

APA GUIDELINES for the Psychological Practice with Boys and Men

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INTRODUCTION

Boys and men are diverse with respect to their race, ethnicity, culture, migration status, age, socioeconomic status, ability status, sexual orientation, gender identity, and religious affiliation. Each of these social identities contributes uniquely and in intersecting ways to shape how men experience and perform their masculinities, which in turn contribute to relational, psychological, and behavioral health outcomes in both positive and negative ways (e.g., Arellano-Morales, Liang, Ruiz, & Rios-Oropeza, 2015; Kiselica, Benton-Wright, & Englar-Carlson, 2016). Although boys and men, as a group, tend to hold privilege and power based on gender, they also demonstrate disproportionate rates of receiving harsh discipline (e.g., suspension and expulsion), academic challenges (e.g., dropping out of high school, particularly among African American and Latino boys), mental health issues (e.g., completed suicide), physical health problems (e.g., cardiovascular problems), public health concerns (e.g., violence, substance abuse, incarceration, and early mortality), and a wide variety of other quality-of-life issues (e.g., relational problems, family well-being; for comprehensive reviews, see Levant & Richmond, 2007; Moore & Stuart, 2005; O'Neil, 2015). 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).

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 (2017a), older adults (2014), transgender and gender-non-conforming persons (2015a), 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 (a) improve service delivery among populations, (b) stimulate public policy initiatives, and (c) 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

Professional Practice Guidelines are statements that suggest or recommend specific professional behavior, endeavor, or conduct for psychologists (APA, 2015b). 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, 2015b). Guidelines may be superseded by federal or state laws, and APA (2015b) distinguishes between clinical practice guidelines and Professional Practice Guidelines, noting that the former provides specific recommendations about clinical interventions whereas the latter are “designed to guide psychologists in practice with regards to particular roles, populations, or settings and provide them with the current scholarly literature ... representing [and] reflect consensus within the field” (p. 823). Additionally, as noted by APA (2015b), guidelines “may not be applicable to every professional and clinical situation” (p. 824). Thus, these guidelines are not definitive and are designed to respect the decision-making judgment of individual professional psychologists. In addition, consistent with the recommendations and procedures outlined by APA (2015b), these guidelines will need to be periodically reviewed and updated at least every 8 to 10 years, 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) across multiple helping professions (e.g., nursing, social work, counseling, school counseling, psychiatry). 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 girls and women or boys and men, 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 (McDermott et al., 2017), ability (Griffith & Thorpe, 2016), socioeconomic class (Liu, 2017; Liu, Colbow, & Rice, 2016), and race (Hammond, Fleming, & Villa-Torres, 2016; McDermott et al., 2017). 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, expectations, and consequences associated with being a boy or man.

CISGENDER

Cisgender is used to refer to people whose sex assigned at birth is aligned with their gender identity (Green, 2006; Serano, 2006). These guidelines address conflict that cisgender, transgender, and gender-nonconforming individuals may experience due to societal expectations regarding gender roles (Butler, 1990).

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 (for reviews, see Pleck, 1981, 1995). The negative effects of gender role strain are mental and physical health problems for the individual and within relationships (O’Neil, 2008, 2013; 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 a set of descriptive, prescriptive, and proscriptive of cognitions about boys and men (Levant & Richmond, 2007; Pleck, Sonenstein, & 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: anti-femininity, 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). Additionally, acknowledging the plurality of and social constructionist perspective of masculinity, the term *masculinities* is being used with increasing frequency (Wong & Wester, 2016).

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). GRC 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 affectionate behavior between men (discomfort expressing care and affectionate 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, 2013, 2015 for reviews).

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, classism, and heterosexism; and results in limited access to social power (Robinson, 2012; Worell & Remer, 2003).

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, 2008).

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).

GENDER-SENSITIVE

A gender-sensitive treatment, prevention program, or other psychological intervention has been adjusted or manipulated to potentially be more effective or appropriate for men based on the extant literature.

Need for Professional 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, 2013, 2015) and physical health (Courtenay, 2011; Gough & Robertson, 2017). Indeed, boys and men are overrepresented in a variety of psychological and social problems. For example, boys are disproportionately represented among schoolchildren with learning difficulties (e.g., 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 greatest risk of being a victim of violent crime (e.g., homicide, aggravated assault; 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; Wong, Ho, Wang, & Miller, 2017). Further complicating their ability to receive help, 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 4 times more likely than women to die of suicide worldwide (DeLeo 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 (for a review, see Addis, 2008). 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 (Bruchmüller, Margaf, & Schneider, 2012). Other investigations have identified systemic 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 psy-

chological services (Hammer et al., 2013; Mackenzie, Gekoski, & Knox, 2006; 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 well-being. 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; Gough & Robertson, 2017). For example, despite men 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). Sex differences in risk-taking are largely responsible for this discrepancy, but all of these problems can be exacerbated by social identity 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 (Gallardo & McNeill, 2009; Liang, Salcedo, & Miller, 2011; Schwing, Wong, & Fann, 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 (for a review, see Liu, 2005). Research further suggests that having adequate knowledge of men's gender role socialization has important implications for psychological practice with boys (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.

Guidelines for Psychological Practice with Boys and Men

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 against 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 culture, 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") 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 (e.g., mimicking behaviors and interests), family (e.g., imitating parent and sibling behaviors), peers (e.g., conforming to group social norms to avoid ostracism), and society (e.g., adhering to media portrayals of gender conformity) to adopt traditional masculine ideals, behaviors, and attitudes. Yet for some 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,

heterosexual, cisgender, able-bodied, and privileged (Liu, 2005). Moreover, the ideal, dominant masculinity is generally unattainable for most men (Pleck, 1995). Men who depart from this narrow masculine conception by any dimension of diversity (e.g., race, sexual orientation, gender identity, and gender expression) may find themselves negotiating between adopting dominant ideals that exclude them or being stereotyped or marginalized (Liang, Rivera, Nathwani, Dang, & Douroux, 2010; Liang et al., 2011; Schwing et al., 2013).

