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Conceptualizing men: A transdiagnostic model of male distress

Roger Kingerlee*

Gateway House, Wymondham, UK

Purpose. This review aims to produce a comprehensive, parsimonious, and empirically based model of male psychological distress from the perspective of cognitive behaviour therapy (CBT) that may apply in the majority of clinical situations involving men in Britain and possibly elsewhere.

Methods. This paper reviews studies that pertain to male psychological distress. Studies are selected via examination of the literatures around men's psychological health. Criteria for inclusion of studies are direct and indirect relevance to male distress. Studies are examined on the basis of their possible contribution to a comprehensive yet critical model of male functioning, and are grouped according to their neurological, developmental, and cultural origins.

Results. The review suggests that certain factors inform the psychological presentation of males across disorders, and can help predict therapy-interfering behaviours and outcomes. A transdiagnostic model of male distress emerges from existing data and theory containing the hypothesized reflection abandonment mechanism (RAM) that helps account for characteristic male externalizing and therapy-interfering behaviours.

Conclusions. Existing data and theory can be synthesized to produce a cognitive behavioural model of male distress that adds value to case conceptualizations regardless of the disorder involved, and has predictive value regarding men's access to and engagement with psychological services.

It is an apparent paradox that, while men have often tended to hold the most powerful positions in many societies over recent centuries and continue to do so (Greer, 1999), relatively little attention has been paid to the psychological functioning of men, notably in the United Kingdom (Wilkins, 2010). This lack of attention is still more surprising given the epidemiological data that show that in most countries, the male:female suicide rate is at least 4:1, and higher in some countries (6.69:1 in Belarus) (Hawton, 2009; Joiner, 2007). Certain psychological problems are also more common in males. The male:female ratio of conduct disorder, for example, typically varies between 2:1 and 4:1 (Meltzer, Gatward, Goodman, & Ford, 2000).

*Correspondence should be addressed to Dr. Roger Kingerlee, Gateway House, Unit 1, Gateway 11 Business Park, Wymondham NR18 0WF, UK (e-mail: roger.kingerlee@nwmhp.nhs.uk).

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It is now increasingly recognized, however, that men's psychological functioning deserves attention in its own right (Banyard, 2009; Sabo & Gordon, 1995), not least since men find it more difficult than women to request psychological help (Perlick & Manning, 2007) – a difficulty that, combined with other factors, can have tragic outcomes in both homicide *and* suicide. Over 90% of people involved in such cases are male (Logan *et al.*, 2008). Indeed, the issue of male psychological health may be still more pressing in the current recession, since some experts believe males may be at heightened risk of suicide, as in the late 1920s (Hawton, 2009).

Against this background of neglect, it is perhaps not surprising that male-specific psychological models have not – with few exceptions, mostly from the United States (e.g., Cochran & Rabinowitz, 1996; Good & Mintz, 2005; Kendler, Gardner, & Prescott, 2006; Mahalik, 2005a, 2005b; Pollack, 2005) – been forthcoming. However, in the light of review, existing psychological evidence, theory, and practice with British men can, when seen through the critical lens of social constructionism (e.g., Edley & Wetherell, 1995) and synthesized, produce a transdiagnostic model of male distress from the perspective of cognitive behaviour therapy (CBT) that, while avoiding essentialism and acknowledging different masculinities (e.g., Connell, 2005), adds precision and predictive value to many or even most formulations of men's psychological issues.

Method

Material concerning men's psychological health was sought up to January 2011. Criteria for inclusion were that material was directly or indirectly relevant to male psychological distress and CBT. Electronic searches were conducted on major psychological, medical, nursing, social care, and social science databases. The databases included (but were not restricted to) PsycInfo, Medline, British Nursing Index, and Social Care Online. Electronic searches used such terms as 'men', 'men's', and 'males'. These were combined with such terms as 'cognitive behavioural therapy', 'CBT', 'distress', 'psychological health', 'sex differences', 'psychological development', 'meaning', and 'culture', such that all reasonable permutations were used. Electronic searches were also conducted in this manner regarding men, CBT, and the common specific disorders, including depression, anxiety, bipolar disorder, psychosis, schizophrenia, and posttraumatic stress disorder. For instance, on 20 January 2011, an unlimited PsycInfo title search for the terms 'men', 'depression', and 'cognitive behaviour therapy' yielded 5,454 published articles.

