Guidelines for Psychological Practice with Boys and Men
Although boys and men, as a group, tend to hold privilege and power based on gender, they also experience unique problems. Boys and men demonstrate disproportionate rates of behavioral problems (e.g., suspension and expulsion), academic challenges (e.g., dropping out of high school), mental health issues (e.g., suicide), physical health problems (e.g., cardiovascular problems), public health concerns (e.g., violence, substance abuse, incarceration), and a wide variety of other quality of life issues (e.g., relational problems, family well-being) (see; Levant & Richmond, 2007; Moore & Stuart, 2005; O’Neil, 2008 for comprehensive reviews). Additionally, many men do not seek help when they need it and many report distinctive barriers to receiving gender-sensitive psychological treatment (Mahalik, Good, Tager, Levant, & Mackowiak, 2012).

Psychologists are uniquely positioned to address these concerns, and the development of guidelines for psychological practice with boys and men may help to attend to the barriers that lead to the aforementioned disparities. Indeed, the American Psychological Association (APA) has developed guidelines for psychologists working with specific populations such as gay/lesbian/bisexual clients (2012), racial and ethnic minority clients (2003), older adults (2014), and girls and women (2007). The APA also has developed guidelines for psychological practice in health care delivery systems (2013a), forensic psychology (2013b), and psychological evaluation in child protection matters (2013c). These guidelines serve to (1) improve service delivery among populations, (2) stimulate public policy initiatives, and (3) to provide professional guidance based on advances in the field. Accordingly, the present document offers guidelines for psychological practice with boys and men.

**Purpose and Scope**
Guidelines are “statements that suggest or recommend specific professional behavior, endeavor, or conduct for psychologists. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. Thus, guidelines are “aspirational in intent”, and they are intended to facilitate the continued systematic development of the profession to help assure a high level of professional practice by psychologists (APA, 2002, p. 1048). Guidelines may be superseded by federal or state laws. APA (2002) also distinguishes between treatment and practice guidelines, noting that treatment guidelines “provide specific recommendations about clinical interventions”, in contrast to practice guidelines, which “consist of recommendations to professionals for conduct and issues to be considered in particular areas of practice” (p. 1048). Additionally, as noted in APA’s Criteria for Practice Guideline Development and Evaluation (APA, 2002), practice guidelines, “may not be applicable to every professional and clinical situation” (p. 1048). Thus, these guidelines are not definitive and are designed to respect the decision-making judgment of individual professional psychologists. In addition, these guidelines will need to be periodically reviewed and updated at least every 8 to 10 years, beginning from the year of acceptance by the APA Council of Representatives, to take into account advances in research, changes in practice, and the effects of changing contemporary social forces and context. Hence, readers are advised to check the current status of these guidelines to ensure that they are still in effect and have not been superseded by subsequent revisions.

The present document articulates guidelines that enhance gender- and culture-sensitive psychological practice with boys and men from diverse backgrounds in the United States. These guidelines provide general recommendations for psychologists who seek to increase their awareness, knowledge, and skills in psychological practice with boys and men. The beneficiaries
of these guidelines include all consumers of psychological practice including clients, students, supervisees, research participants, consultees, and other health professionals. Although the guidelines and supporting literature place substantial emphasis on psychotherapy practice, the general guidelines are applicable to all psychological practice (e.g., individual, couples and family work, group work, psycho-educational programming, consultation, prevention, teaching, career counseling) in its broadest sense across multiple helping professions (e.g., nursing, social work, school counseling). Rather than offering a comprehensive review of content relevant to all areas of practice, this document provides examples of empirical and conceptual literature that support the need for practice guidelines with boys and men. We encourage institutions, agencies, departments, and/or individuals to discuss ways in which these guidelines may be applied to their own settings and relevant activities.

**Definitions**

**Gender.** Gender refers to psychological, social, and cultural experiences and characteristics associated with the social statuses of female or male, whereas sex refers to biological aspects of being male or female. Gender includes assumptions, social beliefs, norms, and stereotypes about the behavior, cognitions, and emotions of males and females (Pleck, 1981, 1995). Gender norms and stereotypes also vary within and between groups associated with other dimensions of diversity such as ethnicity, sexual orientation, disability, class, and race (Levant & Pollack, 1995). Although gender and sex can be seen as overlapping and fluid categories with multiple meanings (Marecek, 2002), this document uses the term gender to refer primarily to the social experiences and expectations associated with being a boy or man.

**Gender Bias.** The term gender bias refers to beliefs and attitudes that involve stereotypes or preconceived ideas about the roles, abilities, and characteristics of males and females that may
contain significant distortions and inaccuracies. Psychologists have an ethical obligation to recognize and confront these biases (APA, 2010).

Gender Role Strain. Gender role strain is a psychological situation in which gender role demands have negative consequences on the individual or others (see Pleck, 1981, 1995 for a review). The negative effects of gender role strain are mental and physical health problems for the individual and within relationships (O’Neil, 2008; Pleck, 1995). Boys and men experience gender role strain when they (a) deviate from or violate gender role norms of masculinity, (b) try to meet or fail to meet norms of masculinity, (c) experience discrepancies between real and ideal self-concepts based on gender role stereotypes, (d) personally devalue, restrict, or violate themselves, (e) experience personal devaluations, restrictions, or violations from others, and/or (f) personally devalue, restrict, or violate others because of gender role stereotypes (Pleck, 1995).

Masculinity Ideology. Masculinity ideology is set of descriptive, prescriptive, and proscriptive of cognitions about boys and men (Levant & Richmond, 2007; Pleck, Sonestein, & Ku, 1994). Although, there are differences in masculinity ideologies, there is a particular constellation of standards that have held sway over large segments of the population, including: antifemininity, achievement, eschewal of the appearance of weakness, and adventure, risk, and violence. These have been collectively referred to as, traditional masculinity ideology (Levant & Richmond, 2007).

Gender Role Conflict. Gender role conflict (GRC) is defined as problems resulting from adherence to “rigid, sexist, or restrictive gender roles, learned during socialization, that result in personal restriction, devaluation, or violation of others or self” (O’Neil, 1990, p. 25). Gender role conflict is the most widely studied aspect of masculine gender role strain, and researchers have demonstrated that men experience conflict related to four domains of the male gender role:
success, power, and competition (a disproportionate emphasis on personal achievement and
control or being in positions of power); restrictive emotionality (discomfort expressing and
experiencing vulnerable emotions); restrictive affective behavior between men (discomfort
expressing care and affective touching of other men); and conflict between work and family
relations (distress due to balancing school or work with the demands of raising a family; see
O’Neil, 2008 for a review).

Masculinity Ideology. Masculinity ideology is defined as “cultural belief systems about
masculinity and male gender.” These belief systems are composed of social norms that either
prescribe or proscribe traits and behaviors to boys and men. Acknowledging the plurality of and
social constructionist perspective of masculinity, the term, “masculinities” is being used with
increasing frequency.

Oppression. Oppression includes discrimination against and/or systematic denial of
resources to members of groups who are identified as, inferior, or less deserving than others.
Oppression is most frequently experienced by individuals with marginalized social identities, is
manifested in both blatant and subtle discrimination in areas such as racism, ageism, sexism, and
heterosexism, and results in limited access to social power (Robinson & Howard-Hamilton,

Privilege. Privilege refers to unearned sources of social status, power, and
institutionalized advantage experienced by individuals by virtue of their culturally valued and
dominant social identities (e.g., White, Christian, male, and middle/upper class) (McIntosh,
1998).

Psychological Practice. Psychological practice includes activities related to all applied
areas of psychology such as clinical, counseling, and school psychological practice, supervision
and training, consultation, teaching and pedagogy, research, scholarly writing, administration, leadership, and social policy (APA, 2010).

**History and Development**

The APA Board of Directors provided $20,000 to develop these guidelines that financed an initial three day brainstorming and planning session in September, 2005. APA continued to provide staff support for several years under the leadership of Ron Palomares, which included securing rooms and resources at the 2006, 2007, and 2008 APA conventions for continued meetings. The Society for the Psychological Study of Men and Masculinity (Division 51) provided $3000.00 for a three-day meeting in March, 2009 where Fred Rabinowitz, Matt Englar-Carlson, Mark Kiselica, and Ron Levant made progress in bringing various elements into an integrated document. The final document was compiled and updated by Ryon McDermott and Matthew Kridel and edited by Ryon McDermott, Christopher Liang, Fred Rabinowitz, Chris Kilmartin, and Matt Englar-Carlson.