When trying to understand the complex role of masculinity in the lives of diverse boys and men, it is critical to acknowledge that gender is a non-binary construct that is distinct from, although interrelated to, sexual orientation (APA, 2015a). Heteronormative assumptions often falsely conflate sexual and masculine identity for men (Shields, 2008), as well as disregard sexual attraction and gender role adherence for those who identify as a sexual minority, transgender, or gender nonconforming (APA, 2015a; Nagoshi, Brzuzy, & Terrell, 2012). Expression of romantic or sexual attraction might present gay, bisexual, transgender, and gender nonconforming individuals with gender role-related conflict that is, in part, born from violations of heteronormative gender role ideals (Schwartzberg & Rosenberg, 1998), and potentially alienate sexual- and gender-minority men from a complete male identity (Wester & Vogel, 2012). This may ostracize some gay, bisexual, transgender, and gender-nonconforming individuals from an inherent sense of male identity (APA, 2015), leading to feeling pressured to adopt dominant masculine roles to reduce feelings of minority stress (Green, 2005; Skidmore, Linsenmeier, & Bailey, 2006). Additionally, some sexual and gender minority individuals do not wish to label their gender identity and do not feel masculine behaviors are an essential component of male gender identity (Bockting, Benner, & Coleman, 2009). For these individuals, masculinity may be conceptualized as a set of characteristics that fall on a spectrum and are expressed differently from one individual to another, vary over the course of one's identity development, or may depend on external

context (Diamond & Butterworth, 2008; Nagoshi & Brzuzy, 2010; Vegter, 2013).

Although the cultural and societal pressures to endorse, conform to, and perform dominant masculinity are considerable, men still have agency and can part from dominant ideals (Iwamoto & Liu, 2009). Men not meeting dominant expectations 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 that challenge the expectations of dominant masculinity, such as that of the "cool pose" of African American men (Majors & Billson, 1993) or the engagement of John Henryism (e.g., working harder) behaviors identified among 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 African American boys are more likely to be perceived as older, less innocent, more responsible for their actions, and being more appropriate targets for police violence. Thus, while most men experience pressures to conform to hegemonic masculinity, some men, particularly those from marginalized groups, may be targets of gendered, racial, and heterosexist stereotypes (Vaughns & Spielberg, 2014).

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, coaches, religious leaders, and other community figures), become aware of how masculinity is defined in the context of their life circumstances. Psychologists aspire to help boys and men over their lifetimes navigate restrictive definitions of masculinity and create their own concepts of what it means to be male, although it should be emphasized that expression of masculine gender norms may not be seen as essential for those who hold a male gender identity. For others, masculinity may function as a means to avoid further marginalization (Sánchez & Vilain, 2012). Clinicians may explore the importance and perceptions of masculinity in minority populations to obtain a better understanding of gender expression across various intersecting identities. Toward that end, psychologists strive to understand their own assumptions of, and countertransference reactions toward, boys, men, and masculinity (Mahalik et al., 2012). Psychologists also can explore what being a man means with those 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, 2013), and 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 social identities across the lifespan.

Rationale

There are multiple dimensions to identity, including, age, ethnicity, gender, race, sexual orientation, socioeconomic sta-

tus, spirituality, immigration status, and ability status, and each contributes to a boy's basic sense of self and influences his behavior as he grows (David, Grace, & Ryan, 2006; Wilson, 2006; Vacha-Haase, Wester, Christianson, 2010). Gender is one of the most fundamental of these dimensions (for a review, see Banaji & Prentice, 1994). Gender identity development begins before 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 (and girls) 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., 2006). 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, transgender, or intellectually, psychiatrically, or physically disabled may be the targets of various forms of prejudice and microaggressions (Abbot, Jepson, & Hastie, 2016; Nadal, 2008) and often experience conflicts between dominant and minority views of masculinity (Kiselica, Mulé, & Haldeman, 2008; Liu & Concepcion, 2010). Boys with feminine identities or expressions may face especially negative reactions to non-normative gender expressions, including emotional expressions such as passivity or crying (Kane, 2006), and experience strong pressure to demonstrate and conform to masculine expressions. Research has demonstrated the more boys violate norms of masculinity, the more verbal and physical abuse they may face from peers (Kosciw, Greytak, Giga, Villenas, & Danischewski, 2016). These experiences may lead to mental health problems, including depressive symptoms (Dank, Lachman, Zweig, & Yahner, 2014), self-injury (Dickey, Reisner, &

Juntunen, 2015) and suicidality (Clements-Nolle, Marx, & Katz, 2006). Furthermore, policing of masculinity expression in boys by their caregivers tends to be ineffective and emotionally damaging to the child, and creates tension in the relationship (Hill & Menville, 2009). Nonetheless, throughout childhood, boys may choose to conform to these norms rather than face disapproval. Further, Liu and Concepcion (2010) argue that some Asian American boys and men give in to the pressure to conform to hegemonic masculinity standards by endorsing masculinity that does not represent their preferred identities. In other situations, African American 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 (Liang, Molenaar, & Heard, 2016; Majors & Billson, 1993). Refugee and immigrant boys and men often have different experiences from boys and men born in the United States (Zayas, 2015) as their development is shaped by traumatic experiences (Brabeck, Lykes, & Hunter, 2014).