Beyond CBT, studies from different theoretical perspectives regarding men were included. Epidemiological studies were also included, as was quantitative, qualitative, and mixed-methods research. The search was augmented by following up useful references in located papers, reviews, and books, and each issue of the US journal *Psychology of Men and Masculinity* was searched. The majority of the material consulted was in English, but material in other languages (e.g., German) was consulted where relevant. The existing material can be divided as follows.

Neurological factors

While the field of sex differences and their behavioural and psychological impact remains problematic (Denman, 2004), some reliable evidence points to significant neurological sexual dimorphism that emerges early in life, and that may directly or indirectly impact later psychological functioning (Becker *et al.*, 2008; Cahill, 2005).

First, there are significant differences in brain size between the sexes that are present at birth. Recent research suggests that male neonates' brains are around 8% larger than female neonates' brains – a difference that persists throughout life (Gilmore *et al.*, 2007). Furthermore, sexual dimorphism may also affect specific brain areas. Some (but not all) evidence suggests, for example, that the amygdala, which is involved in emotional processing, is larger in men than in women (Goldstein *et al.*, 2001). Connectedly, evidence is emerging that common and sex-specific sets of brain regions regulate emotion (Mak *et al.*, 2009). In regulating negative emotion, Mak *et al.* (2009) found that men were more likely than women to recruit brain regions associated with cognitive (versus affective) processing.

Second, there is evidence of differences in the timing between the neurological development of the sexes. Research indicates that girls develop areas of the brain associated with language processing, fine motor skills, and social skills before boys (between birth to age six), while boys showed increasing ability to assess spatial relationships and coordinate gross motor movement during the same period. By age 16, boys overcome this developmental lag (Hanlon, Thatcher, & Cline, 1999). Other research suggests that girls may reach their optimal cognitive functioning sooner than boys (Clark *et al.*, 2006).

Third, it is recognized that hormonal differences can affect the developing brain. Higher levels of foetal testosterone are, for example, associated with reduced eye contact and smaller vocabulary in infancy – issues that can impact emotional abilities later in childhood (Lutchmaya, Baron-Cohen, & Ragatt, 2002). In view of this, some argue that, on average, males develop strengths in 'systematizing', and corresponding male weaknesses in 'empathising' (Baron-Cohen, 2003).

Despite these putative neurological sex differences, however, their actual impact on psychological functioning is questionable. In recent critiques, Eliot (2010) and Fine (2010) argue that neurological sexual dimorphism is minimal, but that its effects on psychological functioning are amplified via complex interactions, notably with cultural and developmental factors (Rutter, 2006). Put another way, if neurological sexual dimorphism is slight, other factors must account for established epidemiological sex differences, including the higher male suicide rate (Joiner, 2007). It is to these factors that we now turn.

Developmental factors

Developmental factors may also affect males differentially. First, certain evidence indicates that primary caregiver interactions with infants differ depending on the sex of the child. One, older line of evidence suggests that primary caregivers interact differently with male and female children. In studies of mother–child interactions of toddlers, Dunn, Bretherton, and Munn (1987) found that children who were often engaged in conversations about feeling states by their mothers at 18 months were more likely to talk about their feelings when they were 24 months old. This effect, moreover, was particularly marked for girls. With children of 18 months, mothers encouraged communication about feelings more with girls than with boys, and by 24 months, the girls were found to be talking more about feelings than boys. In the light of which evidence, it would not be unreasonable to hypothesize that an emotional trajectory has been set for male development – at a lower level, on average, than for females.

More recent empirical, large-scale cross-cultural research supports the notion of differential emotional development between the sexes. In a study of 220 Argentine,

Italian, and US families with children of 20 months old, researchers found that mothers of girls were more sensitive and optimally structuring than mothers of boys, and that daughters were more responsive and involving than sons (Bornstein *et al.*, 2008). If correct, this research would amplify the view that young boys are left to cope more independently than young girls during developmental stages known to be highly sensitive to the caring environment (Gerhardt, 2004).

A body of psychodynamic theory continues this theme. Feminist theorists, notably Chodorow (e.g., 1978, 1994) tend to see masculinity as a defensive construction via which boys define themselves in contrast to their mothers. This fosters a repudiation of the feminine within and beyond the male self and interferes, it is argued, with men's relational abilities (Chodorow, 1994).

