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Twelve reasons to take a more balanced view of issues that confront men: Editorial for a special issue on male psychology

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I'm delighted to have been invited to be the guest editor for this special issue of *Psychreg Journal of Psychology* (PJP) on male psychology. Having co-founded the *Male Psychology Network* and *Male Psychology Section* of the *British Psychological Society*, and co-edited the very popular *Palgrave Handbook of Male Psychology and Mental Health* (Barry et al.,2019), and co-author of the forthcoming book *Perspectives in Male Psychology: An introduction* (in press), it's a great pleasure to be able to bring together a collection of 12 new papers, submitted from seasoned academics and from newcomers to the field.

As an experienced researcher, it's very exciting to see so many different methodologies represented here, from cross-sectional and longitudinal, qualitative and quantitative, and from a clinical case report to a study involving 7,000 men. We also have papers from authors based in different countries, and the range of themes is exciting too. Not only are there studies focusing on mental health – something now recognised as an important issue male psychology – but also several submissions highlighting the relevance of bias against men in various ways.

If this special issue of PJP was a diagnostic test of the health of male psychology in 2020, I would be very impressed to see so many green shoots sprouting vigorously across the world. Given that male psychology only began life as a concept in 2010 when clinical psychologist Martin Seager proposed a BPS Section, and considering that the call for papers for this special issue only went out in August 2020 , it is very rewarding to see how far this field has come.

Given the replication crisis in psychology, the first paper in this special issue gives us reason to feel optimistic. It combines two surveys I conducted, firstly of 2,000 men in the UK in 2017 and a year later 5,000 men in the US. The main UK finding was that by far the best predictor of men's mental wellbeing is job satisfaction, and this was resoundingly echoed in the US sample. The public response to some media coverage of the two surveys was very positive, perhaps in part because the findings were a welcome change to the 'toxic masculinity' narrative so often found in the media. You can find out about some of the other interesting findings by reading *Job satisfaction, relationship stability and valuing one's health are the strongest predictors of men's mental wellbeing*.

The next paper is an interesting combination of clinical case studies, demonstrating how expressive writing can be a useful way of dealing with posttraumatic stress. For anyone who has ever found writing to be a therapeutic / cathartic experience, this paper makes a lot of sense. Read Dr Kevin Wright's *Effects of expressive writing on posttraumatic stress symptoms and other traumas: Case study of male clients in therapy settings.*

The paper *Loneliness, impaired well-being and partner abuse victimisation of separated fathers in Wales* is a very welcome contribution from a highly respected academic, Dr Richard Bradford. His survey highlights how men can suffer terribly from abusive relationships, even after the relationship is – on paper at least – over.

In one of the first longitudinal studies of the impact of family breakdown on men, Louise Liddon and I found that *Child contact problems and family court issues are related to chronic mental health problems for men following family breakdown***.** As with Richard Bradford's paper, this study puts a spotlight on the chronic mental turmoil that many men experience in the months and years after their family comes apart.

We are fortunate that one of the leading authorities on male childlessness – in the UK if not the world – has submitted a paper to this PJP special issue, on the question of *Male Broodiness: Does the Desire for Fatherhood Effect Men?* In his paper Dr Rob Hadley uses mixed methods to explore yet another issue that is often either overlooked or misunderstood. Rob is no stranger to male psychology, having contributed to the *Palgrave Handbook of Male Psychology and Mental Health*, and having spoken at the *Male Psychology Conference* on a number of occasions, and the forthcoming online *BPS Male Psychology Section* mini-conference on 11th December.