**Need For Practice Guidelines For Boys and Men**

Boys and men have historically been the focus of psychological research and practice as a normative referent for behavior rather than as gendered human beings (O’Neil & Renzulli, 2013; Smiler, 2004). In the past 30 years, researchers and theorists have placed greater emphasis on ecological and sociological factors influencing the psychology of boys and men, culminating in what has been termed, the New Psychology of Men (Levant & Pollack, 1995). For instance, socialization for conforming to traditional masculinity ideology has been shown to limit males’ psychological development, constrain their behavior, result in gender role strain and gender role conflict, (Pleck, 1981, 1995; O’Neil, 2008; O’Neil & Renzulli, 2013) and negatively influence mental health (e.g., O’Neil, 2008) and physical health (Courtenay, 2011). Indeed, boys and men
are overrepresented in a variety of psychological and social problems. For example, boys are disproportionately represented among school children with learning difficulties (e.g., elevated ADHD rates; lower standardized test scores) and behavior problems (e.g., bullying, school suspensions, aggression) (Biederman et al., 2005, Centers for Disease Control and Prevention, 2015). Likewise, men are overrepresented in prisons, are more likely than women to commit violent crimes, and are at the greatest risk of being a victim of violent crime (Federal Bureau of Investigation, 2015).

Despite these problems, many boys and men do not receive the help they need (Addis, & Mahalik, 2003; Hammer, Vogel, & Heimerdinger-Edwards, 2013; Knopf, Park, & Maulye, 2008). Research suggests that socialization practices that teach boys from an early age to be self-reliant, strong, and to minimize and manage their problems on their own (Pollack, 1995) yield adult men who are less willing to seek mental health treatment (Addis & Mahalik, 2003). Further complicating their ability to receive help, evidence suggests that many men report experiencing gender bias in therapy (Mahalik et al., 2012), which may impact diagnosis and treatment (Cochran & Rabinowitz, 2000). For instance, several studies have identified that men, despite being four times more likely than women to die of suicide worldwide (De Leo et al., 2013), are less likely to be diagnosed with internalizing disorders such as depression, in part, because internalizing disorders do not conform to traditional gender role stereotypes about men’s emotionality (see Addis, 2008 for a review). Instead, because of socialized tendencies to externalize emotional distress, boys and men may be more likely to be diagnosed with externalizing disorders (e.g., conduct disorder and substance use disorders) (Cochran & Rabinowitz, 2000). Indeed, therapists’ gender role stereotypes about boys externalizing behaviors may explain why boys are disproportionately diagnosed with ADHD compared to girls.
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(Bruchmüller, Margaf, & Schnieder, 2012). Other investigations have identified system gender bias toward adult men in psychotherapy (Mahalik et al., 2012) and in other helping services such as domestic abuse shelters (Douglas & Hines, 2011). Broader societal factors, such as the stigma of seeking psychological help, also negatively impact men’s help-seeking behaviors and the subsequent delivery of psychological services (Hammer et al., 2013; Mahalik et al., 2012).

In addition to specific mental health concerns and help-seeking behaviors, a combination of biological, social, and economic factors may have unique consequences for men’s physical health and wellbeing. For most leading causes of death in the United States and in every age group, boys and men have higher death rates than girls and women (Courtenay, 2011). For example, despite having greater socioeconomic advantages than women in every ethnic group, the age-adjusted death rate has been found to be at least 40% higher for men than women (Hoyart & Xu, 2012). All of these problems are exacerbated in minority statuses such as race, ethnicity, sexual orientation, or social class (Courtenay, 2011).

In summary, contemporary studies indicate that the physical and mental health concerns of boys and men are associated with complex and diverse economic, biological, developmental, psychological, and sociocultural factors. Many of these factors also intersect with men’s multiple identities (e.g., Gallardo & McNeill, 2009; Liang, Salcedo, & Miller, 2011; Schwing, Wong, & Fang, 2013; Shields, 2008), indicating that understanding how boys and men experience masculinity is an important cultural competency. The psychology of men, however, is rarely taught at either undergraduate or graduate levels (O’Neil & Renzulli, 2013), including multicultural counseling courses (see Liu, 2005 for a review). Research further suggests that having adequate knowledge of men’s gender role socialization has important implications for psychological practice with boys (e.g., Bruchmüller et al., 2012) and men (Mahalik et al., 2012).
Therefore, compelling evidence exists supporting the need for guidelines for psychologists who provide services to boys and men. In the sections to follow, specific guidelines and additional rationale are presented.

**Guideline 1: Psychologists strive to recognize that masculinities are constructed based on social, cultural, and contextual norms.**

**Rationale**

Clinician awareness of one’s stereotypes and biases of boys and men is a critical dimension of multicultural competence (Liu, 2005; Mahalik et al., 2012). Understanding the socially constructed nature of masculinity and how it affects boys and men, as well as psychologists, also is an important cultural competency (Levant & Silverstein, 2005, Liu, 2005; Mellinger & Liu, 2006; Sue & Sue, 2012). It is common to use the term “masculinities” rather than “masculinity” to acknowledge the various conceptions of masculine gender roles associated with an intersection of multiple identities (e.g., rural, working class adult White masculinities may take a different form than urban teenage Mexican American masculinities; Kimmel & Messner, 2012). Certain forms of masculinities are more socially central and associated with authority, social power, and influence (Connell & Messerschmidt, 2005). In Western society, the dominant ideal of masculinity has moved from an upper-class aristocratic image to a more rugged and self-sufficient ideal (Kimmel, 2012). Thus traditional masculinity ideology can be viewed as the dominant (referred to as “hegemonic” masculinity) form of masculinity that strongly influences what members of a culture take to be normative.

Prescriptions and proscriptions for behaviors that either align with or contradict the dominant ideal of masculinity are not linear, uniform, or without resistance (Pleck, 1995). Many
men are socialized by friends, family, peers, and society to adopt traditional masculine ideals, behaviors, and attitudes. Yet for many men, this dominant ideology of masculinity has inherent conflicts. For instance, dominant masculinity was historically predicated on the exclusion of men who were not White, upper-class, able-bodied, and privileged (Liu, 2005), and the ideal masculinity is generally unattainable for most men (Pleck, 1995). Men who depart from this narrow masculine conception by virtue of any dimension of diversity (e.g., race or sexual orientation) may find themselves negotiating between adopting dominant ideals which exclude them or not subscribing to these ideals and being stereotyped or marginalized as a result (Liang, Rivera, Nathwani, Dang, & Douroux, 2010; Liang et al., 2011; Schwing et al., 2013).

Although the cultural pressure to endorse, conform to, and perform dominant masculinity is considerable, men still have agency and can influence the dominant ideals (Iwamoto & Liu, 2009). Marginalized men often create their own communities, within which they develop cultural standards, norms, and values that may depart from dominant masculinity. For instance, in racial and ethnic, youth, or gay communities, boys and men may develop forms of resistance in action and attitudes which challenge the expectations of dominant masculinity such as the “muscle man” identity adopted by some gay men (Sánchez, Greenberg, Liu, & Vilain, 2009), that of the “cool pose” of African American men (Majors & Bilson, 1993), or the engagement of John Henryism (e.g., working harder) behaviors identified of African American adult men (Matthews, Hammond, Nuru-Jeter, Cole-Lewis, & Melvin, 2013). Although such adaptations challenge hegemonic masculinity, they often carry with them significant problems of their own. For example, despite evidence indicating that African American men engage in John Henryism (Matthews et al. 2013), the long-term effects of these behaviors may be detrimental to health and well-being (McEwen, 2004). Further, despite ethnic minority boys and men’s engagement in
positive behaviors, they may be stereotyped and subject to labeling by educators, law enforcement, and mental health professionals as aggressive or hypermasculine. For instance, Goff, Jackson, Di Leone, Culotta, and DiTomasso (2014) demonstrated how Black boys are more likely to be perceived as older, less innocent, more responsible for their actions, and as being more appropriate targets for police violence. Thus although all men experience pressures to conform to hegemonic masculinity, some men, particularly those from marginalized groups, may be targets of gendered, racial, and heterosexist stereotypes.

Application.

Psychologists are encouraged to expand their knowledge about diverse masculinities and to help boys and men, and those who have contact with them (e.g., parents, teachers), become aware of how masculinity is defined in the context of their life circumstances. Moreover, psychologists aspire to help boys and men navigate restrictive definitions of masculinity and create their own concepts of what it means to be male in our changing society. Toward that end, psychologists should understand their own assumptions of and countertransference reactions towards boys, men, and masculinity (Mahalik et al., 2012). Psychologist also can explore what being a man means with those that they serve. Further, psychologists may utilize available assessment instruments to help boys and men discover the benefits and costs of their gendered social learning (Mahalik, Talmadge, Locke, & Scott, 2005), such as the Male Role Attitudes Scale (Pleck et al., 1994), the Male Role Norms Inventory- Short Form (Levant, Hall, & Rankin, 2012), the Conformity to Masculine Norms Inventory (Mahalik et al., 2003), as well as measures of gender role conflict (O'Neil, Helms, Gable, David, & Wrightsman, 1986) gender role stress (Eisler & Skidmore, 1987), and normative male alexithymia (Levant et al., 2006). See Smiler and Epstein (2010) for a review and critique of these instruments.
Guideline 2: Psychologists strive to recognize that boys and men integrate multiple aspects to their identities across the lifespan.