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 have been associated with poor psychological and physical health outcomes (Alvarez, Liang, & Neville, 2016). For instance, adult African American men in the United States are at greater risk for higher blood pressure, prostate cancer, cardiovascular disease, and stroke (Hammond, 2012; Hammond et al., 2016). Indeed, the relationship between racial discrimination and depressive symptoms was found to be best explained by White, Eurocentric masculine ideals of restrictive emotionality (Hammond, 2012) and self-reliance (Matthews et al., 2013). Among, adult Latino men, Arellano-Morales and her colleagues (2016) found that gender role conflict and life satisfaction were inversely associated among Latino day laborers who experienced high levels of racism but not those who reported lower levels. Regarding Asian American men, investigators have identified that many stereotypes depict them as feminized, weak, or otherwise unmanly (Wong,

Horn, & Chen, 2013; Wong, Owen, Tran, Collins, & Higgins, 2012). Such gendered racism may have a unique effect on Asian men's self-views. For instance, in samples of Asian American men, researchers identified that perpetual foreigner racism-related stress and a desire to appear more "American" predicted unique variance in maladaptive drive for muscularity attitudes beyond the internalization of an athletic-muscular ideal (Cheng, McDermott, Wong, & La, 2016). In terms of immigration status, the vast majority of unaccompanied minors subsequently apprehended by border patrol agents are male (Byne & Miller, 2012). Young men are often escaping unrelenting and escalating violence from their country of origin (Carlson & Gallagher, 2015), and these experiences often re-shuffle the emotional, behavioral, and relational dynamics of these individuals and their families (Gonzalez, 2011; Jimenez-Castellanos & Gonzalez, 2012; Suarez-Orozco, Yoshikawa, Teramishi, & Suarez-Orozco, 2011).

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 grand parenting status or loss of a spouse, and health problems often arise, internal conflicts can ensue, especially for men who base their identities on being a financial provider, having physical strength and stamina, or 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 (Vachon-Haase et al., 2010). Other experiences common to many men across the lifespan, such as serving in the military, can also have significant impacts on men's identities from young adulthood through old age (Leppma et al., 2016). Indeed, an older man's military service and combat experience may be relevant to his overall well-being, as well as have a negative impact on health-related changes with age (Wilmoth, London, & Parker, 2010). Likewise, transition to retirement can be especially important for older adults who strongly identified with their work and career. Indeed, retirement (and other job changes) may be associated with a loss of power and/or privilege. For example, research demonstrates increased morbidity and mortality risks post-retirement, including suicide, and suggests the potential benefits of preventative interventions for some men facing retirement (Bamia, Trichopoulos, & Trichopoulos, 2008; Brockman, Müller, & Helmert, 2009). Sexual and gender minority persons adhering to rigid masculinity ideologies may have a more difficult time transitioning into older age, since an array of factors influence socialized gender roles at this developmental stage. For example, as older sexual and gender minority individuals leave the workforce, they face significant concerns about independence and financial resources (Dickey & Bower, 2017; Witten & Eyler, 2015), and are more likely than cisgender, heterosexual men to live alone and report lack of social support (Witten & Eyler, 2015). Finally, adherence to rigid masculinity norms for aging gay, bisexual, transgender, and gender-nonconforming persons has been correlated with higher incidents of self-destructive behaviors (e.g., substance use, unprotected sex), physical and mental health problems (e.g., depression, suicide, neglecting medical needs), and fears of not being able to express their male identity due to dementia or being misgendered after death (Courtenay, 2000; Oliffe, 2007; Porter et al., 2016; Sánchez, 2016; Westwood & Price 2016).

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., 2006; Liang et al., 2010; Liu & Concepcion, 2010) throughout the lifespan. For example, as men's career identities shift throughout their lives (Liu, Englar-Carlson, & Minichiello, 2012), psychologists could benefit from understanding and applying general knowledge about adult development and aging (APA, 2014) when working with older adults negotiating role transitions from employed to unemployed (whether by planned retirement or involuntary unemployment) (James, Matz-Costa, & Smyer, 2016). Working toward such goals may be especially challenging with aging, multiracial, multiethnic, and sexual and gender 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, career, mental health, and social needs of sexual and gender minority, racial and ethnic minority, boys and men across socioeconomic status, and multiethnic and multiracial boys and men. Providers may need to initiate a discussion about topics related to social and emotional support systems given that social isolation is often identified as an issue for sexual minority and transgender and gender-nonconforming individuals (Porter et al., 2016).

Psychologists look to understand the impact of military service over the lifespan of men. Military veterans represent a broad range of intersecting identities (National Center for Veterans Analysis and Statistics, 2014), and veterans themselves are a distinct cultural group with a wide range of experiences based on military branch, time and place of service, and occupation (National Center for PTSD, 2014; Sherman, Larsen, Borden, & Brown, 2015). In addition to understanding military culture, hierarchy, and reintegration issues, psychologists strive to recognize the connections between military service, masculinities, and common mental health concerns such as post-traumatic stress disorder, traumatic brain injury, substance-related disorders,

depression, anxiety, and suicidal ideation, as well as psychological help-seeking (Leppma et al., 2016; Jakupcak, Primack, & Solimeo, 2017).

Psychologists strive to understand that some racial and ethnic minority boys and men may not have 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, ableism, and other forms of discrimination (Liu & Concepcion, 2010; Nadal, 2008; Reel & Bucciare, 2010; 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 identities; 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 communities (Liu, 2005). Such practices include a transformation of traditional approaches to those that may be more culturally congruent with their clients' backgrounds (Cervantes, 2014; 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, Dittmann, & Crosby, 2008; Vaughns & Spielberg, 2014). 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 et al., 2008; Liu & Concepcion, 2010) and to recognize value conflicts 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 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).

Psychologists also strive to work to address the unique relational needs of gay, bisexual, and transgender boys within the family and peer context. Parents and caregivers of sexual and gender minority children, particularly fathers and male caregivers, may benefit from education about the psychology of masculinities, including a range of masculine expression, intersectional identity factors, and the role of social power in maintaining traditional notions of masculinity. Additionally, understanding the likely involvement of genetic factors in the development of gender identity has been especially effective in reducing transphobia in men (Knafo, Iervolino, & Plomin, 2005). These biological factors may be especially helpful for individuals with religious affiliation and conservative social and political views, who may equate masculinity with heterosexuality (Elischberger, Glazier, Hill, & Verduzco-Baker, 2016).