A paper from another contributor to the *Palgrave Handbook of Male Psychology and Mental Health*, Nathan Hook, explores an issue with far-reaching implications for the *gender empathy gap*: the question of whether there is a sex difference in in-group bias. Find out the result of his study in the enigmatically titled *Men say that he shall come again, and he shall win the holy cross: Gender differences in shared-religion bias in identifying with fictional characters.*

One of the key papers in male psychology of the past 10 years was published in 2014 in *The Psychologist* magazine, on the topic of the feminisation of therapy (Morison et al., 2014). The lead author was Dr Linda Morison, and I was very fortunate to have teamed up with Linda, along with Martin Seager, Louise Liddon and Jordan Holbrook, to produce another arguably ground-breaking paper, which concluded that *Adults are expected to take responsibility for their problems, especially when those problems are congruent with traditional gender role expectations.*

Dr James Nuzzo is an exercise scientist, and though is a relative newcomer to male psychology has recently produced several excellent papers focusing on sex differences in relation to sports and exercise. His paper in this special issue continues his research excellence and originality, discussing *Bias against men's issues within the United Nations and World Health Organization.*

Sometimes papers based on lived experience come across as overly subjective and difficult to generalise to the experiences of others. A paper on the experiences of a male mature psychology student in South Africa might at first sound as if it would fall into this category, but I challenge anyone who reads the paper by Angelo Vincenzo De Boni not to feel that you are walking in the shoes of someone whose experiences resonate with you, no matter what part of the world you are from. Vincent describes vividly how gender politics frustrate his efforts to learn about psychology, and how his own experiences make him question the prevailing gender narrative he is expected to uncritically accept. *A male perspective of psychology from the Rainbow Nation* is, in terms of methodology, one of the most modest papers in this special issue of PJP, but nonetheless it is one of the most powerful.

One of the most downloaded chapters of the *Palgrave Handbook of Male Psychology and Mental Health* was on gamma bias (Seager & Barry, 2019). This concept resonated with many people – as shown by the number of views of our animation on the topic (Male Psychology Network, 2019) – as a coherent and comprehensive explanation for the types of gender biases that we see all around us. Gamma bias joined to the two gender biases already recognised (alpha bias, beta bias), and delta bias is a new addition. Although much more specific than gamma bias, it highlights an issue that many people will recognise, for example, in relation to workplace gender equality quotas and programmes. Find out about *Delta bias in how we celebrate gender-typical traits and behaviours* by Martin Seager and myself.

Given the relatively low uptake of men to therapy, the question of how to make therapy more male-friendly has one that has received much attention in the Male Psychology Network, and our work so far on sex differences in preferences (Liddon et al., 2018) for therapy has attracted a lot of interest. Our new survey examining how therapists view masculinity in therapy has yielded findings that are so interesting we thought that it would be helpful to share our preliminary findings from the initial participants (we are still recruiting at the time of writing) in this special issue of the *PJP*. If you have ever wondered *How much*

are therapists' views on patriarchy related to their approach to therapy for men, you can find out in this special issue. If you want to find out more, Louise Liddon and I write about this topic in our new book *Perspectives in Male Psychology: An Introduction* (in press).

The issue of therapy for men is a hot topic, especially since there now exist guidelines that suggest taking a view of men that is, in part, influenced by patriarchy theory. One clinical psychologist in the US felt so impassioned about this issue he has written an open letter to the *American Psychological Association* (APA) asking them to reconsider their position: *'An open message to the APA on ethics and ideology'*. We think Dr Shawn Smith's letter, in calling psychologists to make therapy for men more male-friendly, is a fitting conclusion to this *PJP* special issue on male psychology.

There is little else to say, other than I hope you enjoy the diversity of the 12 papers in this special issue, and I hope they might inspire you to reflect in new ways on male psychology.

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Job satisfaction, relationship stability, and valuing one's health are the strongest predictors of men's mental well-being

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In recent years, psychologists have applied some of the ideas from positive psychology to the study of masculinity to discover what factors contribute to men's mental health. This line of research acts as a counterbalance to other research which focuses mainly on problems related to masculinity. This paper describes two surveys – one of 2,000 men in the UK in 2017, and another of 5,000 men in the US in 2018 – which assessed core values and well-being. The main outcome measured was mental well-being, using the Positive Mindset Index (PMI). The surveys were conducted online and were analysed using multiple linear regression. Both surveys found that men typically aspire to moral values such as honesty and reliability more than physical values such as fitness and being athletic. In both surveys, taking other variables into account, the strongest predictor by far of mental positivity was job satisfaction (β = 0.49, p < .0000000001 in the UK, and β = 0.35, p <. 01^{-85} in the US). Relationship stability was the second strongest predictor of PMI in the UK (β = 0.12, p < .000000001) and marriage was the fifth strongest predictor in the US (β = 0.07, p < .0005). Valuing one's health was another strong predictor of PMI in both surveys (β = 0.12, p < .000006 in the UK, and β = 0.17, p <.02^{-9} in the US). Findings are discussed concerning our understanding of men's mental health needs. The contrast to the fashionably negative view of masculinity in the media and social sciences is noted.