Rationale

There are multiple dimensions to identity, including ethnicity, gender, race, and sexual orientation, and each contributes to a boy’s basic sense of self and influences his behavior as he grows (David, Grace, & Ryan, 2004; Wilson, 2006). Gender is one of the most fundamental of these dimensions (see Banaji & Prentice, 1994 for a review). Gender identity development begins at birth, shaped by the expectations that parents and other significant adults have for how a boy should be treated and how he should behave (Basow, 2006). Boys begin to make distinctions between males and females during infancy (Banaji & Prentice, 1994) and increasingly assign certain meanings to being male based on their gender socialization experiences (David et al., 2004). Over time, a boy’s gender identity becomes crystallized and exerts a greater influence on his behavior (Banaji & Prentice, 1994). By the time he reaches adulthood, a man will tend to demonstrate behaviors as prescribed by his ethnicity, culture, and different constructions of masculinity.

Inconsistent and contradictory messages can make the identity formation process complicated for some populations of boys and men (Wilson, 2006). For instance, boys and men from racial or ethnic minority backgrounds as well as those who are gay, bisexual, or transgender be the targets of various forms of prejudice and microaggressions (Nadal, 2008), and often experience conflicts between dominant and minority views of masculinity (Liu & Concepcion, 2010; Kiselica, Mulé & Haldeman, 2008). Some of these boys and men give in to the pressure to conform to hegemonic masculinity standards by endorsing masculinity that does not fully represent their preferred identities (Liu & Concepcion, 2010). In other situations, boys and men
who feel they cannot abide by hegemonic masculinity standards construct standards of their own, which can take the form of gang behavior, cool pose, and unique dress codes (Majors & Billson, 1992). Moreover, the painful experiences associated with becoming the target of racism and inequality can lead some minority males to avoid identifying with their cultural heritages (Liu & Concepcion, 2010) and create a significant source of stress (Nadal, 2008).

Boys and men who are members of more than one minority group may have an especially difficult time resolving identity-related conflicts. For example, gay boys and men of color may experience racism in the LGBT community, while also experiencing homophobia/heterosexism in their racial/ethnic community and may choose to turn on and off certain aspects of their identities as they move between different cultural contexts (Nadal, 2008). Similarly, multiethnic and multiracial boys and men may feel pressure from their families to embrace one portion of their identities while experiencing demands from peers to accentuate different ones. These types of vacillations can result in identity confusion and contribute to the development of mental health problems (Nadal, 2008).

As men grow into old age, they take on different roles and challenges that often impel a re-examination of gender expectations. Given that work roles may change through retirement, family roles may change through grandparenting status or loss of a spouse, and health problems often arise, internal conflicts can ensue, especially for men who base their identities in being a financial provider and having physical strength and stamina, and functioning well sexually (Kilmartin & Smiler, 2015). Moreover, identity changes impelled by aging may interact with any of the aforementioned sources of identity such as race, ethnicity, and sexual orientation (Vacha-Haase, Wester, & Christianson, 2010).

Application
Psychologists strive to understand the important role of identity formation to the psychological well-being of boys and men (Basow, 2006) and attempt to help them recognize and integrate all aspects of their identities (David et al., 2004; Liang et al., 2010; Liu & Concepcion, 2010). Working toward this goal may be especially challenging with aging, multiracial, multiethnic and sexual minority males (i.e., gay, bisexual and transgender) who tend to experience more complicated identity-related conflicts (Nadal, 2008). Thus, psychologists are encouraged to understand the special developmental, educational, mental health, and social needs of sexual minority, racial and ethnic minority, and multiethnic and multiracial boys and men.

Psychologists strive to understand that some racial and ethnic minority boys and men may have not had opportunities to learn about specific aspects of their family’s heritage. Therefore, acquiring knowledge about their previously unacknowledged group(s) may offer opportunities to discover additional aspects of their identities or dispel negative and/or unrealistic images that society has promoted about those reference groups (Liu & Concepcion, 2010).

Psychologists also strive to reduce and counter the damaging effects of microaggressions by teaching boys and men from historically marginalized backgrounds skills to cope with racism, homophobia, biphobia, transphobia, ageism, and other forms of discrimination (Liu & Concepcion, 2010; Nadal, 2008; Vacha-Haase et al., 2010) and by working with families, schools, and communities to provide supportive environments for these populations.

Psychologists working with boys and men strive to become educated about the history and cultural practices of diverse groups; to understand how these practices relate to racial, ethnic, and cultural identities; to have awareness of how masculinity is conceptualized in these groups; and to communicate this understanding and integrate it into meaningful therapeutic interactions, such as participating in cultural ceremonies and becoming integrated into their clients’ respective
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communities (Liu, 2005). Such practices include a transformation of traditional approaches to
those that may be more culturally congruent with their clients’ backgrounds (Liu & Concepcion,
2010). Effective practice also involves learning about the impact of racism and homophobia on
the behavior and mental health of boys and men (Helms, Jernigan, & Mascher, 2005), including
how prejudicial assumptions and expectations can negatively alter their genuine talents,
performances, and identities (Purdie-Vaughns, Stelle, Davies, Ditlmann & Crosby, 2008).
Overall, psychologists are encouraged to attain the attitudes, knowledge, and skills necessary to
effectively work with multicultural issues with boys and men (Liu, 2005) and with aging men
(Vacha-Haase, et al., 2010).

Psychologists strive to become aware of and eradicate any biases they have toward boys
and men from historically marginalized groups (Kiselica, Mulé et al., 2008; Liu & Concepcion,
2010) and to recognize value conflicts that they may have with their service recipients (Nadal,
2008). These biases may manifest in use of heterosexist assumptions (e.g., asking a male client if
he has a wife without knowing his sexual orientation) or values (e.g., encouraging a gay man to
dress or act less “flamboyantly”) (Nadal, 2008). While attempting to understand, respect, and
affirm how masculinity is defined in different cultures, psychologists also try to avoid within-
group stereotyping of individuals by helping them to distinguish what they believe to be
desirable and undesirable masculine traits and to understand the reasons upon which they base
these beliefs (Liu & Concepcion, 2010).

Guideline 3: Psychologists understand the impact of power, privilege, and sexism on the
development of boys and men and on their relationships with others.

Rationale
Although privilege has not applied to all boys and men in equal measure, in the aggregate, males experience a greater degree of social and economic power than girls and women (Flood & Pease, 2005). However, men who benefit from their social power are also confined by system-level policies and practices as well as individual-level psychological resources necessary to maintain male privilege (Mankowski & Maton, 2010). Thus, male privilege comes with a cost (Liu, 2005). Male privilege also tends to be invisible to men, yet they can become aware of it through a variety of means, such as education (Kilmartin, Addis, Mahalik, & O’Neil, 2013) and personal experience (O’Neil, Egan, Owen, & Murry, 1993). Indeed, awareness of privilege and the harmful impacts of beliefs and behaviors that maintain power over women have been shown to reduce sexist attitudes in men (Becker & Swim, 2012) and have been linked to participation in social justice activities (e.g., White, 2006).

Although the majority of men may not identify with explicit sexist beliefs (McDermott & Schwartz, 2013), sexism exists as a byproduct, reinforcer, and justification of male privilege. For some men, sexism may become deeply engrained in their construction of masculinity as a function of gender role socialization (O’Neil, 2008). For instance, most boys are taught from an early age that they will suffer negative consequences for violating masculine role norms (Pollack, 1995). Pleck (1995, 1981) theorized that the cumulative influence of restrictive gender role socialization practices are emotionally painful and damaging, such as when boys shame one another for acting in ways that are socially constructed as feminine.