Operationalizing these ideas, US scholars have produced psychodynamic models of 'masked' depression or distress (e.g., Blazina, 2001; Cochran, 2005; Cochran & Rabinowitz, 1996; Pollack, 1998, 2005). In perhaps the most fully developed model, Pollack (2005) suggests that compared to girls, boys are often subject to a more or less traumatic, premature psychological abandonment by their primary caregivers. This attachment-related phenomenon, Pollack (2005) argues, leaves males vulnerable to difficulties with emotional regulation, including strong feelings of shame. Against this, Addis (2008) points out that there is no actual evidence hitherto of an underlying depressive disorder in men whose symptoms are hidden. Nevertheless, empirical evidence is emerging that men's abilities to emotionally self-regulate – including a tendency to suppress emotions – are influenced by the nature of early maternal care, and are in turn related to avoidance of close interpersonal relationships in adulthood (Land, Rochlen, & Vaughn, 2011; Schwartz, Waldo, & Higgins, 2004).

Second, some evidence suggests that developing males may, on average, focus more on issues involving status. While it must be acknowledged that research in this area is not conclusive (Cameron, 2009; Goodwin, 2006), some evidence suggests that when children tell make-believe stories, boys' narratives focus on lone characters in conflict, whereas girls' narratives focus on familial and social relationships (Sandberg & Meyer-Bahlberg, 1994). Similar patterns emerge in children's play, suggesting that males are, on average, less concerned with sharing of minds and more interested in establishing dominance (Argyle, 1994; Baron-Cohen, 2003).

Perhaps related to these ideas, males seem, from an early juncture, to have a less developed 'theory of mind' – the ability to make accurate inferences about others' psychological states – compared with females. By the age of 7, for example, when asked to judge when someone might have said something that was inappropriate, girls score more highly than boys (Baron-Cohen, O'Riordan, Jones, Stone, & Plaisted, 1999).

Third, sex differences in early help-seeking behaviours have been observed. With children of 6 years, Benenson and Koulnazarian (2008) found that boys were significantly less likely than girls to express hurt or distress, either to teachers or their parents. Interestingly, to judge by established evidence and clinical experience, this difference in help seeking largely persists into adulthood. Persuading men to ask for, receive, and continue to receive psychological help is notoriously difficult, not least since men fear being seen as incompetent and/or not 'masculine' (Addis & Mahalik, 2003; Weiss, 1985). These issues are amplified where males have been sexually abused (Scarce, 1997; Stalker, Schachter, Teram, & Lasiuk, 2009; Vojvoda & Southwick, 2007).

Taken together, the above evidence suggests the intriguing possibility that males' status-seeking behaviours may interfere with or override their help-seeking behaviours – starting from early boyhood.

Finally, while firm empirical data are lacking, it might be suggested, given the research above on the early developmental environment with caregivers (Bornstein *et al.*, 2008), and help seeking (Benenson & Koulnazarian, 2008), that boys may be more vulnerable than girls to feelings of shame at times of distress. If, as some argue (Fogel, 2009; Schore, 1998), internal working models developed in infancy encode coping strategies of affect regulation that are unconsciously used to regulate distress in situations that might elicit attachment behaviours, this may impact men if, during development, they learn to associate psychological distress with shame specifically. Such an early association could, *ipso facto*, explain men's later abandonment or avoidance of psychological help seeking.

Overall, at least some of the available evidence suggests that, relative to developing females, males may be treated differently by primary caregivers; be more focused on matters of rank; and have less well-developed theory of mind skills and, from an early age, find help seeking more difficult.

Cultural factors

Then there are cultural factors that interact with male psychological development and subsequent behaviours. The cultural messages given to developing males, in the United Kingdom and elsewhere, are often conflicted (Frosh, Phoenix, & Pattman, 2002), embedded in complex family dynamics (Kraemer, 2005) and – though the mechanisms of influence are not yet fully understood – entwined with neurological and developmental factors (Eliot, 2010; Fine, 2010). One result of these processes has been the social construction of various heterosexual and homosexual masculinities (e.g., Beynon, 2002; Edley & Wetherell, 1995; Kimmel & Messner, 1998; Whitehead & Barrett, 2001).