Keywords: job satisfaction; masculinity; positive psychology; relationship; well-being

In recent years, masculinity has become a somewhat tarnished term. The term 'toxic masculinity' has become common in the media, and other negative views about masculinity are expressed in popular culture and social sciences with apparently little regard for the potentially harmful influence of this narrative on boys and men (Barry et al., 2020). Even within psychology, there has developed recently a somewhat negative view of men. The 'New Psychology of Men', a movement started in the US in the 1990s, developed questionnaires that defined masculinity differently, constructing it in a way which included attitudes such as misogyny and homophobia (Mahalik et al., 2003). In the past two decades, a large number of surveys have used variations on this new construct of masculinity, claiming to confirm the various ways in which masculinity is problematic. However this approach has not been without criticism, and there are calls to have a more positive and realistic view of men and masculinity (Seager & Barry, 2019). This view draws upon another movement in psychology that began in the US in the 1990s – the positive psychology movement – from which valuable lessons can be applied to masculinity research. This Positive Psychology/Positive Masculinity (PPPM) model (Kiselica & Englar-Carlson, 2010), suggests that male-typical traits can be helpful and can be harnessed to enhance mental health.

A basic issue about the new psychology of men is that it imposes a negative construct of masculinity upon men rather than allowing men to demonstrate what masculinity is like for themselves. In contrast, the research described in the present paper was a result of the question 'what are men like in the UK and US today?' It aimed to find answers to this by casting a wide net in terms of exploring a range of aspects of life. So, as well as asking how much men identify with various core values (such as courage and competitiveness), questions asked about a range of aspects of life, from work to family to spirituality, and included room for free-text responses. Therefore, the two studies described in this paper are exploratory and aimed to allow participants to express themselves without overly imposing preconceptions of masculinity on them.

The first study was conducted in the UK, followed by a study in the US. The second study was modified a little, adding some background questions (e.g., sexuality) and slightly modifying one or two of the other questions. The original reports, including full questionnaires, are available online (Barry & Daubney, 2017; Barry, 2018).

This paper presents the surveys chronologically, first with the methods and results sections for the UK sample (Study 1), followed by the methods and results in sections for the US sample (Study 2). After that, the discussion section combines the findings from the two surveys. The full survey questions have been published previously (Barry & Daubney, 2017; Barry, 2018).

Study 1: UK sample

METHODS

Design

This study is a cross-sectional online survey analysed using multiple linear regression. Demographic variables were used as predictors. The dependent variables were mental positivity and ratings of values.

Variables

Core values. The degree to which participants aspired to values in their daily life, such as dependability, reliability, was assessed (see list of values in appendix).

Dependent variable. The dependent variable in this study is mental positivity, measured using The Positive Mindset Index (PMI).

The Positive Mindset Index (PMI). The PMI consists of six items (happiness, confidence, being in control, emotional stability, motivation, and optimism), and uses a five-point Likert scale. This scale shows good internal reliability (Cronbach's alpha = 0.926) and good concurrent validity a range of other validated instruments measuring constructs such as *psychological health* (r = .678); *suicidality* (r = –.539); *happiness* (r = .689); and *self-esteem* (r = .766) (Male Psychology Network, 2020).

Free text responses. This includes answers expressed in the respondent's own words.