The impact of sexism extends from boyhood into adulthood. Early socialization experiences in childhood, such as being repeatedly shamed for expressing vulnerable emotions can have lasting influence into adulthood in ways that shape intrapersonal and interpersonal functioning (Fischer, 2007; Pollack, 1995). For example, several controlled experiments have
found that adult men who endorse sexist male role norms are likely to aggress against male and female participants who violate those norms (e.g., Parrott, Zeichner, & Hoover, 2008; Reidy, Shirk, Sloan, & Zeichner, 2009). Men who rigidly adhere to sexist, patriarchal masculine norms tend to also endorse and commit higher levels of intimate partner and sexual violence toward women (Kilmartin & McDermott, 2015). Feminist scholars have argued that some men use violence and control in relationships as a way of maintaining sexist beliefs and dominance over women (e.g., the Duluth Model; Pence & Paymar, 1993). Researchers in the psychology of men and masculinity have identified that insecurities stemming from early childhood experiences (such as attachment insecurities) are linked to adherence to traditional masculinity ideology (Schwartz, Waldo, & Higgins, 2004). Recent research also suggests that insecurely attached men not only rigidly adhere to sexist gender role ideology, but that they may act on those schemas in ways that lead to intimate partner violence (Mahalik, Aldarondo, Gilbert-Gokhale, & Shore, 2005; McDermott & Lopez, 2013). In addition to increasing the possibility of engaging in partner violence, men who accept sexist constructions of masculinity are often restricted by codes of conduct that inhibit their ability to be emotionally vulnerable and form deep connections in adult relationships. For instance, although the isolating effects of these beliefs likely depend on a variety of social and ecological contexts (Addis, Mansfield, Syzdek, 2010), numerous studies have provided evidence that endorsement of sexist male roles is related to men’s fear of intimacy and discomfort with physical affection with other men (see O’Neil, 2008 for a review).

Application

When working with boys and men, psychologists can address issues of privilege and power related to sexism in a developmentally appropriate way to help them obtain the
knowledge, attitudes, and skills to be effective allies and potentially live less restrictive lives.

Men who understand their privilege and power may be less apt to rely on power, control, and violence in their relationships (McDermott, Schwartz, & Trevathan-Minus, 2012; Schwartz, Magee, Griffin, & Dupis, 2004). Research suggests that helping men understand the negative consequences of sexism for themselves and their relationships with others reduces endorsement of sexist attitudes (Becker & Swim, 2012). Given the connections between sexism and other forms of prejudice, psychologists may find it useful to link oppressions as a pedagogical strategy, especially when working with boys and men in groups. Psychologists working with boys and men may model gender egalitarian attitudes and behaviors. Modeling non-sexist constructions of masculinity may be especially important. For instance, researchers have found that men tend to overestimate the degree to which other men hold sexist beliefs, and developing awareness of this discrepancy reduces sexist beliefs (Kilmartin et al., 2008). To further help accomplish this goal, psychologists are encouraged to explore their perceptions of boys and men and to understand that, although not all boys and men hold sexist ideologies, these beliefs are ingrained in the culture at large.

Guideline 4: Psychologists strive to develop a comprehensive understanding of the factors that influence the interpersonal relationships of boys and men.

Rationale

Throughout the life-span, males experience many developmental changes and challenges pertaining to intimacy, sex, and emotions, beginning with the universal task of forming intimate attachments with others. A key role of parents is to provide sons with emotional support while promoting separation and individuation. The associated developmental challenge for a boy is to learn how to use his parents as a secure base from which he can explore the world and develop a
secure and unique sense of self. The manner and degree to which his parents foster this separation and individuation process can exert a strong influence on a son’s overall psychological functioning and on his later intimate relationships (Loukas & Prelow, 2004; Schwartzman, 2006).

Because of the pressure to conform to traditional masculinity ideology, some men shy away from expressing their tender feelings and prefer participating in physical activities, talking about external matters (such as sports, politics or work), engaging in good-natured ribbing, exchanging jokes, and seeking and offering practical advice with their friends (Kiselica, English-Carlson, Horne & Fisher, 2008). Traditional masculinity ideology discourages men from being intimate with others and is the primary reason men tend to have fewer close friends than women (Keddie, 2003; Klein, 2006), and this is particularly evident in all male groups (Way, 2011).

However, the majority of boys and men indicate that they have close male friends with whom they share secrets, are emotionally intimate, and view as a brother (Baumeister & Sommer, 1997; Cross & Madson, 1997; Way, 2011). Boys and men are capable of forming close attachments with others, and this capacity for bonding continues into adulthood in same-sex and cross-sex friendships (Way, 2011) and romantic attachments (Carver, Joyner & Udry, 2003; Smiler, 2013). These relationships enhance the emotional and physical well-being and social adjustment of boys and men throughout the lifespan (Smiler, 2013; Vaillant, 2012).

Boys and men’s relationships must be understood in the context of sexual diversity and gender variance. Gay, bisexual, and transgender boys and men are likely to enjoy strong, healthy bonds with family members and peers during their early years, but they regularly experience numerous, stressful relationship challenges as they grow older. Family bonds can be strained, and in some cases shattered, when a gay, bisexual, or transgender youth comes out to his family.
Establishing friendships outside of the family can be difficult during later childhood and adolescence because homophobic peers often target gay and bisexual boys for abuse. Even when same-sex and cross-sex friendships are formed, they can be altered when gay and bisexual youth reveals his sexual orientation to his peers. Intimate relationships for these youth are often tinged with fear, anxiety, and uncertainty (Kiselica, Mulé et al., 2008). Nevertheless, gay and bisexual boys typically have a multitude of same-sex and other-sex friendships, and these relationships provide these young men with important benefits such as support and companionship (Diamond & Dubé, 2002). Gay, bisexual, and transgender boys and men tend to eventually come to terms with their sexual orientation, develop sexual identity, gender identity, and engage in healthy platonic, romantic, and sexual relationships (Cohen & Savin-Williams, 2012). The nature of these relationships is greatly affected by the coming out process. Some keep these relationships hidden closeted, while others are quite open (Reynolds & Hanjorgiris, 2000). Whether they have decided to be open or not are closeted or out, they engage in many different types of relationships with other males, including casual friendships, impersonal sexual encounters, and life-long committed relationships.

Application

Psychologists strive to promote healthy intimate relationships, emotions, and sexual behaviors in boys and men. Recognizing the primacy of early human attachments, psychologists attempt to help parents form close bonds with their sons through teaching parents about the developmental needs of boys, to respond to boys in a nurturing manner, and to foster a healthy separation and individuation process with their sons.

Psychologists strive to use a variety of methods, such as interactive all male groups, to help boys and men develop healthy same-sex friendships (e.g., Levant, 1996; Mortola, Hiton &
Grant, 2008). These approaches promote male-to-male bonding and help participants examine concerns related to socialization pressures on boys and men to be hypercompetitive and hyperaggressive with one another. Psychologists can discuss with boys and men the messages they have received about withholding affection from other males and help them to see how codes of constricted masculinity and homophobia might deter them from forming close relationships with male peers (Brooks, 1998). In that vein, psychologists should strive to develop in boys and men a greater understanding of the diverse and healthy ways that they can demonstrate their masculinities. Psychologists should also listen for terms that boys and men are more likely to use, such as “trust,” “main friend/man,” or “he’s got my back.” Psychologists also may strive to utilize various methods to foster healthy friendships and intimate relationships between male and females. Psychologists also strive to create psychoeducational classes and workshops designed to promote gender empathy, respectful behavior, and communication skills that enhance cross-sex friendships, and to raise awareness about, and solutions for, problematic behaviors such as sexual harassment that deter cross-sex friendships (Wilson, 2006).

Guideline 5: Psychologists strive to encourage positive father involvement and healthy family relationships.

Rationale

There are about 70 million fathers in the United States (United States Census Bureau, 2014). Nationally representative samples suggest more than 80% of fathers report being involved in their children’s lives, but little more than half of fathers believe they are doing “a very good job” as parents (Jones & Mosher, 2013). Thus, for many fathers, the acceptance of new familial and relationship roles is of particular salience and may include a variety of difficult transitions and responsibilities (Tichenor, McQuillan, Greil, Contreras, & Shreffler, 2011). Additionally, the
traditional paternal breadwinner role is less entrenched in modern families and is giving way to a
new focus on the father as a more involved, available, and equal co-parent (Cabrera, Tamis-
LeMonda, Bradley, Hofferth, & Lamb, 2000). Further, for many men, simply providing financial
support is not enough, as they expect more of themselves (e.g., teaching, physical support,
emotional support) as fathers (Summers, Boller, Schiffman, & Raikes, 2006).

Socio-cultural factors such as increasing rates of women entering the paid labor force and
the shifting structure of American families from predominantly married, two-parent households
to a wider variety of family compositions may be contributing to the evolution of new fathering
behaviors and roles. Many fathers by their own volition have bucked traditional masculinity
norms and roles of fathers (e.g., breadwinning) in order to be stay-at-home fathers or fill more
non-traditional roles in the family such as coparenting (Marks & Palkovitz, 2004; Rochlen,
Suizzo, McKelley, & Scaringi, 2004). This includes spending more time with their children,
assuming more childcare tasks, and filling new paternal roles such as the primary caregiver as a
“stay-at-home” dad (Bianchi, Robinson, & Milkie, 2006; Maume, 2011).