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 in a patriarchal society (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 often comes with a cost in the form of adherence to sexist ideologies designed to maintain male power that also restrict men's ability to function adaptively (Liu, 2005).

Sexism exists as a byproduct, reinforcer, and justification of male privilege. Although the majority of young men may not identify with explicit sexist beliefs (McDermott & Schwartz, 2013), for some men, sexism may become deeply engrained in their construction of masculinity (O'Neil, 2015). For instance, most boys are taught from an early age that they will suffer negative consequences for violating masculine role norms (Reigeluth & Addis, 2016). The impact of such sexism extends from boyhood into adulthood, sometimes influencing critical identity-formative processes such as career choices (Fouad, Whiston, & Feldwisch, 2016) and thus contributing to gender imbalances in female- or male-dominated professions. Growing up in a patriarchal society may also contribute to important public health concerns such as gender-based violence. Indeed, early socialization experiences in childhood, such as being repeatedly shamed for expressing vulnerable emotions, can have lasting influence into adulthood in ways that shape their intimate relationships (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 vio-

late those norms (e.g., Parrott, Zeichner, & Hoover, 2006; Reidy, Shirk, Sloan, & Zeichner, 2009). Men who rigidly adhere to sexist, patriarchal masculine norms also tend to 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). 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 promote or justify intimate partner violence (Mahalik, Aldarondo, Gilbert-Gokhale, & Shore, 2005; McDermott & Lopez, 2013).

An analysis of masculine norms may shed light on the context of violence against gender and sexually diverse people, as spaces where this discrimination occurs are often marked by traditional masculinity (Leone & Parrot, 2015). An integral aspect of traditional masculinity is the social power awarded to conformity to masculine norms, while aberrant gendered behavior is punished through gender policing. Sexual minority and transgender and gender-nonconforming persons may be seen as transgressing traditional masculine roles and eschewing stereotypes of binary gender categories. For instance, transgender women may be perceived as men who are “pretending” or “dressing up,” while transgender men may be seen as “not real men” (Salamon, 2009). These harmful perceptions are validated through court systems that enshrine “trans panic” defenses for hate crimes against transgender women (Smith & Kimmel, 2005). Research has carefully detailed the role of masculinity in aggression (both verbal and physical) against those who do not conform to strict gender narratives, leading to violent and often fatal hate crimes against transgender and gender-nonconforming people (Kelley & Gruenewald, 2014).

In addition to increasing the possibility of engaging in 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 (for a review, see O’Neil, 2015). In a marital context, husbands’ masculine gender role conflict has been positively associated with their wives’ depression (Breiding, Windle, & Smith, 2008), and several studies have found negative relationships between traditional, sexist masculinities and intimate relationship well-being (O’Neil, 2008, 2015; Moore & Stuart, 2005). Traditional masculinity ideologies have also been linked to parenting concerns, including work-family conflicts (Fouad et al., 2016).

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. Male privilege 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, 2015; O’Neil, Egan, Owen, & Murry, 1993). Indeed, awareness of privilege and the harmful impacts of beliefs and behaviors that maintain patriarchal power 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). When working with gender-diverse survivors of systemic gender oppression, it is important to assess for experiences of trauma and barriers that are enforced in ways that either favor cisgender masculinity or assume a binary identity (Richmond, Burnes, Singh, & Ferrara, 2017). Providers are encouraged to help clients to develop self-advocacy

skills and to tap into their personal and collective resilience in addressing these difficult experiences (Dickey, Singh, Chang, & Rehrig, 2017).

Men who understand their privilege and power may be less apt to rely on power, control, and violence in their relationships (McDermott, Schwartz, & Trevathan-Minnis, 2012; Schwartz, Magee, Griffin, & Dupuis, 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). Psychologists can help clients develop awareness of systems that assume cisgender masculinity expression is the expected norm, and identify how they have been harmed by discrimination against those who are gender nonconforming. 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 that 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 lifespan, males experience many developmental changes and

challenges pertaining to intimacy, sex, and emotions, beginning with the universal task of forming intimate attachments with others. Although there is tremendous social and cultural diversity inherent in parenting approaches, some boys are socialized from an early age to avoid intimacy and deep connections with others (Pollack, 1995; Way, 2011), potentially leading to serious relational difficulties later in life (O'Neil, 2015). Indeed, several studies have identified connections between adult attachment insecurity and men's adherence to traditional masculinity ideologies (Mahalik et al., 2005; McDermott & Lopez, 2013; Schwartz et al., 2004).

Additionally, traditional masculinity ideology encourages men to adopt an approach to sexuality that emphasizes promiscuity and other aspects of risky sexual behavior, such as not learning a partner's sexual history or engaging in sex without protection from pregnancy or disease transmission (Kimmel, 2008; Pleck, Sonenstein, & Ku, 2004; Smiler, 2013). Indeed, heterosexual men's adherence to traditional, sexist aspects of masculinity has been connected to sexual assault perpetration (Flood, 2015; Kimmel, 2008; for a review, see McDermott, Kilmartin, McKelvey, & Kridel, 2015), as well as decreased condom use and increased casual "hook-up" sex (Flood, 2008; Pleck et al., 2004; Smiler, 2013).

In addition to influencing sexual relationships, 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); this is particularly evident in all-male peer groups (Way, 2011). Because of the pressure to conform to traditional masculinity ideology, some men shy away from directly expressing their vulnerable feelings and prefer building connection through physical activities, talking about external matters (e.g., sports, politics, work), engaging in "good-natured ribbing," exchanging jokes, and seeking and offering practical advice with their male friends (Garfield, 2015; Kiselica, Englar-Carlson, Horne & Fisher, 2008; Pollack, 1998; 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). Thus, 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 & Heasley, 2016; Vaillant, 2012).

It is important to note that gay, bisexual, and transgender boys and men are also 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, following disclosure of non-heteronormative or transgender identity. For example, individuals who adhere to traditional masculine gender roles hold more negative attitudes toward transgender and gender-nonconforming persons (Tebbe & Moradi, 2012), while affirming families are associated with superior mental health outcomes for transgender and gender-nonconforming persons (Olson, Durwood, DeMeules, & McLaughlin, 2016; Ryan, Russell, Huebner, Diaz, & Sánchez, 2010).