Predictor variables

> Age. Age was measured in years, and categorised into age groups (18–29, 30–39, 40–49, 50–59, 60–85) for some analyses.
>
> Job satisfaction. Job satisfaction was assessed with a single item (as advocated by (Wanous et al., 1997), on a six-point Likert scale: How satisfied are you with your job? [6 = highly satisfied… 1 = highly dissatisfied].
>
> Relationship status. Relationship status was operationalised by putting participants into two categories: those who were married, in a civil partnership, cohabiting or in a steady relationship (coded as 1) and those who were divorced, widowed, separated, or single (coded as 0).

Values. Eight domains, each with around seven items, were created by the research team for this study: work, friendships, romantic relationships, family, sport and leisure activities, health, community, and education. Each domain was described by several items, for example, the *sport and leisure activities* domain asked how important winning, fun, feeling healthy etc. were to participants. Answers were on a six-point Likert scale from 'very unimportant' to 'very important'.

Setting

The setting was online.

Participants

Participants were recruited via various websites, including the *Men's Health Forum*, *Psychology on The Net*, and *MensMindsMatter*, and also social media. An invitation to participate in the study was posted on each participating site. To ensure the broad UK reach across all demographics, the survey was also promoted by Martin Daubney via articles written for *Telegraph Men*, and *The Round Table* newsletter/website; the *Fathers 4 Justice* website, Facebook page/newsletter plus radio interviews conducted by Martin Daubney on Talkradio and Talksport.

Exclusion criteria

Not giving key information e.g., age, gender; being under 18; not completing the consent form.

Sample size

Based on the sample size calculations for multiple linear regression described in (Tabachnick et al., 2007) it was decided that at least 400 cases were needed for sufficient statistical power.

Procedure

A notice regarding the survey appeared on participating websites and the social media of the research and his associates in the *Male Psychology Network*. The questionnaire survey is shown. The survey data was collected using UCL's RedCap survey software.

Ethics

Informed consent was given before the survey could be started. Participants were informed that they could withdraw from the study at any point. Participants were not required to give any identifying information, such as contact details. Data were treated following the Data Protection Action (1998). Contact details for support are given in the patient information section of the survey, for any participants who may become upset due to reading the survey questions. Ethical approval for the study

was granted by University College London's Graduate School Research Ethics Committee (REC reference: 4075/013).

Statistics

Means and *SD*s and parametric tests were used where relevant assumptions were met. Missing data were deleted pairwise so that where a participant gave some information but had not given responses to all items, data for the responses they gave could be included in the analysis. The predictors of mental positivity were identified using the enter method with multiple linear regression. To reduce the chance of a type 1 error due to multiple testing, the threshold for significance was set at $p <. 01$. All statistical tests were two-tailed. All statistical analyses were carried out using SPSS statistical software for Windows, Version 22.

RESULTS

The survey ran between May and September 2018, until the sample quota was reached. The final sample consisted of 2,000 men born or a resident in the British Isles (Table 2). The mean (*SD*) age of the sample was 41.9 (15.2) years old. Table 2 shows that the most usual location of participants was London (20.3%). 45% of the men were married (Table 3). 38% of the men were fathers. The mean (*SD*) number of children was 1.2 (1.3). 89% stated their ethnicity; 93% were White, 3% were Black, Asian, or Chinese, and the rest were 'other'.

Table 1
Age Group of the Participants

Age group	% of sample
18–29	22.6
30–39	22.9
40–49	24.8
50–59	19.2
60–85	10.4

Table 2
Location in the UK of the Participants

Location	% of sample
South East England	16.2
London	20.3
North West England	9.9
East of England	10.0
West Midlands	5.7
South West England	8.2
Yorkshire and the Humber	7.1
East Midlands	7.1
North East England	3.3
Scotland	6.6
Wales	3.2
Ireland	2.5

Table 3
The Relationship Status of the Participants

Relationship status	% of sample
Single	29.6
Divorced, widowed, separated, etc.	7.6
Cohabiting or in relationship	17.4
Married or civil partnership	45.4

Value system

Participants were presented with a list of 35 values (e.g., *loyalty*, *honesty*, etc) and asked how important to them each were on a scale from 1 to 6, where 6 indicates 'very important'. Table 4 shows the five values that were considered most important and five considered least important.