Father involvement has been defined as having three components (Pleck, 2007, 2010)
that include positive engagement activities (e.g., more intensive interactions that promote
development), warmth and responsiveness (e.g., the ability to respond to the child’s needs with
warmth and caring), and control (e.g., parental monitoring and knowledge of child and child
whereabouts, including involvement decisions about monitoring). Two auxiliary domains are
indirect care (e.g., activities for the child that are necessary without the child being present such
as providing food and clothing and scheduling health care appointments) and process
responsibility (e.g., taking initiative to care for the child rather than waiting for someone else to
do so).
Father involvement has been consistently linked to positive child outcomes. Longitudinal studies continue to support early findings of the positive influences father involvement has on children’s behavioral, psychological, cognitive, and economic health (Sarkadi, Kristiansson, Oberklaid, & Bremer, 2008). Father involvement with infants and young children has been associated with advanced language development, a lower likelihood of cognitive deficits on the Bayley Short Form-Research Edition, a facilitator of positive prefeeding behavior, and fewer behavioral problems later in childhood (Bronte-Tinkew, Carrano, Horowitz, & Kinukawa, 2008; Erlandsson, Dsilna, Fagerberg, Christensson, 2007; Pancsofar & Vernon-Feagans, 2006; Trautmann-Villalba, Gschwendt, Schmidt, & Laucht, 2006). For school-aged children (approximately 4-12), father involvement has been associated with increased levels of academic achievement, more positive school attitudes, literacy development, academic competence, nonverbal cognitive functioning, fewer internalizing behavior problems, higher levels of emotion regulation, math and reading skills, and social adjustment (Cabrera, Cook, McFadden, & Bradley, 2012; Cook, Roggman, & Boyce, 2012; Pougnet, Serbin, Stack, & Schwartzman, 2011). For adolescents, father involvement has been associated with healthier eating patterns, lower internalizing problems especially for daughters, higher self-esteem, less delinquency, fewer depressive symptoms, less violent behavior, better grades, and less substance use (Booth, Scott, & King, 2010; Day & Padilla-Walker, 2009; Stamps Mitchell, Booth, & King, 2009; Stewart & Menning, 2009).

For many men, becoming a father clearly has consequences for their lives and identities (Habib & Lancaster, 2006). Being a good father is an important factor in their definition of success (Tichenor et al., 2011). Becoming a father can be a time for growth by resolving wounds from a man’s own father (Levant, 1996) and for reinventing fatherhood, or at least trying to
become the father one always wanted. Paternal identity has been positively correlated with
generativity, which is concern for future generations and thus, important for fostering healthy
family relationships (Christiansen & Palkovitz, 1998). A father scoring high on generativity
would presumably demonstrate growth and be on a positive life course trajectory (Palkovitz &
Palm, 2009). Habib and Lancaster (2006) found a positive correlation between increased
emphasis on paternal identity and paternal-fetal bonding, which was defined as a subjective
feeling of love for the unborn child. Therefore, a high importance placed on one’s identity as a
father facilitates bonding and investment.

Correlational evidence has found a positive association between parenting involvement
and positive changes in new fathers’ health (e.g., psychological well-being) (Knoester, Petts, &
Eggebeen, 2007; Schindler, 2010). A recent longitudinal study that tracked males from boyhood
to fatherhood (ages 11 – 31 years) revealed that following the birth of their first biological child,
criminal behavior, tobacco and alcohol use all decreased among new fathers (Kerr, Capaldi,
Owen, Wiesner, & Pears, 2011). Evidence from a sibling and twin model found that becoming a
father after very young adulthood is associated with fewer chronic illnesses among mostly
married men (Pudrovksa & Carr, 2009). First-time fathers have reported positive changes in their
relationships with health professionals, friends, and family, an increased sense of responsibility
and a more united relationship with their spouse (Chin, Hall, & Daickes, 2011). Other studies
have found that first-time fathers begin to wear their seatbelts more often, learn new parenting
skills, engage in positive coparenting practices, engage in less risk-taking and more self-care
activities (Chin et al., 2011; Genesoni & Tallandini, 2009). Furthermore, many fathers describe
the birth of their child as a “magical moment,” “jolting,” “transformative,” and the catalyst for
“settling down” (Cowan, Cowan, & Knox, 2010; Palkovitz, 2002). As stated by Knoester and
Eggebeen (2006, p. 1554), “In other words, there is evidence that becoming a new father transforms men’s lives.” However, some men experience difficulties in the transition to fatherhood. Postpartum depression affects roughly 10% of fathers in the 3-6 month period following birth and is associated with more negative and fewer positive parent-infant interactions (Paulson, 2006, 2010). Men also experience grief and loss due to miscarriages and pregnancy loss (Reinhart & Kiselica, 2010).

**Application**

Provided that positive paternal engagement tends to have long-term emotional and psychological benefits for both children and fathers (Mauer & Pleck, 2006; Pleck, 1997), psychologists strive to promote healthy father involvement. Psychologists can promote unique strengths of father involvement such as rough and tumble play and economic provision. Active play (i.e., “rough and tumble”) and exercise with their children have shown to be more gendered activities of father involvement and important to child health (Berg, 2010; Fletcher, Morgan, May, Lubans, & St. George, 2011; Garfield & Isacco, 2012). According to Bogels and Phares (2008), active play between fathers and children has a functional element correlated with several positive child outcomes such as competitiveness without aggression, cooperation that buffers anxiety, healthy experimentation, social competence, peer acceptance and popularity, and a sense of autonomy.

Despite changing economic and demographic trends such as more dual career families and more mothers in the workforce than previous generations, paternal financial contributions to their children (i.e., “provider” and “breadwinner”) have remained a salient aspect of men’s parenting role, identity, and involvement. Fathers are still more often the breadwinners within families and their financial contributions have been shown to contribute to children’s education,
well-being, and protect against childhood poverty and the associated negative outcomes (Schindler, 2010). At the structural and institutional level, psychologists can help fathers eliminate custodial, legal, psychological (depression, anxiety, substance abuse, alcohol abuse, low self-efficacy), interpersonal (i.e., relationship discord/conflict with co-parent), and economic barriers to their positive involvement (Isacco & Garfield, & Rogers, 2010).

Fathering programs are a valuable component of family life education. Psychologists can identify institutional resources to promote positive fathering. For example, high-dosage Head Start programs for fathers have been linked with increased father involvement and higher mathematics scores for children (Fagan & Iglesias, 1999). Fathering empowerment programs increase fathers’ beliefs in their ability to teach their children (Fagan & Stevenson, 2002). Psychologists can employ special parent education curriculums to prepare expectant fathers for the challenges, duties and joys of fatherhood (e.g., Hayes & Sherwood, 2000; National Family Preservation Network, undated; National Fatherhood Initiative, 2007). Specialized programs can be used with particular populations such as teenage (Kiselica, Rotzien, & Doms, 1994) and incarcerated fathers (National Fatherhood Initiative, 2007).

Guideline 6: Psychologists strive to support educational efforts that are responsive to the needs of boys and men.

Rationale

The provision of a high quality education characterized by a safe and supportive learning environment, a challenging curriculum, and systematic career education and counseling, enhances the intellectual, emotional, and social development of students and helps them to prepare for their future roles in the community and workforce (Baker & Gerler, 2007). Boys who take advantage of educational opportunities are more likely to find employment and earn higher
salaries than their peers who drop out of school (Bureau of Labor Statistics, 2008); however, there are data to suggest that a disproportionate number of boys are underperforming academically (Kena et al., 2014). This problem appears to be particularly salient for Black and Latino boys (see Fergus, Noguera, & Martin, 2014). Boys also face greater odds of being diagnosed with a developmental disability (Boyle et al., 2011) that can impair academic functioning and/or result in placement in special education classes. Thus, helping boys to overcome their school-related difficulties is crucial because young men experiencing these problems are at risk to drop out of school, earn less income, change jobs more often, and suffer longer periods of unemployment than males who complete high school and college (U. S. Department of Labor Statistics, 2006). These types of labor-related difficulties are commonly a source of significant stress (Kiselica, Englar-Carlson et al., 2008).

Addressing the school-related problems of boys is also important because many of the problems posed by boys in schools, e.g., classroom disruption, poor organization, sexual harassment, bullying, and discourtesy, have a detrimental impact on the academic and social experiences of other students (Juvonen, Wang, & Espinoza, 2011; Lacey, & Cornell, 2013). There is also a clear link between school failure and a host of other problems, including antisocial behavior, drug abuse, high-risk sexual behavior, and premature fatherhood, all of which place tremendous social and economic burdens on society (Bradford & Noble, 2000).

