

Men’s engagement was supported foremost by a safe atmosphere with explicit rules that prevented judgment or advice giving. The safety to engage also meant that participants were made to feel competent and respected with pacing that matched their unique level of readiness for change. Men valued group structuring (e.g., taking turns with guidelines and protocol) that facilitated the sharing and normalizing of experiences, feelings, and presenting symptoms. Shared affection between members also aided men’s engagement. This style of affection was often marked by dramatic and courageous reframes or becoming angry on behalf of one another (e.g., “It’s bullshit that you feel like a monster. That pisses me off, you belong here”). The group leaders were frequently cited as instrumental in men’s engagement, in particular due to their high levels of competence and straightforward, genuine humanness (as opposed to coming across as therapists). Other important factors were the collaborative group structure and teamwork, the to-the-point ‘Spartan’ conditions of the therapeutic retreat, and external knowledge that the program is regarded as highly effective.

Hindering CIs and WL items were relatively scarce compared to helping CIs. Nonetheless, nearly all participants considered other members’ disengagement, aloofness, or
disingenuousness to be impediments to their own engagement. This may be the hindering CI counterpart to the helping CI experiences of members who cited that their own therapeutic gains were proportionate to how much they ‘gave’ to others through committed and enthusiastic engagement. WL items all involved a further desire for therapeutic integration. This helps to support the success of the program, as men who were initially skeptical became engaged and eager to continue.

One interesting theme that emerged was that during interviews, the emphasis on factors we might associate with traditional male socialization (e.g., requiring that competence and autonomy be acknowledged, ‘testing’ leaders with direct questions, etc.) at the outset of the program later shifted to more overall humanistic needs (e.g., feeling loved and valued, relief from unbearable feelings of aloneness, etc.). This may suggest a decrease in the masculine posturing associated with gender role strain, such as the well-cited masculine ideology that men must always remain composed and in control (David & Brannon, 1976; Pascoe, 2012).

One possibility is that as trust and safety were established, men’s senses of self-worth and attachment security within the group were able to exist independent of the masculine ideology that they initially used to relate to one another. Because GRSP suggests that the male social process often comes at odds with men’s goals of therapeutic healing, the spontaneous freedom to express vulnerability may have been like a pressure release valve for gender role strain (i.e., men escaped the double bind of seeking and avoiding help). While this is prospectively supported by an overall slight reduction in male ideology as measured by the MRNI-R, a large sample mixed-methods study would be helpful to better explore this. Implications and further directions are discussed further below.
4.1 Theoretical Agreement

In revisiting the ninth credibility check, the findings fit with scholarly literature. In terms of Kiselica and Englar-Carlson’s (2010) framework, support emerged for nine of their 10 positive male aspects of male socialization that may help to foster engagement. Male relational styles surfaced as men bonded over proud moments and worked together as a unit with a shared goal. The sharing of affection fit with male ways of caring as the men expressed warmth through anger on each other’s behalf or through noble declarative statements (e.g., “What you did may not have been right, but guess what? We’re here for you and we’re not going anywhere”). A sense of generative fatherhood appeared such as when two members referred fondly to one another as “dad” and “son.” A parental sense of self-sacrifice and member-to-member nourishing was cited not only within the therapeutic group but also in between sessions such as during meals or outside where members smoked and talked together.

Members placed a high value on being respected, valued, and autonomous contributors, appealing to male self-resilience. For instance, men reported engaging further once they knew that decisions would not be forced upon them. The worker/provider tradition of men and male courage, daring, and risk-taking were upheld as the members expressed having worked extremely hard in foreign and uncomfortable territory. These efforts were far from self-centered as men shouldered great burdens to help others, such as when Participant 1 expressed having relived his own anguish knowing it was what would help another member. Some men who at first were reserved left wishing they could have gone “even deeper.” Men’s use of humor was also cited numerous times, in particular as participants recanted the importance of taking ‘friendly jabs’ at each other during meals. A
sense of *male heroism* also emerged in terms of men who, despite being reluctant to engage, contributed outside of their comfort zone knowing that others progress was dependent upon this.

As Stevens (2007) had stressed, an educational component was important to men. A straightforward explanation of the *how* and *why* behind interventions helped to address suspicions of ulterior motives and appealed to men’s desires to understand the process. After all, these men did not want to be handed a solution. They wanted to know exactly what was going on so they could match the leaders’ efforts pound-for-pound in working towards their goals.