Table 4
The Five Values Considered Most Important and Least Important

Rank	Values	*M*	*SD*
1	Honesty	5.3	1.0
2	Reliability	5.3	1.0
3	Dependability	5.3	1.0
4	Loyalty	5.3	1.0
5	Commitment	5.0	1.0
~			
31	Fitness	4.1	1.1
32	Collaboration	4.1	1.2
33	Creativity	4.0	1.2
34	Adventurousness	3.9	1.6
35	Athleticism	3.7	1.3

Regional differences in positivity

Table 5 shows regional variation in mental positivity, whereby positivity was lowest in North East England (3.24) and highest in South West England (3.50)

Table 5
Regional Differences in Mental Positivity, After Taking Age, Relationship Status, and Parental Status into Account

Location	*M*	*SD*
South East England	3.49	.68
London	3.39	.68
North West England	3.39	.75
East of England	3.48	.73
West Midlands	3.49	.75
South West England	3.50	.70
Yorkshire and the Humber	3.44	.68
East Midlands	3.44	.68
North East England	3.24	.74
Scotland	3.34	.67
Wales	3.30	.71
Ireland	3.34	.85

Table 6a
Mental Health: Importance to Men of Different Ages

	Age group				
	18–29	30–39	40–49	50–59	60–85
Very unimportant	2.0%	1.3%	0.8%	1.8%	1.0%
Unimportant	2.0%	2.0%	2.4%	0.8%	1.5%
Slightly unimportant	4.7%	3.5%	3.8%	2.4%	2.0%
Slightly important	13.2%	13.2%	9.9%	10.8%	9.4%
Important	31.9%	37.7%	37.2%	39.3%	43.3%
Very important	46.2%	42.3%	45.9%	44.9%	42.9%

Table 6b
Physical Health: Importance to Men of Different Ages

	Age group				
	18–29	30–39	40–49	50–59	60–85
Very unimportant	1.6%	0.4%	0.4%	0.8%	0.0%
Unimportant	1.6%	1.5%	0.6%	1.1%	0.5%
Slightly unimportant	2.9%	3.7%	4.7%	2.1%	2.5%
Slightly important	18.5%	19.6%	14.8%	16.3%	12.4%
Important	43.4%	45.4%	43.9%	43.2%	44.6%
Very important	32.1%	29.3%	35.6%	36.6%	40.1%

Values and demographics as predictors of mental positivity

Table 7 shows that the strongest predictor of mental positivity is *job satisfaction*. *Romance* showed the weakest relationship with mental positivity.

Table 7
Demographic and Value-Related Predictors of Mental Positivity in Men

Predictor	β	*t*
Age	.05	2.66**
Job satisfaction	.49	24.69*********
Relationship status	.12	6.01********
Work	.05	1.78
Friendships	.01	.41
Romance	.00	.07
Family	.07	3.08***
Personal growth	.09	4.00****
Sport & Leisure	.07	3.11**
Health	.12	4.71*****
Community	.02	.76
Education	.02	.76

* $p < .01$, ** $p < .001$, *** $p < .0001$, **** $p < .00001$, ****** $p < .0000001$ (two-tailed)

The above findings show that men's mental positivity is strongly related to *job satisfaction*, *relationship status* (having a long-term relationship rather than being single), *valuing health*, *valuing personal growth*, and *valuing family*.

The impact of core value domains on mental positivity

Taking the value domains that proved to be significant in the previous table, using multiple linear regression, the factors within each domain were assessed for their impact on mental positivity, after considering the effect of age and marital status.

Table 8 shows that of the values related to *sport and leisure*, after considering the effect of age and marital status, the strongest predictor of mental positivity is feeling healthy.

Table 8
Demographic and Value-Related Predictors of Mental Positivity in Men

Predictor	β	*t*
Feeling healthy	.14	4.98******
Competition	.12	3.30****
Socialising	.07	2.67**

* $p < .01$ ** $p < .001$, *** $p < .0001$, **** $p < .00001$, (two-tailed)

Table 9 shows that of the values related to Health, after considering the effect of age and marital status, the strongest predictor of mental positivity is *living longer*.