Aspects of masculinity ideology may contribute to the school-related problems for boys (O’Neil & Luján, 2009). Dysfunctional boy codes for behavior, such as the belief that being studious is undesirable, suppress academic striving among some boys (Franklin, 2004; Wilson, 2006). Constricted notions of masculinity emphasizing aggression, homophobia, and misogyny may influence boys to direct a great deal of their energy into disruptive behaviors such as
bullying, homosexual taunting, and sexual harassment rather than healthy academic and extracurricular activities (e.g., Steinfeldt, Vaughan, LaFollette, & Steinfeldt, 2012).

Application

Psychologists strive to raise awareness about the special academic and school-adjustment problems of boys among teachers, educational support staff, school administrators, parents, and policy makers. For example, although boys are more likely to be diagnosed with ADHD, there are often few observed gender differences in the expression of ADHD between boys and girls (Biederman et al., 2005). Psychologists can be mindful of the existing diagnostic criteria for ADHD and not let the client’s gender influence the diagnosis (Bruchmüller et al., 2012). Because many school-related difficulties for boys emerge at an early age, psychologists can initiate changes in practices that will enhance the early school adjustment of boys who are struggling academically, such as remedial reading instruction, training behavioral inhibition, and providing verbal experience (Eliot, 2009). Psychologists are also encouraged to engage boys in strength-based experiential groups to promote friendships and support among boys while helping them critically examine dysfunctional boy codes and restrictive notions of masculinity (e.g., Mortola et al., 2008).

Psychologists strive to assist school officials with the development of anti-bullying policies and implementation of anti-bullying campaigns (Orpinas & Horne, 2005). Because sexual harassment and bullying of sexual minority youth is an especially common problem exhibited by boys in schools, it is recommended that school policies contain specific language addressing bullying associated with sexism and homophobia (e.g., Kiselica, Mulé et al., 2008). Psychologists are encouraged to develop strategies to assist both perpetrators and victims of bullying, helping the former to be accountable for their behavior as well as to distinguish
between healthy and unhealthy uses of power and understand how their misuse of power hurts others, and helping the latter recover from trauma and engage in risk reduction (e.g., Reese, Horne, Bell & Wingfield, 2008; Wilson, 2006). Psychologists are encouraged to assist in the development of positive school climates (Olweus & Limber, 2010; Orpinas & Horne, 2005). This can be accomplished through modeling non-restrictive masculinity behaviors, sensitive awareness of appropriate limit setting, and affirming and encouraging boys (e.g., Wilson, 2006; Kiselica, Englar-Carlson et al., 2008).

Psychologists also strive to promote the career development and workforce readiness of boys and men. Ideally, developmental career counseling and education begins with boys at the grade school level and continues into the high school years with services designed to assist young men to choose a career and make the transition into the workforce or higher education (Baker & Gerler, 2007). A particular focus of career education with boys includes encouraging them to explore the full range of career options, not just those that men have traditionally pursued. In addition, psychologists strive to be mindful of the difficult barriers and the culture-specific issues impeding the educational and career development of racial and ethnic minority, immigrant, and low-income boys by creating partnerships with schools, health care facilities, social service agencies, and businesses to provide them with mentors to guide and inspire educational striving, skills to cope with stressful life circumstances, and incentives to succeed in school, go on to college, and enter the workforce (Kiselica, 2008).

Guideline 7: Psychologists strive to reduce the high rates of problems boys and men face and act out in their lives such as aggression, violence, substance abuse, and suicide.

Rationale
Although the vast majority of males are not violent, boys and men commit nearly ninety percent of violent crimes in the United States (United States Department of Justice, 2011). Many boys and men have been socialized to use aggression and violence as a means to resolve interpersonal conflict (Moore & Stuart, 2005). Family, peers, and media often reinforce the connection between aggressive behavior and masculinity (Kilmartin & McDermott, 2015, Kilmartin & Smiler, 2015). Childhood physical and/or sexual abuse victimization has been found to be a significant precursor to aggressive acting out in boys and men (Jennings, Piquero, & Reingle, 2012; Tyler, Johnson, & Brownridge, 2008). Other risk factors for aggressive behavior include poor parental and teacher supervision, low academic achievement, frequent viewing of violent media, and living in high crime neighborhoods (Reese et al., 2008).

Men are at high risk of being the victims of violent crime (Federal Bureau of Investigation, 2015). For African American males ages 10 to 24, homicide is the leading cause of death; it is the second leading cause of death for Hispanic youth of the same ages (United States Department of Justice, 2011). Men who have experienced violence and abuse in childhood are more likely to have higher rates of mental illness (Cashmore & Shackel, 2013). Men who are violent toward their partners are more likely to have been physically abused and/or witnessed domestic violence as children than those who are not violent (Renner & Whitney, 2012).

Suicide rates are also higher for men who have been abused or witnessed abuse in childhood (Cashmore & Shackel, 2013), and men constituted more than 70% of suicide deaths in the United States between 2000 and 2012 (American Foundation of Suicide Prevention, 2015). In a majority of epidemiological studies, substance abuse and alcohol abuse rates for men were two to three times higher than those of women (Kessler, McGonagle, Zhao, Nelson, Hughes, Eshelman, Wittchen, & Kendler, 1994). Many men use alcohol or other drugs as coping
mechanisms in response to difficult emotional situations and uncomfortable affective states (Cochran, 2005; Nolen-Hoeksema & Harrell, 2002), and investigators have uncovered strong links between alcohol and suicide completion (e.g., Kaplan et al., 2013). Although the depression rates among men are 50% that of women (Martin, Neighbor, & Griffith, 2013), researchers believe that many men express depression covertly, manifesting as irritability, interpersonal distancing, sensitivity to threats to self-esteem and self-respect, compulsivity, somatic complaints, and difficulty with motivation and concentration (Martin, Neighbor, & Griffith, 2013). Lending credence to the covert aspect of many men’s depression are suicide rates four times that of women, despite the lower depression rate for men as defined by DSM criteria (American Foundation of Suicide Prevention, 2015; Cochran & Rabinowitz, 2000, 2003; Lynch & Kilmartin, 2013).

Application

Psychologists strive to understand the multiple factors that lead to aggression and violence in boys and men (Reese et al., 2008). By having empathy for the meaning of aggressive and violent behavior, psychologists strive to prevent violence by using psychological methods that increase empathy for others, model control of aggressive behavior, and increase communication skills and problem-solving (Kilmartin & Smiler, 2015; Reese, et. al., 2008). In educational, correctional, and therapeutic settings, psychologists are encouraged to work with boys and men who have had difficulties with aggression and violence, and to focus on treatment and remediation with incarcerated individuals. Psychologists strive to have empathy for men’s traumatic pain while holding them accountable for their behavior at the same time.

Many boys and men do not willingly reveal the extent of childhood trauma to others (Lisak, 2001). Psychologists are encouraged to be attentive to the shame many men feel about
discussing abuse and emotional distress (Shepard & Rabinowitz, 2013) and strive to remain empathic, supportive, and patient with their interventions with boys and men who may manifest defensive and masked reactions to educational and therapeutic interventions. Psychologists are especially encouraged to assess for early psychological trauma in men who present for depression, substance-abuse, post-traumatic stress, and intimate partner violence (Lisak & Beszterczey, 2007). Psychologists strive to be aware of potential underlying affective disorders such as depression and anxiety when considering therapeutic interventions with men who display aggression and violence (Cochran & Rabinowitz, 2000; Fleming & Englar-Carlson, 2008).

Guideline 8: Psychologists strive to help boys and men engage in health-related behaviors.

Rationale

For most leading causes of death in the U.S. and in every age group, males have higher death rates than females (see Courtenay, 2011). Despite having greater socioeconomic advantages than women, men’s life expectancy is almost 5 years shorter than women (76.3 years for men, 81.1 for women); in every ethnic group the age-adjusted death rate is higher for men than women (Hoyart & Xu, 2012). A sex difference in risk-taking is largely responsible for this discrepancy. For example, accidents are the leading killer among all males aged 1 to 44 in the U.S. (Centers for Disease Control and Prevention, 2010). Men’s age-adjusted death rates for heart disease and cancer—the two leading causes of death, which account for almost half of all deaths—are 50% and 80% higher, respectively, than women’s rates (Department of Health and Human Services, 2009; Jemal et al., 2008), and one in two men will develop cancer in his lifetime (American Cancer Society, 2008). Between 2011 and 2013, men’s mortality rates for colorectal cancer, a generally preventable disease with regular
screenings, were significantly higher than women’s, suggesting that many men do not engage in preventative care (American Cancer Society, 2015). Men’s higher rates of circulatory system diseases before age 65 are also likely due to higher rates of smoking, alcohol use, and diets higher in fats and red meat and lower in fruits and vegetables (see Courtenay, 2011).