However, while different heterosexual and homosexual masculinities must be acknowledged (Finn & Henwood, 2009), and while men can become more emotionally skilled over the lifespan (Knight, 2004), acceptable notions of heterosexual manhood, masculinity, and social status for many men can remain culturally bound up with strength on the one hand, and a lack of emotionality on the other (Clare, 2000; Farrell, 1993; Kimmel, 2001). Such notions of manhood that, it is argued, tend to marginalize and oppress other notions, have been collectively termed hegemonic masculinity (Connell, 2005; Lusher & Robins, 2010). And while such masculinities are likely to be socially constructed from various sources as discussed, they can nonetheless be damaging.

Work from the cultural standpoint of the United States has begun to explore these matters clinically. Here, gendered socio-cultural practices around masculinity are taken to produce restrictive norms that impact men's behaviour, and health. Indeed, considerable empirical support indicates a relationship between restrictive masculine norms, or gender role strain in men, and poor health (O'Neil, 2008). Hyper-masculine attitudes may therefore, and ironically, be self-defeating.

Related to this area of research, gender-aware, male-specific models of psychotherapy have begun to arise in the United States. Such models, which add a male-sensitive overlay to standard treatments (Good & Brooks, 2005), include integrative therapy (Good & Mintz, 2005), interpersonal therapy (Mahalik, 2005b), and group therapy for men (Rabinowitz, 2005). While demonstrably useful in clinical practice, how much value is added in empirical terms remains debatable.

A further recent development has been the CBT-oriented work of Mahalik (e.g., 1999, 2005a; Mahalik & Morrisson, 2006) who, reviewing authoritative US sources on masculine gender roles to identify overlapping constructs, pinpoint nine areas variously termed themes, masculine injunctions, or schemas. The nine themes – all of which are

directly or indirectly associated to either status or control of the emotions – identified by Mahalik (2005a) are (1) winning, (2) emotional control, (3) risk taking; (4) violence; (5) playboy; (6) self-reliance; (7) primacy of work; (8) disdain of homosexuals; and (9) physical toughness. Each area, Mahalik (2005a) argues, can produce masculine-specific cognitive distortions. To take one example, the notion of winning above, men might evince the cognitive distortion that 'Winning isn't everything, it's the only thing'. Mahalik's (2005a) nine themes, coupled with two further themes, (10) dominance and (11) pursuit of status, have also been incorporated into an 11-factor measure, the Conformity to Masculine Norms Inventory (CMNI) (Mahalik *et al.*, 2003; Mahalik, Talmadge, Locke, & Scott, 2005). As Mahalik *et al.* (2005) say, the CMNI, with its 94 items, is likely to be useful with at least some men, even though firm empirical support for all the sub-scales is lacking, and while the measure was developed using a White, heterosexual, US sample. In sum, while a small body of work addresses men's psychological issues from the perspective of CBT, this work is oriented to male experiences in the United States, is in its infancy, and is likely, given differing masculinities (Beynon, 2002), to have limited clinical applicability elsewhere.

It is possible, therefore, that interacting neurological, developmental, and cultural factors may affect the social construction of masculinities, and the maturing male, in psychologically significant ways. Specifically, at least some evidence indicates that males may be at a developmental disadvantage when it comes to learning emotional skills. It may also be that, since some males tend to focus on issues of rank and status, males find psychological distress and associated help seeking especially problematic – possibly since these may be perceived to signal a (further) shameful social defeat in the male mind. Finally, while some scholars have begun to operationalize this material in the form of male-specific psychological models, this has only occurred largely or wholly in the United States.

Given all of which, a comprehensive yet parsimonious model of male psychological distress can be proposed that, while acknowledging differing masculinities, could be applied as a tool to aid critical reflection in the United Kingdom, and possibly beyond. This model appears below.

The male-specific profile

In view of the interaction of the neurological, developmental, and cultural factors described above, it is arguable that some men exemplify a male-specific profile (MSP) that, once constructed, is identifiable within men transdiagnostically, that is, across various psychological disorders. The MSP is adapted from major work in the field of personality disorders by Young, Klosko, & Weishaar (2003). Importantly, though, it is *not* suggested that many or all men exhibit personality issues, but rather that men are subject to neurological, developmental, and cultural pressures that impact their functioning in characteristic ways, notably under stress.

Young *et al.* (2003) use the term schema to mean a linked, and potentially rigid collection of feelings, thoughts, and behaviours or, more simply, any broad organizing principle for making sense of one's life experience. Four parts of Young *et al.*'s (2003) system could apply, in modified form, here.