Table 9
Values Related to Health Which Predict Mental Positivity

Predictor	β	*t*
Living longer	.15	5.55******
Mental health	.35	4.61*****
Physical health	.13	3.80****
Feeling good	.08	2.60**

* $p < .01$ ** $p < .001$, *** $p < .0001$, **** $p < .00001$, (two-tailed)

Table 10 shows that of the values related to Personal growth, after considering the effect of age and marital status, the strongest predictor of mental positivity is *feeling more fully 'me'*.

Table 10
Values Related to Personal Growth Which Predict Mental Positivity

Predictor	β	*t*
Feeling more fully 'me'	.12	4.12****
Religious observance	.11	3.91****
Being the 'real me'	.12	3.90****

* $p < .01$ ** $p < .001$, *** $p < .0001$, **** $p < .00001$, (two-tailed)

Table 11 shows that of the values related to Work, after considering the effect of age and marital status, the strongest predictor of mental positivity is *making an impact on business success*.

Table 11
Values Related to Work Which Predict Mental Positivity

Predictor	β	*t*
Making an impact on business success	.22	8.50**********
Feeling inspired by workmates	.08	2.71**
Chat with workmates	.07	2.62**

* $p < .01$ ** $p < .001$, *** $p < .0001$, **** $p < .00001$, (two-tailed)

Table 12 shows that of the values related to *family*, the strongest predictor of mental positivity is *being like my father*.

Table 12
Values Related to Family Which Predict Mental Positivity

Predictor	β	*t*
Being like my father	.08	2.84**

* $p < .01$ ** $p < .001$, *** $p < .0001$, **** $p < .00001$, (two-tailed)

Study 2: US sample

METHODS

Design

Same details in Study 1, above.

Variables

Core values. See Study 1 above.

Dependent variable. The dependent variable in this study is mental positivity, measured using the Positive Mindset Index (PMI). See details in Study 1, above.

Free text responses. Answers expressed in the respondent's own words.

Predictor variables

US Region. All of the US, or individual census regions (Northeast, Midwest, South, or West).

Population density. Living in either a city, suburb or rural environment.

Ethnicity. Chosen from a list (see Table 13).
Age. Age was measured in years, and categorised into age groups (18–29, 30–39, 40–49, 50–59, 60–95) for some analyses.

Gender. There were three options: male, female-to-male transsexual, or non-binary.

Sexual orientation. There were three options: heterosexual or straight; gay; or bisexual. The second two categories were combined in most analyses.

Relationship status. Relationship status was operationalised by putting participants into two categories: those who were married (coded as 1) compared to those who were single or in any other type of relationship e.g., in a civil partnership, cohabiting or steady relationship, divorced, widowed, separated, or single (coded as 0).

Parent status. The number of children was given and coded into 1 = has one or more children; 0 = has no children.

Political affiliation. Several options were given (see Table 1).

Military service. Several options were given (see Table 1). These were coded into: 1 = 'active duty now or in the past', or 0 = 'basic training only, or no training'.

Employment status. The options are shown in Table 1. These were dummy coded with 1 = 'working full-time' as the reference category, and others coded as 0.

Educational level. The options are shown in Table 1, and analysed as ordinal data.

Value domains. Details in Study 1, above.

Job satisfaction. Details in Study 1, above.

Setting

The setting was online.

Participants

Participants were men aged over 18. They were recruited from a panel of 3.1 million people across the US by *Toluna*, a professional data collection company with a professional membership and code of ethics. A quota sample of men and women, stratified by US region, was taken.

Exclusion criteria

Not completing the consent form; not meeting age and gender criteria; not living in the US.

Sample size calculation

Details are the same as in Study 1, above.

Procedure

During September 2018, potential participants who met the inclusion criteria for this study were identified from the panel. These people were contacted, and the study runs until our quota was reached. Recruitment was completed in eleven days. The survey data was collected using SurveyGizmo survey software.

Ethics

Details in Study 1, above. As is usual when panel members complete a survey, participants were paid a small fee for participation. Ethical approval for the study was granted by University College London's Department of Psychology Ethics Committee (REC reference: CEHP/2017/562).