Health disparity patterns of heightened risk behaviors for men begin in early adolescence, as adolescent and young adult males engage in more risk behaviors that they are increasingly likely to engage in over time (Mahalik et al., 2013). Gender role socialization often encourages men to adopt masculine ideologies that may be associated with health risk behaviors and existing health disparities (McDermott, Schwartz, & Rislin, 2015; Wong, Owen, & Shea, 2012) such as substance abuse (de Visser & Smith, 2007; Iwamoto, Cheng, Lee, Takamatsu, Gordon, 2011; Peralta, 2007), coronary prone behavior (Eisler, 1995; Watkins, Eisler, Carpenter et al., 1991), violence and aggression (Moore & Stuart, 2005; Kilartin & McDermott, 2015), less willingness to consult medical and mental health care providers (Addis & Mahalik, 2003), less utilization of preventive health care (Courtenay, 2011), and risky sexual and driving behaviors (Courtenay, 2011; Mahalik et al., 2013). In addition, Courtenay (2011) noted that overall men engage in fewer health promoting behaviors, more risk taking behaviors, are more likely to be the perpetrators and victims of physical abuse and violence, have few social supports, less effective behavioral responses to stress, and use fewer health care services.

Perceptions of social norms may shape the health behaviors of men. Research indicates that perceived social norms of men are associated with college student alcohol use (Berkowitz, 2003; Halim, Hasking, & Aileen, 2012; Korcuska & Thombs, 2003), adolescent smoking (Gunther, Bolt, Borzekowski, Liebhart, & Price Dillard, 2006), drinking and driving (Perkins, Linkenbach, Lewis, & Neighbors, 2010), and gay and bisexual men’s condom use
The perceptions of other men are also associated with men’s seat belt use, fighting, seeking social support, getting an annual physical exam, using tobacco, exercising, and dietary choices (Mahalik & Burns, 2011; Hammond et al., 2010). The more men perceive that their male friends were seeking help either in the form of talking to someone about a troubling problem or getting an annual physical in the last year, the more likely men report having done the same (Mahalik et al., 2007; Hammond, Matthews, Mohottige, Agyemany, & Corbie-Smith, 2010). Finally, men may be more likely to attend to their health in contexts where their efforts to maintain good health and functional capacity strengthen their claims to manhood (Calasanti, Pietilä, Ojala, & King, 2013) or when their functional, physical capacity is required to perform their jobs (Springer & Mouzon, 2009). Perception of the nature of the problem as normative also influences help-seeking.

The health challenges for many men from historically marginalized groups (e.g., men of color, gay and bisexual men, transgender men) are long rooted in sociopolitical (e.g., the unequal distribution of power), socio-historical (e.g., biased and inaccurate histories of peoples), and socio-structural (e.g., legal, education, and economic systems) forces that oppress individuals (Jones, Crump, & Lloyd, 2012; Liu & Ali, 2005). Insensitivity to racial stereotypes, the interaction of race and gender, cultural values and mores, immigration status, and social and economic conditions have a significant impact on men of color as well as those who live in poverty (Liu & Concepcion, 2010; Takeuchi, Alegria, Jackson, & Williams, 2007).

For many, the crux of working with men is the understanding that masculinity is both associated with a wide range of health (physical and mental) concerns and less willingness to seek help for those problems (Addis & Mahalik, 2003). Good and Wood (1995) classically defined that puzzle as double jeopardy - those that need the most help are also the least likely to
seek it out. Although there is significant public stigma in the United States in regards to seeking help for mental health concerns (Vogel, Bitman, Hammer, & Wade, 2013), men typically report higher levels of stigma compared with women (Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011; Vogel, Wade, & Hackler, 2007). They are more likely to underutilize health (White & Witty, 2009) and mental health services (Addis & Mahalik, 2003) due to not perceiving a need for them (Mojtabai et al., 2011). Indeed, men do not go to counseling as often as women during any given year or over their lifetimes (Addis & Mahalik, 2003; Good & Robertson, 2010; Moller-Leimkuhler, 2002). This is true across diverse groups of men (Holden, McGregor, Blanks, & Mahaffey, 2012; Good & Wood, 1995; Vogel et al., 2011), with evidence suggesting that men of color seek psychological help even less frequently (Chandra et al., 2006; Hammer et al., 2012).

Application

Psychologists strive to educate boys and men about the restrictive nature of masculine ideologies and their relationships to health risk behaviors. At the same time, psychologists are encouraged to help boys and men build health promoting behaviors such as resisting social pressure to eschew health concerns, engaging in preventative medical services, and developing the habits of healthy diet, sleep, and exercise. Psychologists strive to understand some men’s reluctance to seek help by recognizing the influence of masculine gender role socialization. For instance, although men are less likely than women to receive certain psychological diagnoses (e.g. depression and anxiety), psychologists recognize that these discrepancies may be due, in part, to gender role socialization (Addis, 2008; McDermott et al., 2015) which impacts men’s help-seeking behaviors and how they present their physical and psychological distress (Cochran & Rabinowitz, 2000).
Psychologists also strive to help men to obtain the necessary knowledge, attitudes, and behaviors to use their social influence to promote health behaviors in other boys and men with whom they come into contact. Perceptions of other men’s health behaviors may provide information about how individual men should or should not act. Because men often hide or mask feelings of depression (Rabinowitz & Cochran, 2008; Lynch & Kilmartin, 2013), for instance, many men may believe that depression is not normative. These concerns underscore the importance of public information campaigns highlighting the fact that depression is a frequent problem for men (National Institute of Mental Health, 2008; Rochlen, Whilde, & Hoyer, 2005).

Psychologists are encouraged to disseminate information to the public to reshape attitudes about men and mental health.

Guideline 9: Psychologists strive to build and promote gender-sensitive psychological services.

Rationale

A disparity exists between the occurrence and severity of men’s mental health problems and the disproportionately low number of men served by psychological services (Englar-Carlson, Evans, & Duffey, 2014). It has been suggested that many men do not seek psychological help because services are not in alignment with masculine cultural norms that equate asking for assistance for psychological and emotional concerns with shame and weakness (Addis & Mahalik, 2003). An understanding of gender norms when designing services for boys and men may lead to greater participation among this population (Mahalik et al., 2012).

For those men who consult a psychotherapist, there exist normative practices that can result in poor outcomes (Mahalik et al., 2012). For example, clinical methods that emphasize the language of feelings, disclosing vulnerability, and admitting dependency needs, can create
expressive difficulties for males who adopt and adhere to traditional masculine roles (Rabinowitz & Cochran, 2002; Rochlen & Rabinowitz, 2014) Likewise, in the realm of assessment, practitioners can struggle with diagnosing depression in boys and men because symptoms may not conform with traditional DSM criteria (Addis, 2008; McDermott et al., 2015). For example, psychologists may not interpret acting-out/externalizing behaviors such as aggression, addiction, and substance abuse as potentially masking depression (Lynch & Kilmartin, 2013). It is not unusual for some men to understate mental health problems (Paulson & Bazemore, 2010).

Normative male interpersonal behavior can involve an absence of strong affect, muted emotional displays, and minimal use of expressive language, making it difficult for primary care physicians and other health professionals to determine when men are actually experiencing depressive disorders (Martin, Neighbor, & Griffith, 2013). Instead, many men express themselves in terms of externalizing behaviors, many of which are problematic (Cochran & Rabinowitz, 2000). In responding to the problematic externalizing behaviors of boys, such as hyperactivity, aggression, and substance abuse, there has been a tendency for professionals to focus on addressing deficits, rather than strengths (Kiselica, Englar-Carlson et al., 2008). Evidence suggests that medication may be relied upon over psychological interventions with boys, especially in relationship to ADD and ADHD diagnoses (Kapalka, 2008).

Application

Psychologists can take advantage of the numerous gender-based adaptations derived from theoretical work or clinical expertise to accommodate male clients of diverse backgrounds (e.g., Brooks & Good, 2005; Englar-Carlson et al., 2014; Englar-Carlson & Stevens, 2006; Kiselica, et al., 2008; Pollack & Levant, 1998; Rabinowitz & Cochran, 2002; Rochlen & Rabinowitz, 2014 see also division51.org for a complete list of clinical resources for working with boys and men).
Psychologists also may strive to identify ways that psychological services can be more adaptive to the ways men have been socialized (Englar-Carlson, Evans, & Duffey, 2014). Depending on the expectations, psychologists strive to correct erroneous assumptions about psychological interventions or change the structure of interventions to be more congruent for the male client (Rochlen & Rabinowitz, 2014). Psychologists also strive to find ways to increase the perception of normativeness for particular problems (e.g., depression), train professional helpers to recognize the ego-centrality of certain problems (e.g., unemployment for men who view their family role primarily as “provider”), and create alternative non-traditional forums more congruent with masculine socialization (e.g., psycho-educational classes in work settings) (Addis & Mahalik, 2003).