First, in their initial hypothesized Domain, that of Disconnection and Rejection, Young *et al.* (2003) note the schema of Deprivation of Empathy, associated with the expectation of the absence of understanding, listening, self-disclosure from, or mutual sharing of feelings with others. Second, in the same domain, the authors note the

Defectiveness/Shame schema, which is described as the feeling that one is defective or inferior in important respects or that one would be unlovable to significant others if exposed. Third, in their fourth Domain, Other-Directedness, Young *et al.* (2003) describe the Approval-Seeking/Recognition-seeking schema. This schema, Young *et al.* (2003) argue, can include an over-emphasis on status, appearance, social acceptance, or achievement, and in their view is often related to narcissistic (in practice often male) presentations. Finally, in their fifth Domain, that of Overvigilance and Inhibition, Young *et al.* (2003) note that the Emotional Inhibition schema is associated with the excessive inhibition of spontaneous action, feeling, or communication, usually to avoid disapproval by others, feelings of shame, or losing self-control. The Emotional Inhibition schema can involve excessive stress on rationality while disregarding emotions (Young *et al*., 2003). All of which, in modified form, may have relevance for men, as follows.

Status seeking

Developing Young *et al*.'s (2003) Approval-seeking/Recognition-seeking schema, there is, as noted, some developmental evidence that males tend, on average, to be more concerned with seeking rank and status and 'saving face' compared to women (Baron-Cohen, 2003; Sax, 2007). These competitive tendencies, which may have evolutionary roots in status-driven sexual selection processes (Sidanius & Pratto, 1999; Wilson & Daly, 1985), have been observed in the early play of boys, and persist – for example as noted in sex differences in non-verbal behaviour – into adulthood (Argyle, 1994). Provided the psychological situation is stable, this sensitivity is largely unproblematic. But at times of crisis, when males' status may be perceived by them to be threatened, males' psychological fragility can be exposed, leaving them prey to serious psychological difficulties including suicide (Kolves, Ide, & De Leo, 2010), and/or others prey to violence (Gresswell & Hollin, 1994).

Empathic potential

There is some empirical evidence that, on average, men are less empathic than women: men score lower on psychometric tests of empathy (Baron-Cohen & Wheelwright, 2004), and may be less reactive to affective scenes (Proverbio *et al.*, 2009). Evidence and practice working with men across psychological disorders suggest that they show empathic deficits, or, positively stated, potential – implying latent, hitherto undeveloped skills – in two principal ways.

First, in line with Young *et al.*'s (2003) notion of emotional deprivation, men traditionally act and feel as though they will be – or even should be – in some way deprived of care by others, including health services. Consequently, men with psychological issues are often reluctant to ask for help initially, and to discuss their problems when they do (Cochran & Rabinowitz, 2000).

Second, even though they may experience great psychological distress, men often *deprive themselves of empathy*. Since boys and men tend to show an early and persistent interest in dominance and social rank (Baron-Cohen, 2003), and are often socialized towards strength and toughness (Clare, 2000), faced with difficult emotions, men often disavow them. In the rank-aware male psyche, failure – particularly social or public failure – is not an option. This leaves many men intolerant of their own vulnerability or, as they often put it, their 'weakness'. This intolerance, and men's frequent lack of self-soothing capacity (Gilbert, 2007) can lead distressed men to push themselves harder still – notably in work (Halper, 1988) – rather than seek care, or otherwise treat themselves empathically.

Emotional potential

It is also likely that, to a greater or lesser extent, men tend to be more emotionally inhibited, in line with Young *et al.*'s (2003) typology – or emotionally controlled in Mahalik's (2005a) terms – compared with women. Empirical studies have shown that women tend to be significantly freer at expressing their feelings in words, facial expressions, and body language compared with men (Goleman, 1996; Gottman, Katz, & Hooven, 1996). Moreover, research indicates that men are significantly more likely than women to cover up and discount feelings that they perceive to be negative (Gottman *et al.*, 1996). Consequently, men's distress may often be somatized in the form of aches and pains – a more culturally acceptable form of male suffering (Lowen, 1972).