Statistics

Details in Study 1, above.

RESULTS

The final sample consisted of 5,000 people in the US who identified as male. Their demographic characteristics are shown in Table 13.

Table 13
Descriptive Statistics for the whole US Sample (N = 5,000)

		M (*SD*) or *N* (%)
Region	Northeast	857 (17.1%)
	Midwest	1,085 (21.7%)
	South	1,827 (36.5%)
	West	1,133 (22.7%)
	Not stated	98 (2%)
Population density	City	1,818 (36.4%)
	Suburb	2,182 (43.6%)
	Rural	1,000 (20.0%)
Ethnicity	White	3,856 (77.1%)
	Black or African-American	476 (9.5%)
	Hispanic	288 (5.8 %)
	Asian	193 (3.9%)
	Native American	42 (0.8%)
	Native Hawaiian	5 (0.1%)
	Mixed	95 (1.9%)
	Other	45 (0.9%)
Age		33.23 (17.2)
Gender	Male	7,976 (99.5%)
	Female-to-male transexual	10 (0.2%)
	Non-binary	14 (0.3%)
Sexual orientation	Heterosexual	4,436 (89%)
	Homosexual	564 (11%)
Relationship status	Single	1,492 (29.8%)
	In a relationship but not living together	143 (2.9%)
	Living with a partner	319 (6.4%)
	Married	2,462 (49.2%)
	Divorced	432 (8.6%)
	Widowed	152 (3.0%)
Children		1.1 (1.5)
Politics	Democrat	1,530 (30.6%)
	Republican	1,698 (34.0%)
	Independent	1,279 (25.6%)
	Other – write in	77 (1.5%)
	No party represents my views	416 (8.3%)

Table 13 (continued)

		M (*SD*) or *N* (%)
Military service	Active duty in the past	1,045 (20.9%)
	Now on active duty	94 (1.9%)
	No active duty except for initial/basic training	178 (3.6%)
	Never served in the US or other armed forces	3,683 (73.7%)
Employment	Employed full-time	2,241 (49%)
	Employed part-time	542 (11%)
	Retired	1,409 (28%)
	Student	177 (3.5%)
	Homemaker	75 (1.5%)
	Unemployed	470 (9.4%)
Education	High school or less	1,013 (20%)
	Some college	1,368 (27%)
	Completed college	1,225 (25%)
	Some graduate school	251 (5%)
	Graduate school	1,101 (22%)
Income	Under $24,999	953 (19%)
	$25,000 – $49,999	1,260 (25%)
	$50,000 – $74,999	927 (19%)
	$75,000 – $99,999	622 (12%)
	$100,000 – $124,999	340 (7%)
	$125,000 – $149,999	289 (6%)
	$150,000 – $199,999	241 (5%)
	$200,000 or more	209 (4%)
PMI		3.72 (0.80)

The demographics in Table 13 suggest that the sample are a fairly typical cross-section of men in the US.

Value system

Participants were presented with a list of 35 values (e.g. loyalty, honesty, etc.) and asked how important to them each were on a scale from 1 to 6, where 6 indicates ‘very important’. Table 14 shows the ranking of importance of these values.

Table 14
Core Values, in Order of Most Aspired to

Values	*M*	*SD*
Honest	5.40	1.0
Reliable	5.29	1.0
Dependable	5.24	1.0
Respectful	5.21	1.0
Loyal	5.18	1.0
Listening	5.03	1.0
Loving	5.01	1.0
Thoughtful	5.01	1.0
Committed	4.99	1.0
Positive	4.96	1.1
Consistent	4.93	1.0
Educated	4.90	1.1
Openminded	4.89	1.1
Efficient	4.87	1.0
Respected	4.85	1.1
Equality	4.84	1.1
Humble	4.83	1.1
Motivated	4.80	1.1
Empathetic	4.78	1.1
Quiet Confidence	4.77	1.0
Optimism	4.76	1.2
Improvement	4.75	1.0
Humorous	4.69	1.2
Fun loving	4.65	1.1
Passionate	4.65	1.1
Future facing	4.64	1.1
Courageous	4.58	1.1
Creative	4.55	1.2
Nurturing	4.50	1.2
Collaborative	4.50	1.1
Inspiring	4.48	1.2
Innovative	4.44	1.2
Fit	4.39	1.2
Adventurous	4.25	1.3
Athletic	3.89	1.4

Regional differences in positivity

Table 15 shows regional variation in mental positivity. Positivity was similar across the US.