Application

Psychologists strive to promote healthy intimate relationships in boys and men, where healthy relationships are defined and characterized by respect, emotional intimacy and sharing, and mutuality (Garfield, 2015; Smiler, 2016; Way, 2011). 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 (Lombardi, 2012). Further, psychologists recognize how issues of language acquisition, family intergenerational conflict, conflictual values between culture of origin and the United States, and differences in acculturation compared with parents and elders may be present for first-generation boys and men (Kim, Chen, Li, Huang,

& Moon, 2009; Lorenzo-Blanco, Unger, Baezconde-Garbanati, Ritt-Olson, & Soto, 2012; Schwartz, Unger, Zamboanga, & Szapocznik, 2010).

Providing an affirmative and caring environment where clients can explore the intersecting influence of masculinities and race, sexual orientation, and class on behavior is significant to resolving mental health difficulties for sexual and gender minorities (Pelletier & Tschurtz, 2012). Effective clinical care may benefit from examination of the client's and clinician's own binary notions of gender identity as tied to biology, as well as developing insight into how to avoid pathologizing clinical language (Carroll & Gilroy, 2002; Singh, Boyd, & Whitman, 2010).

Psychologists strive to use a variety of methods to promote the development of male-to-male relationships. Toward addressing this goal, psychologists recognize and challenge socialization pressures on boys and men to be hypercompetitive and hyper aggressive with one another to help boys and men develop healthy same-sex friendships. Interactive all-male groups, (Levant, 1996; Mortola, Hiton, & Grant, 2007), self-help books (Garfield, 2015; Smiler, 2016), and educational videos (Hurt & Gordon, 2007; Katz & Earp, 2013) may be helpful or utilized. 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). Psychologists can discuss with boys and men the messages they have received about withholding affection from other males to help them understand how components of traditional masculinity such as emotional stoicism, homophobia, not showing vulnerability, self-reliance, and competitiveness might deter them from forming close relationships with male peers (Brooks, 1998; Smiler, 2016). In that vein, psychologists strive to develop in boys and men a greater understanding of the diverse and healthy ways that they can demonstrate their masculinities in relationships.

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). Many fathers are unsure about how to be directly involved with their children given that mothers continue to be the primary caregivers, and social services tend to be mother-focused in terms of parenting education and support programs (Broughton & Rogers, 2007). Further, most parenting support programs originate from White middle-class values that do not automatically recognize different cultural attitudes toward child-rearing (O'Brien, 2004). 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).

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 is a function of an intersection between race or ethnicity and cultural ideologies (Toth & Xu, 1999).

Sociocultural 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 reframed traditional masculinity norms and roles of fathers (e.g., breadwinning) to be stay-at-home fathers or fill more nontraditional roles in the family such as co-parenting (Marks & Palkovitz, 2004; McGill, 2014; Rochlen, Suizzo, McKelley, & Scaringi, 2008). 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). In many African American communities, there are higher rates of single-parent/women-led households, but African American fathers are increasingly documented as being involved with their children (Doyle, Magan, Cryer-Coupet, Goldston, & Estroff, 2016; Jones & Mosher, 2013). For some fathers, active involvement is not always an option. Fathers who fall outside the dominant construction of White, able, and heterosexual may face additional barriers to their social inclusion with their children (De Finney & Ball, 2015). Structural and/or financial challenges may limit father/parental involvement for low-income individuals (e.g., working multiple jobs, time constraints due to public transportation, etc.). Issues related to ethnicity, socioeconomic status, ability, sexual orientation, immigration status, language, and religion, among other factors, can present barriers that limit fathers' level of contact and engagement with their children as well as their visibility in debates about fatherhood (Coakley, 2013).

Father involvement for resident and nonresident fathers has been consistently linked to positive child outcomes (Marsiglio, Amato, Day, & Lamb, 2000). Longitudinal studies continue to support early findings of the positive influences father involvement has on children's behavioral, psychological, cognitive, and financial stabil-

ity (Sarkadi, Kristiansson, Oberklaid, & Brember, 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 pre-feeding 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 and math and reading skills, and social adjustment (Cabrera, Cook, McFadden, & Bradley, 2012; Cook, Roggman, & Boyce, 2012; Pougnet, Serbin, Stack, & Schwartzman, 2011). For nonresident fathers, children's well-being is tied less to fathers' general behaviors (spending time or money) and more to being involved in activities with their children that nurture the father-child relationship (Adamsons & Johnson, 2013). 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 longitudinal study that tracked males from boyhood to fatherhood (ages 11–31) revealed that following the birth of their first biological child, criminal behavior and 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 (Pudrovska & 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, & Daiches, 2011). Other studies have found that first-time fathers begin to wear their seatbelts more often, learn new parenting skills, and engage in positive coparenting practices, less risk-taking behaviors, 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- to 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 (Rinehart & Kiselica, 2010).

Application

Provided that positive paternal engagement and inclusive communication tend to have long-term emotional and psychological benefits for both children and fathers (Maurer & Pleck, 2006; Pleck, 1997), psychologists strive to promote healthy father involvement and father engagement in treatment with their children and families. Father involvement in clinical treatment bodes well for improvement in child outcomes (Bagner & Eyberg, 2003; Lundahl, Tollefson, Risser, & Lovejoy, 2008). Psychologists can promote strengths of father involvement. For instance, active play and physical exercise with their children have been linked to higher levels of father involvement and better 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., being a "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 and well-being while also protecting against childhood poverty and the associated negative outcomes (Schindler, 2010). At the structural and institutional level, psychologists can help fathers eliminate custodial, legal, psychological (e.g., depression, anxiety, substance abuse, alcohol abuse, low self-efficacy), interpersonal (e.g., relationship discord/conflict with a coparent), communication, and economic barriers to their positive involvement (Isacco, Garfield,

& Rogers, 2010). Psychologists can also support kinship structures that provide father figures for gay adults (Levitt, Horne, Puckett, Sweeney, & Hampton, 2015).