In addition, clinical practice and empirical research also supports the notion that men may be less skilled at identifying and reflecting on their emotions – or show greater degrees of alexithymia – than women (Levant, Hall, Williams, & Hasan, 2009; Salminen, Saarijarvi, Aarela, Toikka, & Kauhanen, 1999). And while men may, relatedly, tend to ruminate less and become depressed less often than women, on average (Nolen-Hoeksema, 2004), men may also be disadvantaged, and possibly less emotionally skilled, when significant problems strike. Evidence is accumulating here. A recent, large-scale Australian study found that compared with females, separated males were at increased risk of developing suicidality during marital separation, even after adjusting for age, and employment (Kolves *et al.*, 2010). Overall, therefore, it is probably reasonable to say that men often tend to have potential for the development of further emotional skills.

Shame-avoiding

Finally, it is possible, given the factors described above that can affect male development, that men link psychological distress itself – a *de facto* threat to their status – with an aversive sense of shame. Psychodynamically oriented theorists have long argued that those with narcissistic issues – who tended, historically, to be males – often present with shame-related feelings (Kohut, 1977; Lowen, 1985). In clinical practice, however, it is commonly observed that even men without definable narcissism-related issues find it hard to discuss their symptoms, and indeed their 'negative' feelings, without a strong sense of shame, at least to begin with (Cochran & Rabinowitz, 2000; Krugman, 1995; Pollack, 2005). Coupling clinical practice with empirical evidence, furthermore, it might be suggested that not only do men wish to avoid feelings of shame, but since help seeking may signal another social defeat in the male mind, they avoid help seeking also (Addis & Mahalik, 2003; Berger, Levant, McMillan, Kelleher, & Sellers, 2005; Gilbert & Andrews, 1998).

Overall, it is hypothesized that, across disorders, a significant proportion of male psychological distress is partly driven and maintained by the MSP consisting of these interlocking components: (a) status seeking, (b) empathic potential, (c) emotional potential, and (d) shame-avoiding. These components appear below (Figure 1).

A consequence of the MSP is that various identifiable meta-cognitive beliefs (Wells, 2000) develop, which may consciously or unconsciously specify certain strategies for men's coping and self-regulation. Often, careful assessment of a psychologically distressed man reveals such meta-cognitive beliefs as:

- 'I must not be weak (or vulnerable)';
- 'I must not show my feelings'; and
- 'I should not be feeling like this'.

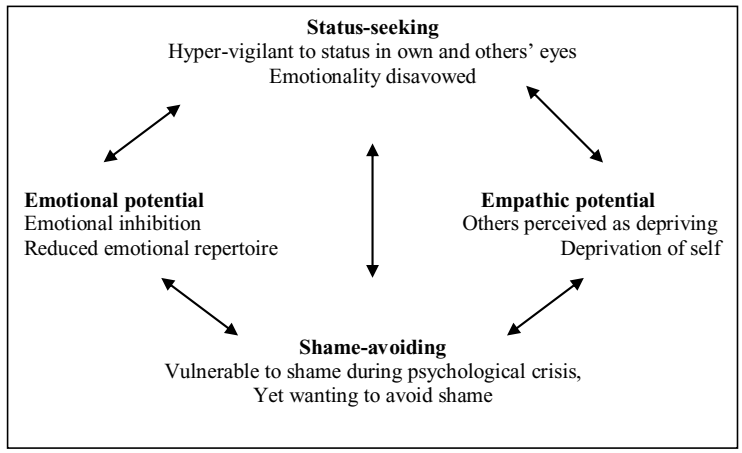

Figure 1. Interlocking components of the male-specific profile.

It is arguable that, given the onset of significant psychological distress in a man's life, the MSP and the associated meta-cognitive beliefs above significantly affect symptom development. Given clinical experience, it is also notable that, in the face of such distress, males' progress towards feelings of shame, and then externalizing behaviours such as substance use, employed as a short-term remedy, can be swift (Chuick *et al.*, 2009).

The male-specific cognitive behavioural maintenance cycle and the reflection abandonment mechanism

Given a critical incident such as a significant loss (e.g., marital separation) to initiate the maintenance cycle (Kendler *et al.*, 2006), it is likely, from the standpoint of CBT, that a variant of the following events occurs, as shown in Figure 2 below.

Initially, the man in question develops an awareness of distress, mediated by internal sensing mechanisms (Damasio, 1999; Fogel, 2009), for example via intrusional thoughts and/or feelings (Wells, 1997). Owing to the function of the MSP, however, associated meta-cognitive beliefs may be activated, including notions that (1) negative feelings or mood states are unacceptable, (2) must be hidden from others, and (3) are shameful. Certain automatic negative thoughts may be generated, often relating to such notions as the man's perceived weak and shameful nature, or not being a 'real man' (Kimmel, 2001). All of which may undermine further mentalizing (Allen, Fonagy, & Bateman, 2008).