Other incidents that paralleled expert advice were moving beyond therapeutic conventions with activities that men may better bond over such as sharing meals, playing games, and even tasks such as moving tables (Kiselica, 2008); communicating in the same manner and at the same pace of male clients, such as avoiding emotional terms and referring to activities and events at the program’s outset (Lynch & Kilmartin, 1999); clarifying through speech and action that there is no ulterior motive beyond working together to a solution (Stevens, 2007); and cultivating a physical space friendly to comradery, such as having magazines, guitars, snacks, and (a lot of) coffee around (Robertson, 2006).

### 4.2 Missing Categories and Implicit Incidents

While there was theoretical support for the inductively formed categories, both the literature and expert consultation revealed potential incidents and categories that were surprisingly absent. One example was the lack of incidents based on the physical, hands-on nature of the program (versus a talk therapy). Action-orientation as an effective means of working with male clients has been referred to extensively within men’s counselling
literature (Good & Brooks, 2005; Kiselica & Englar-Carlson, 2010). Indeed, the VTP is highly action focused and parallels Powell’s (2013) suggestion that men work best in groups that ‘do things’ together with a number of integrative interventions and shared goals. It is possible that this was helpful to men’s engagement, albeit on an implicit level that the men did not consciously think about. In a sense this would be a strength of the program, however it also means that we cannot overtly verify that action-orientation helped engagement as it was not discussed.

Also going unmentioned in interviews was the strategic use of language. VTP facilitators rarely use words like ‘therapy’ or ‘depression’ and instead talk about ‘picking up tools,’ ‘completing a course,’ or ‘treating an injury.’ This male-sensitive approach to language is supported by expert theorists (e.g., Robertson, 2006). There is at least indirect evidence of this approach’s effectiveness as the men were quick to use the language of ‘injury and repair’ both during the program and interviews. Similar to action-orientation, this may have been so seamlessly introduced into the program that the men were unaware the role it played in their engagement. Again, however, without being explicitly cited we cannot consider this a helping factor for men in this study.

Another surprise was that while there is theoretical support for non-mixed groups (i.e., men’s groups; Kiselica and Englar-Carlson’s, 2010; Powell, 2013) that only two participants cited the all men’s format as important to their engagement. One thing to consider is that these interviews took place post-program, and as mentioned above men by this point seem to have reached a relatively non-gendered stance on what helped (e.g., the strict adherence to male gender role had waned somewhat as the men spoke in more
emotion(al terms). Ironically, however, it is possible that an all-male format was a gateway in helping the men step outside the confines of gender role strain (as further discussed below).

Chapter 5: Conclusion

5.1 Implications and Knowledge Dissemination

Because men tended to cite incidents appealing to traditional masculinity that occurred at the outset (e.g., the leader presented himself as ‘just another guy’) and then more general, universal human needs (i.e., that might be shared by men and women alike) that occurred later in the program (e.g., that other members communicated validation and affection), there are implications for men’s engagement at the ‘front end’ of helping programs. That is, the early stages of therapy may be a particularly make-or-break period for men. While this is not unique to therapeutic alliance literature (Bordin, 1994), working with traditionally socialized men still represents a minority (Hoover et al., 2012) and culturally specific interventions such as those cited in this article appear critical to ensure that ambivalent or precontemplative men do not slip through the cracks (Englar-Carlson, 2006; Keslica, 2008).

A unique implication of this study is the paradox that to help men step outside of the double bind of gender role strain (i.e., men may need help, but this violates masculine principles of self-reliance; Pleck, 1995) practitioners are wise to first work within the very masculine ideology that often creates reluctance. That is, to work with the momentum of traditional male socialization by respecting men’s competence and autonomy, demonstrating similarities between client and therapist, being ‘just another person’ instead of a therapist, and to convey absolutely no judgment. In this study’s group, once trust was established and men had ‘picked up the tools’ of emotional exchange, the male gender-role seemed to soften
as the taboo of vulnerability disappeared and men expressed care and even lovingness (in their words) towards each other.