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 (Hayes & Sherwood, 2000; National Family Involvement Network, n.d.; National Fatherhood Initiative, 2007). Specialized programs can be used with particular populations such as teenagers (Kiselica & Kiselica, 2014; 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 individuals and helps them to prepare for their future roles in the community and workforce (Foxy, Baker, & Gerler, 2017). 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), and

although certain college majors continue to be male dominated, men in general are falling behind their female peers in higher education (Kena et al., 2014). These problems appear to be particularly salient for African American and Latino boys (Fergus, Noguera, & Martin, 2014) and men (Kena et al., 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. Moreover, it is well documented that boys of color are disproportionately punished more severely for similar behavioral issues compared to their White peers (Skiba, Michael, Nardo, & Peterson, 2002), and such practices are linked to more serious legal problems later in life for men of color (Rios, 2011). Thus, helping boys to overcome school-related challenges (e.g., structural, learning, educational, social, etc.) is crucial because young men experiencing these problems are at risk of dropping out of school, earning less income, changing jobs more often, and suffering longer periods of unemployment than males who complete high school and college (United States Department of Labor Statistics, 2018). These types of labor-related difficulties are commonly a source of significant stress (Kiselica 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, 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 various other social 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).

Moreover, aspects of masculinity ideology may contribute to the school-related problems of 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 (A.J. 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 (Steinfeldt, Vaughan, LaFollette, & Steinfeldt, 2012).

Application

Psychologists strive to raise awareness about the special academic, communication, and school-adjustment problems of boys among teachers, educational support staff, school administrators, parents, and policy makers. Boys are more likely to be diagnosed with ADHD (Arnett, Pennington, Willcutt, DeFries, & Olson, 2015; Willcutt, 2012), likely because the presentation is associated with problematic externalizing behaviors (e.g., classroom disruption). Girls with ADHD often have more attentional issues than hyperactivity issues, which are not as noticeable (Ruckledge, 2010). Thus, 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 (Mortola et al., 2007).

Psychologists strive to assist school officials with the development of anti-bullying policies and implementation of anti-bullying campaigns (Orpinas & Horne, 2010). Children with disabilities—sensory, cognitive, and physical disabilities—are disproportionately impacted by bullying (Simpson, Rose, & Ellis, 2016), with some evidence suggesting that boys engage in higher rates of cyberbullying (Heiman & Olenik-Shemesh, 2015). Further, 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, racism, and homophobia (Kiselica et al., 2008). Psychologists are encouraged to develop strategies to assist both perpetrators and victims of bullying, helping perpetrators 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 victims recover from trauma and engage in risk reduction (Reese, Horne, Bell, & Wingfield, 2008; Wilson, 2006). Psychologists are thus encouraged to assist in the development of positive school climates (Olweus & Limber, 2010; Orpinas & Horne, 2010); this can be accomplished through modeling nonrestrictive masculinity behaviors, awareness of appropriate limit setting, and affirming and encouraging positive behaviors (Wilson, 2006; Kiselica 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 (Foxy et al., 2017). 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 address the difficult barriers and the culture-specific issues impeding the educational and career development of racial and ethnic minority, immigrant, boys with cognitive disabilities, 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 et al., 2008). For example, gender diverse people are 3 times as likely as cisgender people to be unemployed (S.E. James et al., 2016).

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 90% 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 behavior 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). For some men, perpetrating violence, including violence against gender-diverse people, serves to protect and enhance the perpetrator's own masculinity (Reigeluth & Addis, 2016). Therefore, aggression may serve as public behavior wherein men can prove their masculinity, either against a worthy rival or against those considered unworthy of the label man (K. Franklin, 2004; Whitehead, 2005), in order to bolster confidence in their masculine identity.

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). Gender-diverse men are disproportionately targeted by the criminal justice system and incarcerated. For example, documented rates of arrest for transgender and gender-nonconforming people range from 35 to 72%, and 35% of transgender people have been victimized while imprisoned by inmates and guards (Beck, 2014).

Suicide rates are also higher for men who have been abused or witnessed abuse in childhood (Cashmore & Shackel, 2013), and men in general constituted more than 70% of suicide deaths in the United States between 2000 and 2012 (American Foundation of Suicide Prevention, 2015). Childhood suicide rates have increased among school-aged African American males in relation to White males (Bridge et al., 2015)

In addition, suicide rates in men over 70 are higher than in any other demographic group worldwide (World Health Organization, 2014). The suicide rates of American Indian and Alaska Native men have increased by 38% in recent years (Case & Deaton, 2015). In epidemiological studies, substance abuse and alcohol abuse were correlated with higher suicide rates among men (Pompilli et al., 2010). Many men use alcohol or other drugs as a trauma-related avoidance response to difficult emotional situations and uncomfortable affective states (Elder, Domino, Mata-Galán, & Kilmartin, 2017), and investigators have uncovered strong links between alcohol and suicide completion (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 et al., 2013). Lending credence to the covert aspect of many men's depression are suicide rates 4 times that of women, despite the lower depression rate for men as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) cri-

teria (American Foundation of Suicide Prevention, 2015; Lynch & Kilmartin, 2013).

A more detailed analysis of the health consequences facing racial and ethnic minority and sexual and gender minority populations of boys and men encountering trauma, substance abuse, depression, and violence can be found in the *Health Disparities in Vulnerable Boys and Men* report made to the APA (2017b).