For boys and adolescents, shorter sessions, informal settings outside of the office (e.g., playground), instrumental activities, using humor and self-disclosure, and psycho-educational groups may provide more congruent environments than traditional psychotherapy (Englar-Carlson & Stevens, 2006; Brooks, 1998). Psychologists strive to provide supportive counseling and career guidance to men with histories of sporadic employment, job adjustment difficulties, and long-term unemployment. Such services would be aimed at addressing the personal issues that might have contributed to their work problems and the impact of those problems on their self-esteem and mental health (Herr, Cramer, & Niles, 2003; Romo, Bellamy & Coleman, 2004). Psychologists are encouraged to advocate for public policy that supports and enhances teenage boys’ career prospects. These may include developmental career counseling and development in the schools, and GED, job training, and job placement services for adolescent and adult males who have dropped out of school or struggled with under-employment or unemployment (Romo et al., 2004).
Psychologists assessing boys and men strive to be aware of traditional masculine gender role characteristics that render underlying psychological states difficult to assess. Psychologists in clinical situations are encouraged to ask boys and men questions about mood and affect and to be willing to probe more extensively when faced with brief responses. Psychologists are encouraged to note discrepancies between self-expression and the severity of precipitating factors, which might have resulted from many men’s relative emotional inexpressivity (Rabinowitz & Cochran, 2008). Psychologists work to accurately assess masculine socialization and ideology using the aforementioned gender-sensitive assessment tools and to learn specific assessment strategies for masculine depression (Cochran & Rabinowitz, 2003) and alexithymia (Levant, Hall, Williams, & Hasan, 2009).

Importantly, psychologists strive to attain a level of gender self-awareness that allows them to act with intentionality, resisting the imposition of their values and biases on male clients (Wisch & Mahalik, 1999). Thus, psychologists strive to recognize the relational style of many men and adapt by substituting other terms for psychotherapy like consultation, meeting, coaching, or discussion, using less jargon, being more active and directive, and matching relational style to the client’s need (Englar-Carlson et al., 2014). Technology oriented interventions (e.g., biofeedback, telemental health) can also be used to engage men who are uncomfortable with the intimacy of traditional psychotherapy approaches (McDermott, Smith, & Tsan, 2014). In addition, Wester and Lyubelsky (2005) have suggested the use of explicit goal setting with men, to reduce ambiguity and encourage engagement.

**Guideline 10: Psychologists understand and strive to change institutional, cultural, and systemic problems that affect boys and men through advocacy, prevention, and education.**

**Rationale**
Some men encounter institutional, cultural, or systemic barriers to their well-being, as evidenced by societal problems wherein men are disproportionately overrepresented. For instance, one of the major areas affecting boys and men is the high incarceration rate in the United States. Data obtained from the Federal Bureau of Prisons (2014) reveals the extent of the problem. For example, men account for 93% of all adults in federal prison to date, and although African American and Latino males constitute approximately 7% and 8% of the general population, respectively, they make up 37% and 34% of the federal prison population. These racial and gender disparities may be the result of racial and gender stereotypes. Indeed, African American and Latino men, compared to White men, are more likely to be detained and searched in cities with “Stop and Frisk” laws (Center for Constitutional Rights, 2013). Men of color also have less access to addiction treatment, a significant cause of racial disparity in the criminal justice system, as more than 60% of federal inmates are incarcerated because of drug offenses (Federal Bureau of Prisons, 2014). Thus, African American men are many times more likely to go to prison for drug offenses than White men (Felner, 2009) even though they are less likely to use illegal drugs (Wu, Woody, Yang, Pan, & Blazer, 2011).

Another area disproportionately associated with boys and men is violence. Epidemiological research indicates that men of all races are at an increased risk for being either a victim or perpetrator of violence, especially during adolescence. The Centers for Disease Control and Prevention (2010) reported that violence is the second leading cause of death among people between the ages of 15 and 24, and reports from state and national surveys of youth behaviors suggest that young men are more likely than young women to engage in serious aggressive behaviors. For instance, findings from the National Youth Risk Survey (Eaton et al., 2012) indicated that teenage boys were significantly more likely than teenage girls to report carrying a
gun to school. Investigators have also noted that nearly every school shooter in the last 30 years
has been an adolescent male (Kalish & Kimmel, 2010; Kaufman, Hall, & Zagura, 2012; Kimmel
& Mahler, 2003). For adults, the National Center for Victims of Crime (2013) estimates that 90%
of all homicides in the United States are committed by men, and men constitute 77% of all
homicide victims. State and local data also indicate that men are far more likely than women to
be arrested and charged with intimate partner violence (Hamby, 2014).

Although most violence is perpetrated by men, most men are not violent. Consequently,
men are often stereotyped as aggressive and violent. These stereotypes can have negative
consequences for heterosexual men who experience violence in intimate relationships from their
female partners. Although abusive women, on average, may do less physical damage than
abusive men (Archer, 2000), physical assaults from female partners have been shown to create a
myriad of psychological problems for men (Randle & Graham, 2011). In addition, male victims
of intimate partner violence experience significant barriers to finding help because the domestic
violence system has historically focused on helping battered women (Douglas & Hines, 2011).

**Application**

Psychologists strive to advocate for public health policies and funding for research,
prevention, and intervention efforts that can enhance the lives of boys, men, and their families by
reducing risk factors within the general population that are known to be associated with
dangerous behaviors and outcomes. For example, psychologists strive to support public policy
initiatives to ease problems associated with incarceration, such as humane treatment for
prisoners, access to drug treatment and other rehabilitation, job training, and alternatives to
incarceration. Likewise, psychologists aim to recognize that male violence affects everyone (men
and women) and, concurrently, that men can also be victims of abusive relationships with
Psychologists also strive to increase awareness of the influence of gender role socialization practices associated with violence and problem behaviors for boys and men among public health officials, other mental health professionals, and policy makers. Work with public health officials to disseminate information regarding the destructive aspects of rigid notions of masculinity may result in inclusion of gender-sensitive public health initiatives for boys and men. Psychologists also are encouraged to advocate for more financial support for research studies aimed at boys and men with special attention to neglected areas of research, such as examining masculinity with other social identity-based experiences (e.g., racism and socioeconomic status) in relation to social problems impacting boys and men. Indeed, despite the disproportionate number of men of color in the prison system for violent crimes, most popular theories of violence and aggression do not take into account men’s gender role socialization and racial experiences (Kilmartin & McDermott, 2015).
References


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1276 performance across middle school grades. The Journal of Early Adolescence, 31, 152-
1277 173. doi:10.1177/027431610379415
1278 Kalish, R., & Kimmel, M. (2010). Suicide by mass murder: Masculinity, aggrieved entitlement,
1280 http://dx.doi.org/10.5172/hesr.2010.19.4.451
1282 disorder. In Kiselica, M. S., Englar-Carlson, M., & Horne, A. M. (Eds.) Counseling
1283 troubled boys. (pp. 163-190). New York: Routledge.
1286 doi: 10.1177/0886260511433516
1288 politics of education, 24, 289-306. doi:10.1080/0159630032000172498
1291 Department of Education, National Center for Education Statistics. Washington, DC.
1294 risk American men’s crime and substance use trajectories following fatherhood. Journal
1295 of Marriage and Family, 73, 1101-1116. http://dx.doi.org/10.1111/j.1741-
1296 3737.2011.00864.x
1297 Kilmartin, C., Addis, M. E., Mahalik, J. R., & O’Neil, J. M. (2013). Teaching the psychology of
1298 men: Four experienced professors describe their courses. Psychology Of Men &
1299 Masculinity, 14, 240-247. doi:10.1037/a0033254
1302 Association.
1304 Sloan.
1306 social norms intervention to reduce male sexism. Sex Roles, 59, 264-273.
1307 doi:10.1007/s11199-008-9446-y
1311 doi:10.1177/0002764203046010010
1314 perspective on helping boys. In M. S. Kiselica, M. Englar-Carlson, & A. M. Horne (Eds),


http://dx.doi.org/10.1177/1097184X04271387


http://dx.doi.org/10.1037/10284-015

http://dx.doi.org/10.1037/1524-9220.7.4.212


http://dx.doi.org/10.1037/a0015652


doi:10.3149/jms.1502.130


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Dynamics, Theory, Research, And Practice, 8(3), 221-231. doi:10.1037/1089-2699.8.3.221