It is also important that nearly all incidents implicitly reflected group process. The constituent elements of the emerging categories formed a very group-focused framework (e.g., safety through group structure, shared experiences of a group of men, collaborative team efforts, etc.). Thus, practitioners are advised to consider the benefits of group work with men, especially in light of the growing body of scholarly suggesting that men work better in a team format (Kisela & Englar-Carlson, 2010; Maccoby, 2002). This is supported more specifically by research conducted both through in-vivo observation of what works and what does not for men therapeutically (Powell, 2013) and through theoretical examination of the social process of men and boys (Benenson et al., 1997).

Group theory also helps to explain the men’s transition from masculine competence based needs to intimate relational needs. For instance, Yalom and Leszcz’s (2005) theoretical group stages progress from (a) orientation, involving ambiguity and the need for approval and structure, to (b) conflict/dominance, when members compete and ‘test’ leaders, finally to (c) cohesiveness, when trust, intimacy, and self-disclosure emerge. Earlier stages parallel the men’s initial need to feel respected, competent, not looked down upon, and the safety to reduce masculine ‘performance.’ The third stage parallels the men’s shift to intimacy and supportive affection. Though Irvin Yalom’s model was chosen for seminal relevance, these stages of development closely parallel the structuring proposed by numerous group theorists (e.g., Borgen, Pollard, Amundson, & Westwood, 1989; Corey, 2000).

These findings are of course moot if knowledge is not effectively disseminated. Given the contemporary appeal of media campaigns like Man Therapy (2013) one must
consider the drawbacks of using only traditional channels such as peer-reviewed publication. While academic papers and conferences represent one important route, they are often limited to a professionally esoteric audience and further yet by the popularity and impact rating of respective journals. Taking full advantage of modern social communication we must make every effort to lobby key stakeholders both in existing programs (e.g., psychiatry, clinical and counselling psychology, etc.) and at the level of the lay public. In terms of the latter, the proliferation of YouTube channels and Twitter feeds (e.g., Men’s Depression and Suicide Network, 2013) offer opportunities to make new knowledge heard by men and those in their lives across generations.

5.2 Limitations and Future Research Directions

One limiting issue ties back to the Transtheoretical Model of Change (Prochaska & Velicer, 1997). While an assumption of this study is that men self-stigmatize and often resist engagement to therapy, all the men attending the VTP had likely reached the action-stage of Prochaska’s model of readiness (i.e., they are ready to take concrete steps to address their presenting issues). While this gives us valuable information about one particular cross-section of men, it would be interesting to work with men in the precontemplation stage to examine what best meets these needs given that this stage often presents the most challenging clients (Powell, 2013). One possible outcome of this research is a descriptive model of how men’s therapeutic engagement and stigmatizing attitudes relate to the TTM stages of readiness.

A second issue pertains to the surprise that certain incidents (e.g., languaging and the program’s action-orientation) were not cited by participants. Given that these factors are often cited as helpful to men’s engagement (e.g., Lynch and Kilmartin, 1999; Kiselica,
it may be the case that they were implicitly helpful in a manner participants did not consciously recall during interviews. This may be a limitation of relying exclusively on interview data that is subject to fallible memory and limited self-awareness (Silverman, 2009). One suggested method to help make these incidents explicit is *interpersonal process recall* (Kagan, 1984) in which participants watch videotaped therapy sessions and ask the researcher to stop the tape whenever something significant occurs (in this case regarding engagement). The methodological combination of reviewing recordings and analyzing transcribed interviews would help to ‘triangulate’ the research objective by corroborating self-report with a more objective in vivo account of what facilitated men’s engagement (Mathison, 1988).

It is of course the case that small sample qualitative research is not generalizable to larger groups. Thus, in working with military veterans in a group format the goal was to examine the microcosm of effective male-therapy interventions that has been relatively unexplored in the wake of decades of correlation based research. Similarly to triangulation with different methods, it is hoped that a variety of qualitative methodologies (e.g., grounded theory, phenomenology, and further critical incident work) are employed to further clarity more specific aspects of men, engagement, process, and change. In this vein, it would also be interesting to work exclusively with men who scored very high in traditional masculine ideology, as this sample scored normatively—a surprise given that military personnel tend to score on the higher end of male socialization (Hinojosa, 2010).