Application

Psychologists strive to understand the multiple cultural and individual difference factors that lead to aggression and violence in men and boys (Reese et al., 2008), including the intersection of exposure to adverse childhood experiences and traditional masculine socialization where applicable (Liang & Rivera, in press). By having empathy for the causes (e.g., lack of personal and social resources to cope with trauma) of aggressive and violent behavior, psychologists strive to prevent violence by adopting trauma-sensitive and gender-sensitive approaches with young boys in schools (Liang & Rivera, in press) and by using psychological methods that increase empathy for others, model control of aggressive behavior, and increase communication skills or 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 when working with incarcerated individuals. In such settings, psychologists strive to have empathy for men's traumatic pain while also holding them accountable for their behavior. Furthermore, given that further research is needed to understand the efficacy of violence intervention programs focused on men's issues, psychologists are encouraged to conduct such effectiveness studies and to test the consequences of modifying existing programs to include issues relevant to boys and men (e.g., rigid adherence to restrictive masculinity ideologies).

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 United States and in every age group, males have higher death rates than females (Courtenay, 2011; Gough & Robertson, 2017). 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 United States (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 1 in 2 men, compared with 1 in 3 women, 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 (Courtenay, 2011). In addition to metabolic diseases, men, especially men who have sex with men, are disproportionately impacted by preventable conditions such as HIV (for a review, see Zeglin, 2015).

Although men's health problems are related to a complex interplay between biology and environment, including sociopolitical factors such as race, socioeconomic status, and other variables related to power and privilege, many gender health disparity patterns can be tied to heightened risk behaviors for men beginning in early adolescence (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, 2016; 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, Schechtman, & Fisher, 1991), violence and aggression (Moore & Stuart, 2005; Kilmartin & 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 and 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 adolescent smoking (Gunther, Bolt, Borzekowski, Liebhart, & Dillard, 2006), drinking and driving (Perkins, Linkenbach, Lewis, &

Neighbors, 2010), and college student alcohol use (Halim, Hasking, & Allen, 2012; Korcuska & Thombs, 2003). Likewise, social norms have been implicated in heterosexual and sexual minority men's condom use (Albarracín, Johnson, Fishbein, & Muellerleile, 2001; McKechnie, Bavinton, & Zablotska, 2013). The perceptions of other men are also associated with men's seat belt use, fighting, seeking out social support, getting an annual physical exam, using tobacco, exercising, and dietary choices (Hammond, Matthews, Mohottige, Agyemany, & Corbie-Smith, 2010; Mahalik & Burns, 2011). 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 (Hammond et al., 2010; Mahalik & Burns, 2011). 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.

In addition to social norms that impact most men's health behaviors, the health challenges for men from historically marginalized groups (e.g., men of color, men with disabilities, gay and bisexual men, transgender men) are long rooted in sociopolitical (e.g., the unequal distribution of power), sociohistorical (e.g., biased and inaccurate histories of peoples), and sociostructural (e.g., legal, education, and economic systems) forces that oppress and stigmatize individuals (Jones, Crump, & Lloyd, 2012; Liu & Ali, 2005). Men and boys of color suffer from higher rates of HIV, cancers, heart disease, cerebrovascular disease, diabetes, and other health conditions compared to their White counterparts (for a review, see Jones et al., 2012). 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 the health of men of color as well as those who live in poverty (Liu & Concepcion, 2010; Takeuchi, Alegria, Jackson, & Williams, 2007). For

instance, investigators have found evidence that being exposed to chronic stress due to poverty or other systemic factors is directly related to poor health behaviors (e.g., smoking, alcohol use, drug use, overeating), possibly as potential coping mechanisms for poverty-related stress (Jackson & Knight, 2006). Transgender and gender-nonconforming individuals also typically face hardships in accessing competent care (Dickey, 2017), including discomfort revealing their gender history to their medical providers, which may be critical to the care they are seeking. For instance, if a gender-diverse person needs to be catheterized, it would be important to discuss one's urinary tract configuration.

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., 2009; Hammer et al., 2013).

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 self-acceptance, fostering a positive identity, 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, anxiety), psychologists recognize that these discrepancies may be due in part to gender role socialization (Addis, 2008), 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 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 (Lynch & Kilmartin, 2013; Rabinowitz & Cochran, 2008), for instance, many men may believe that depression is abnormal or associated with a character flaw. These concerns underscore the importance of public information campaigns highlighting the fact that depression is a normative 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.

To best accomplish the aforementioned health-related goals for boys and men, psychologists recognize the importance of and need for interdisciplinary collaboration (Jones et al., 2012). Health disparities represent a complex interplay between biological and environmental factors. Accordingly, reaching out to medical, public health, and allied health professions is critical.

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, 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). Mental health difficulties of sexual and gender minority men are frequently related to masculine identity. For example, one national sample found gender nonconformity associated with experiences of discrimination (Miller & Grollman, 2015). Access to transgender- and sexual-minority-affirmative care is critical to resolution of these problems, though adherence to traditional masculinity is associated with reluctance to seek psychological help (Yousaf, Popat, & Hunter, 2015).

Researchers have identified normative practices in therapy that can be iatrogenic for men (Mahalik et al., 2012). On one end of the spectrum, 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). On the other end of the spectrum, therapists can sometimes make harmful assumptions that men are unable to express emotions or are hypersexual or aggressive (Mahalik et al., 2012). Likewise, in the realm of assessment, practitioners can struggle with diagnosing depression in boys and men because symptoms may not conform to traditional DSM criteria (Addis, 2008; McDermott et al., 2016). For example, psychologists may not interpret acting out or externalizing behaviors such as aggression, addiction, and substance

abuse as potentially masking depression (Lynch & Kilmartin, 2013). However, it is not unusual for some men to understate mental health problems (Paulson & Bazemore, 2010). Normative male interpersonal behavior can, but does not always, 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). Additionally, 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 et al., 2008). Evidence also suggests that medication may be relied upon over psychological interventions with boys, especially in relationship to ADHD diagnoses (Kapalka, 2008).