The meta-cognitive beliefs may also launch the hypothesized reflection abandonment mechanism (RAM). Since the man perceives his distress as taboo, the effect of the RAM is to propel the man *away* from further reflection on his psychological condition, which he perceives as shameful, and as a threat to his status, *towards* one or more recognized male externalizing behaviours. From an ethological perspective, this spontaneous behaviour, reliably noted in distressed men, bears some resemblance to innate releasing mechanisms (IRMs) noted in animals (Tinbergen, 1951). Such behaviours in men – often maladaptive forms of self-soothing, all more common among men than in women in the United Kingdom (Wilkins, 2010) – may include substance use (Grant, 1995; Kendler *et al.*, 2006; Shead & Hodgins, 2007), 'acting out' (e.g., via increased work-related behaviour) (Halper, 1988), or other externalizing, antisocial behaviour such as violence, around 80% of which against strangers in the United Kingdom is committed by men (Kershaw, Nicholas, &

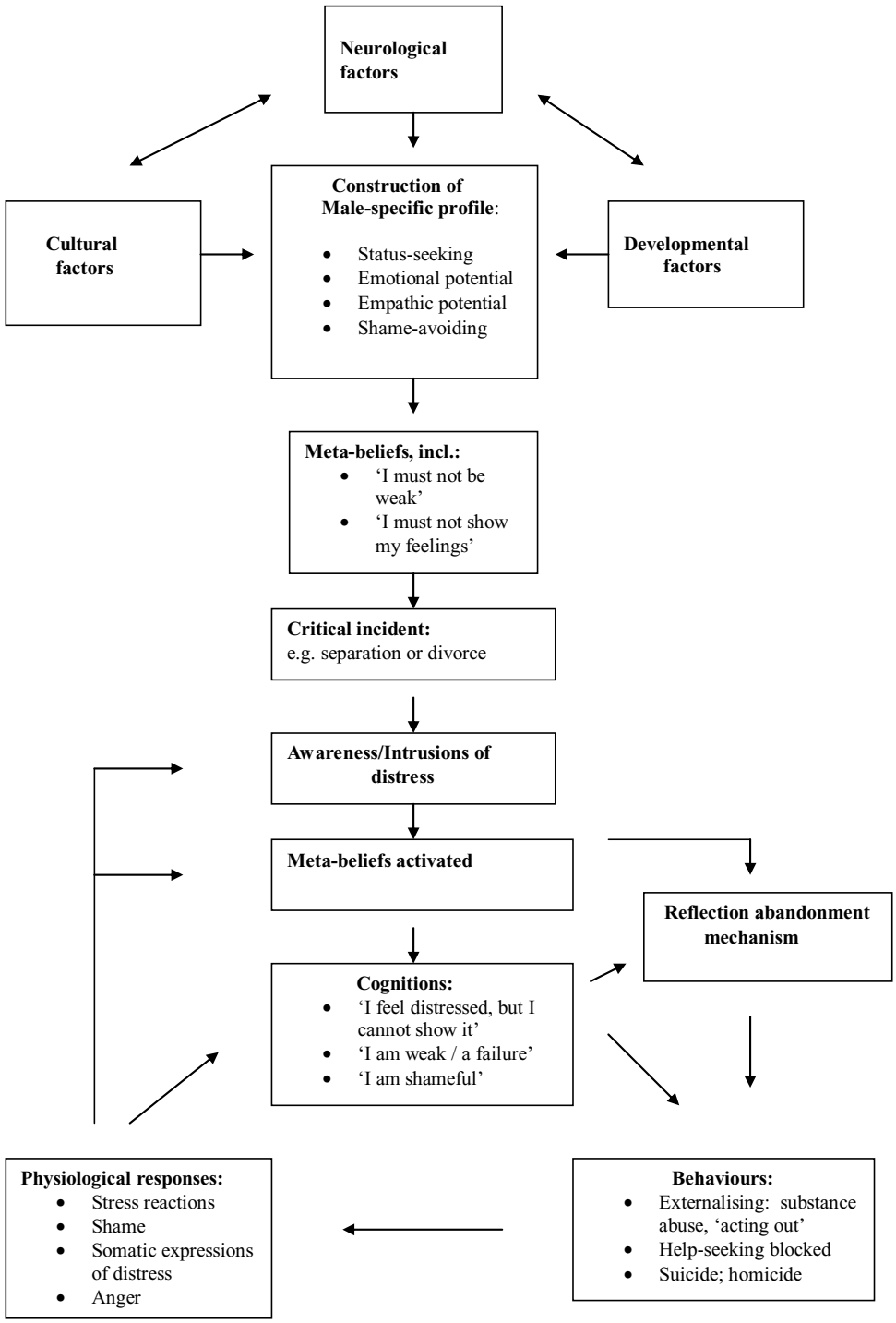

Figure 2. A transdiagnostic model of male distress.