In regards to the tendency for men’s therapeutic needs to shift from male socialization on the front end, to non-gendered human needs (i.e., that might be shared by men and women alike) on the back end, it is important to examine this more directly. One direction would be
a mixed methods study that pairs participants’ experiences with the measurement of gender role strain (e.g., the gender-role conflict scale; O’Neil, Helms, & Gable, 1986), as it is possible that dissonance has decreased as men discover a safety in conveying deeper levels of personal authenticity.
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Westwood, M. J., Cox, D. W., Hoover, S. M., Chan, E. K. H., Kivari, C. A., Dadson, M. R.,


Appendices

Appendix A: Male Role Norms Inventory—Revised

Please complete the questionnaire by circling the number that indicates your level of agreement or disagreement with each statement. Give only one answer for each statement.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Slightly Disagree</th>
<th>No Opinion</th>
<th>Slightly Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<tr>
<td>1. Homosexuals should never marry.</td>
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<td>2. The Prime Minister of Canada should always be a man.</td>
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<td>3. Men should be the leader in any group.</td>
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<td>4. A man should be able to perform his job even if he is physically ill or hurt.</td>
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<td>5. Men should not talk with a lisp because this is a sign of being gay.</td>
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<td>6. Men should not wear make-up, cover-up or bronzer.</td>
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<td>7. Men should watch football games instead of soap operas.</td>
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<td>8. All homosexual bars should be closed down.</td>
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<td>9. Men should not be interested in talk shows such as Oprah.</td>
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<td>10. Men should excel at contact sports.</td>
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<td>11. Boys should play with action figures not dolls.</td>
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<td>12. Men should not borrow money from friends or family members.</td>
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<td>13. Men should have home improvement skills.</td>
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<td>14. Men should be able to fix most things around the house.</td>
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<td>15. A man should prefer watching action movies to reading romantic novels.</td>
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<td>16. Men should always like to have sex.</td>
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<td>17.</td>
<td>Homosexuals should not be allowed to serve in the military.</td>
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<td>18.</td>
<td>Men should never compliment or flirt with another male.</td>
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<tr>
<td>19.</td>
<td>Boys should prefer to play with trucks rather than dolls.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>A man should not turn down sex.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>A man should always be the boss.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>A man should provide the discipline in the family.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>Men should never hold hands or show affection toward another.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>It is ok for a man to use any and all means to “convince” a woman to have sex.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Homosexuals should never kiss in public.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>A man should avoid holding his wife’s purse at all times.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>A man must be able to make his own way in the world.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>Men should always take the initiative when it comes to sex.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>A man should never count on someone else to get the job done.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>Boys should not throw baseballs like girls.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31.</td>
<td>A man should not react when other people cry.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.</td>
<td>A man should not continue a friendship with another man if he finds out that the other man is homosexual.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33.</td>
<td>Being a little down in the dumps is not a good reason for a man to act depressed.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34.</td>
<td>If another man flirts with the women accompanying a man, this is a serious provocation and the man should respond with aggression.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35.</td>
<td>Boys should be encouraged to find a means of demonstrating physical prowess.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36.</td>
<td>A man should know how to repair his car if it should break down.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly Disagree 1</td>
<td>Disagree 2</td>
<td>Slightly Disagree 3</td>
<td>No Opinion 4</td>
<td>Slightly Agree 5</td>
<td>Agree 6</td>
<td>Strongly Agree 7</td>
</tr>
<tr>
<td>---------------------</td>
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</tr>
<tr>
<td>37. Homosexuals should be barred from the teaching profession.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>38. A man should never admit when others hurt his feelings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>39. Men should get up to investigate if there is a strange noise in the house at night.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>40. A man shouldn't bother with sex unless he can achieve an orgasm.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>41. Men should be detached in emotionally charged situations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>42. It is important for a man to take risks, even if he might get hurt.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>43. A man should always be ready for sex.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>44. A man should always be the major provider in his family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>45. When the going gets tough, men should get tough.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>46. I might find it a little silly or embarrassing if a male friend of mine cried over a sad love story.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>47. Fathers should teach their sons to mask fear.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>48. I think a young man should try to be physically tough, even if he's not big.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>49. In a group, it is up to the men to get things organized and moving ahead.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>50. One should not be able to tell how a man is feeling by looking at his face.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>51. Men should make the final decision involving money.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>52. It is disappointing to learn that a famous athlete is gay.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>53. Men should not be too quick to tell others that they care about them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
Appendix B: Interview Protocol–Helping Factors of Men’s Therapeutic Match

Note: Adapted from Butterfield et al. (2009).