Clinicians may also assume that masculinity is not a significant topic for gay and bisexual men. However, internalized heterosexism dramatically shapes masculine identity, due in part to the importance of gay and bisexual men of appearing heteronormative. For instance, gay men rated masculine gay men as significantly more likeable than feminine gay men (Skidmore et al., 2006) and, on average, wished to be more masculine than they perceived themselves to be (Sánchez, Vilain, Westefeld, & Liu, 2010). This may lead gay men to be extremely conscious about masculinity and inhibit emotional disclosure (Elder, Morrow, & Brooks, 2015; Haldeman, 2006; Sánchez & Vilain, 2012).

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 (Brooks & Good, 2005; Englar-Carlson, Evans, & Duffey, 2014; Englar-Carlson & Stevens, 2006; Kiselica et al., 2008; Pollack & Levant, 1998; Rabinowitz & Cochran, 2002; Rochlen & Rabinowitz, 2014; for a com-

plete list of clinical resources for working with boys and men, see division51.net). Psychologists also may strive to identify ways that psychological services can be more adaptive to the ways men have been socialized (Englar-Carlson, 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, nontraditional forums more congruent with masculine socialization (e.g., psychoeducational classes in work settings) (Addis & Mahalik, 2003).

Affirmative couples and family therapy can be utilized to assist family systems in exploring gendered values and the impact traditional masculine roles have on gender and sexual minority individuals. Clinicians can be instrumental in expanding masculine norms to help facilitate a more positive, affirming relational system that improves mental health outcomes for sexual and gender minority persons (Olson et al., 2016; Ryan et al., 2010). Couple and family therapy can facilitate discussions of how multiple identities work together, why some identities are more salient than others, and how various identities are enacted in different spaces (Budge, Thai, Tebbe, & Howard, 2016).

For boys and adolescents, shorter sessions, informal settings outside the office (e.g., playground), instrumental activities, using humor and self-disclosure, and psychoeducational groups may provide more congruent environments than traditional psychotherapy (Kiselica, Englar-Carlson, & Horne, 2008). 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 or retirement transition problems and the impact of those problems on

their self-esteem and mental health (Herr, Cramer, & Niles, 2003; J.B. James et al., 2016; Romo, Bellamy & Coleman, 2004). Psychologists are encouraged to advocate for public policy that supports and enhances teenage boys’ career prospects, especially in settings where there may not be a variety of career prospects (e.g., low socioeconomic status communities). 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 underemployment 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 settings 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 also 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). Additionally, psychologists are aware of the connections between mental health stigma and traditional masculinity ideologies, which may influence men’s responses to traditionally stigmatized mental health problems (e.g., depression, anxiety). Psychologists also strive to reduce mental health stigma for men by acknowledging and challenging socialized messages related to men’s mental health stigma (e.g., male stoicism, self-reliance).

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). Gender self-awareness may help psychologists recognize when they may be framing a psychological problem from

a gendered lens. For instance, psychologists may overlook or discount important problems in men (e.g., depression, body image concerns) because those issues have historically been a focus among women. Thus, psychologists strive to recognize the relational style of many men and adapt by substituting other terms for psychotherapy such as consultation, meeting, coaching, or discussion; using less jargon; being more active and directive; and matching relational style to the client's needs (Englar-Carlson, 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 and straightforward cognitive interventions 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. Native American men are imprisoned at more than 4 times the rate of White men. These racial, ethnic,

and gender disparities may be the result of racial, ethnic, and gender stereotypes. Indeed, compared to White and higher income men, African American, Latino, and Native American men and low income men are more likely to be detained by law enforcement (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 (e.g., possession of marijuana or crack cocaine) than White men (Felner, 2009), even though they are less likely to use illegal drugs (Wu, Woody, Yang, Pan, & Blazer, 2011). Another population of focus due to social and political implications is undocumented boys and men, who are overrepresented in federal detention facilities (Carlson & Gallagher, 2015). For these males, the accumulation of risk factors (e.g., psychological, familial, socioeconomic, environmental), co-occurring within multiple contexts (i.e., dislocation from one's community, probability of physical and psychological trauma during the immigration journey and at border crossings, unpredictable reception and insecurity in detention centers) often negatively impact their lifespan development (Arbona et al., 2014; Henderson, & Bailey, 2013; McLeigh, 2010; Suarez-Orozco et al., 2011). Such institutional inequalities have a profound impact on the mental and physical health of minority men (Jones et al., 2012).

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 Behavior 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 past 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 myriad psychological problems for men (Randle & Graham, 2011). In addition, male victims of intimate partner violence (Randle & Graham, 2011) experience significant barriers to finding help because the domestic violence system has historically focused on helping battered women (Douglas & Hines, 2011). Likewise, men who have experienced sexual abuse from women or men may face significant personal and professional barriers to seeking help (Allen, Ridgeway, & Swan, 2015).

Housing is also a significant area of gender discrimination. Reports demonstrate that 20% of transgender people have experienced housing discrimination, another 20% have experienced homelessness, and 10% have been evicted specifically for their gender identity at some point throughout the lifespan (National Center for Transgender Equality, 2015b). Research has demonstrated the link between housing access and better health outcomes, including less sexual risk-taking (Sevelius, Reznick, Hart, & Schwartz, 2009), decreased intravenous drug use (Fletcher,

Kisler, & Reback, 2014), and reduced odds of suicide attempts (Marshall et al., 2016).

Application

Psychologists strive to disseminate research findings to legislators and policymakers to inform public health policies and funding for research, prevention, and intervention efforts that can enhance the lives of boys, men, and their families. 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, accessible housing, 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 women.

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 policymakers. 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, ability, 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). Such research may attend to the complexities of gender minority people's multicultural identities (APA, 2015; Singh, Hwahng, Chang, & White, 2017), and provide insight into mental health outcomes for those facing multiple layers of oppression (Budge et al., 2016).

EXPIRATION

This document will expire as APA policy in 10 years (2028). Correspondence regarding the 2018 Guidelines for Psychological Practice with Boys and Men should be addressed to the American Psychological Association, Practice Directorate, 750 First Street, NE, Washington, 20002-4242.

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