Walker, 2008; Logan *et al.*, 2008). Some argue, furthermore, that such violence is a direct attempt to avoid shame (Gilligan, 1996). Moreover, it may be reasonable, in the light of practice with men, to hypothesize that the RAM also discourages the distressed man from seeking help from others, even from intimates. The possibility of the restoration of health (Fogel, 2009) then is, at least temporarily, lost. Compared with women, of course, men find it harder to ask for psychological help – broadly in inverse proportion to their valuing of stereotypical male qualities such as strength (Berger *et al.*, 2005).

In more extreme situations, the RAM can be hypothesized to act as a pathway to suicide – abandonment of self and other(s). Since, in the distressed man's perception, reflection on the psychological issues is either difficult, impossible, and/or meaningless, a further self-destructive act that seems logical at the time may be a suicide attempt – which can be seen, among other things, as an effort to regain control (Heifner, 1997; Joiner, 2007). Finally, the male-specific maintenance cycle may be completed by men's somatic expressions of disavowed psychological distress (Hammen & Padesky, 1977), which may include feelings of anger, shame, and stress (Chuick *et al.*, 2009; Thomkins & Rando, 2003). Such somatic responses may then reinforce the overall cycle – including the MSP and associated meta-beliefs.

Clinical and research implications of the model

The transdiagnostic model of male distress proposed here has various potential clinical and research implications. It must be acknowledged, though, that the current model is unlikely to account for all the masculinities observable in the United Kingdom or elsewhere. Refinements will be required.

First, regarding service delivery, the model suggests that attention might be paid to the vexed connection between men and psychological services in and between the primary and secondary domains. Simply, if the operation of the hypothesized RAM in men and in health professionals is unaddressed, men's access of services, already known to be problematic (Addis & Mahalik, 2003) is likely to remain difficult, since unidentified processes of mutual abandonment and avoidance will continue.

Second, at the level of psychotherapy or health care delivery to the individual male, attention may need to be paid in particular to both the MSP and the RAM and associated therapy-interfering behaviours. Clinical experience suggests that if this is not done, both male clients and their therapists are – unconsciously guided by the RAM – likely to move off-task and abandon or prematurely truncate potentially useful psychological discussion (Cochran & Rabinowitz, 2000), as early transference-related issues are unconsciously replayed (Miranda & Andersen, 2007). In other words, males' early psychological experiences of abandonment are all too easily re-enacted.

Third, at the intrapsychic level, it is likely that a male client may benefit if he becomes conscious of, and learns to work around, the RAM, 'stay with', and above all *reflect on* states of psychological distress and their meaning. One aid in remaining psychologically *present* versus *absent* is mindfulness meditation (e.g., Williams, Teasdale, Segal, & Kabat-Zinn, 2007), which many men find useful in (re-)discovering and (re-)stabilizing their subjective emotional present (Fogel, 2009; Fromm, 1994). More broadly, the use of compassion (Gilbert, 2009; Kingerlee, 2006), coupled with awareness of different possible approaches to (therapeutic) realities (MacGilchrist, 2009) is likely to be useful when working with men.

Finally, various empirically testable hypotheses emerge. It might be hypothesized, first, that the strength of the MSP and associated meta-cognitive beliefs would predict the

function of the RAM in both client and therapist, and significantly impact psychological outcomes. It could also be hypothesized, second, that where the precise functions of the MSP and the RAM *are* identified, formulated, and addressed successfully in and around therapy and therapy-interfering behaviours, this would be related to positive outcomes.

In this way, developing awareness of, and critical reflection on men's issues and presentations, clinicians, men, women, and society at large may cease to collude with the invitation to abandon, avoid, or dismiss distressed men – an invitation that, of course, is often unwittingly sent by men themselves.

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