<table>
<thead>
<tr>
<th>Participant #</th>
<th>Date:</th>
<th>Interview Start Time:</th>
</tr>
</thead>
</table>

1. **Establishing Context**

   Preamble: As you may be aware, men are often very resistant to accepting help when they feel stuck or are experiencing difficulties. Even when they do, they are often reluctant to become engaged or committed, and may drop out of a help program. Because you have successfully completed the VTP, I’d like to ask you about the ways in which you felt this program was a good fit, or limited your engagements and sense of belonging. This is the first of two interviews and its purpose is to collect information regarding what helped you engage in the VTP.

   (a) To start things off, maybe you could talk a bit about what made you decide to enroll in the program.

   (b) To participate in this study, it was necessary that you found a good match with the VTP. What does a therapeutic fit mean for you?

   (c) What sort of expectations or pre-existing ideas did you have about therapy or mental health services?

   (d) How did these ideas influence what you expected from the VTP? (Questions are guidelines–probe as necessary to further interview)

2. **Critical Incident Component**

   Transition to main Critical Incident questions: Despite these expectations, you have reportedly found a good fit with the VTP.

   (a) What sort of things allowed you to reach this level of engagement, commitment, and fit? (Example of follow-up probes: “You said the facilitator treating you like a competent equal helped you. How did this impact you specifically?” “Can you give me a specific example of this?” “How did that help you feel you had found a good match?”)

<table>
<thead>
<tr>
<th>Helpful incident and meaning to participants (What did that factor mean to you?)</th>
<th>Importance (How did it help you?)</th>
<th>Example (What led up to it? What was it? What was the outcome?)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

   (b) We’ve covered what helped you find a fit. Are there some things that made it harder to become engaged, committed, and to find a sense of belonging?
<table>
<thead>
<tr>
<th>Hindering factor and meaning to participants (What did that factor mean to you?)</th>
<th>Importance (How did it help you?)</th>
<th>Example (What led up to it? What was it? What was the outcome?)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>...and so on</td>
</tr>
</tbody>
</table>

(c) Provide a summary of material so far covered to transition to Wish List Item question: You’ve helped me to understand some things that helped and hindered you in finding a good match with the VTP. Were there some missing things that would have been helpful that you would have liked to have seen?

<table>
<thead>
<tr>
<th>Wish List Item and meaning to participants</th>
<th>Importance</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>...and so on</td>
</tr>
</tbody>
</table>

(d) If you’ve sought mental health services before, have you always found a good therapeutic match?
(e) If not, was this the first time for you?

3. Demographics Component
   (a) Number of times utilizing mental health services:

   (b) Age:

   (c) Country of birth:

   (d) Marital status:

   (e) Education level:

Interview end time: | Length of interview:
Name of interviewer:
## Appendix C: Emergence Log

<table>
<thead>
<tr>
<th>Date of CI/WL Extraction</th>
<th>Participant</th>
<th>Date Categorized</th>
<th>New Categories Emerged?</th>
</tr>
</thead>
<tbody>
<tr>
<td>13-May</td>
<td>Part3</td>
<td>13-May</td>
<td>All new categories emerged</td>
</tr>
<tr>
<td>13-May</td>
<td>Part2</td>
<td>13-May</td>
<td>All new categories emerged</td>
</tr>
<tr>
<td>13-May</td>
<td>Part1</td>
<td>15-May</td>
<td>No new categories emerged</td>
</tr>
<tr>
<td>21-May</td>
<td>Part4</td>
<td>21-May</td>
<td>No new categories emerged</td>
</tr>
<tr>
<td>21-May</td>
<td>Part5</td>
<td>22-May</td>
<td>1 new HE; no new HI; 2 new WL categories emerged</td>
</tr>
<tr>
<td>21-May</td>
<td>Part6</td>
<td>24-May</td>
<td>No new HE; no new HI; 1 one WL category emerged</td>
</tr>
<tr>
<td>30-May</td>
<td>Part7</td>
<td>30-May</td>
<td>No new categories emerged</td>
</tr>
</tbody>
</table>