Table 15
Regional Differences in Mental Positivity Across the four US Regions

Regions	PMI	*SD*	*N*
Northeast	3.7830	.81333	857
Midwest	3.7259	.80181	1085
South	3.7342	.76003	1827
West	3.6648	.80647	1133
Total	3.7248	.79034	4902

Relationship between age and the importance of physical versus mental health

Tables 16a and 16b & show that men value their mental health more than their physical health.

Table 16a
Mental Health: Importance to Men of Different Ages

	Age group				
	18–29	30–39	40–49	50–59	60–95
Very unimportant	1.8%	1.7%	1.7%	1.5%	0.6%
Unimportant	1.8%	1.5%	1.4%	0.1%	1.0%
Slightly unimportant	4.2%	3.6%	2.9%	3.0%	1.4%
Slightly important	15.5%	11.6%	11.3%	9.6%	8.3%
Important	27.5%	27.2%	32.5%	34.0%	34.0%
Very important	49.2%	54.4%	50.1%	51.0%	55.6%

Table 16b
Physical Health: Importance to Men of Different Ages

	Age group				
	18–29	30–39	40–49	50–59	60–95
Very unimportant	1.9%	1.8%	1.7%	1.4%	0.5%
Unimportant	2.0%	1.0%	1.0%	1.2%	0.4%
Slightly unimportant	5.2%	2.8%	3.6%	2.9%	1.5%
Slightly important	17.7%	15.5%	13.1%	14.9%	13.8%
Important	32.2%	34.3%	35.4%	37.7%	40.4%
Very important	41.0%	44.5%	45.1%	41.9%	43.5%

Table 17a

Predictors of PMI in the Total US Sample (*N = 5,000), Controlling for All Other Variables*

Rank	Variable	β	*t*	Sig.*	Interpretation: 'Independent of other variables…'
1	Job satisfaction (Employed only)	.354	21.129	.0001	men who have more job satisfaction have more well-being
2	Health	.165	6.521	.0001	men who value health have greater well-being
3	Income	.089	4.575	.0001	men who have a higher income have greater well-being
4	Over age 50 vs others	.077	4.170	.0001	men who are aged over 50 have greater well-being
5	Married vs others	.066	3.504	.0001	men who are married have greater well-being than others
6	Sport and leisure	.077	3.318	.001	men who value sports & leisure have greater well-being
7	Military service vs basic or no training	.042	2.698	.007	those who have served in military have greater well-being
The following are below the p < cutoff					
8	Personal growth	.059	2.352	.019	men who value personal growth have greater well-being
9	Friendships	.059	2.341	.019	men who value friendship have greater well-being
10	Family	.058	2.339	.019	men who value family have greater well-being
11	Republicans vs others	.041	2.330	.020	men who support the Republican party have greater well-being than others
12	Education	.055	2.249	.025	men who value education have greater wellbeing
13	Employed full-time vs others	.039	2.019	.044	men who are employed full-time have greater well-being
14	Educational level	.034	2.002	.045	men who have more education have greater well-being
The following are non-significant (p> . 05					
15	City vs rural or suburb	.030	1.920	.055	population density makes no difference to well-being
16	Employed part-time vs others	.030	1.809	.071	being employed part time makes no difference to well-being
17	Homemaker vs others	.021	1.274	.203	being a homemaker has no impact on well-being in men
18	Work	.027	1.208	.227	valuing work has no impact on well-being in men
19	White vs other ethnicities	-.017	-1.062	.288	ethnicity has no impact on wellbeing in men
20	Heterosexual vs gay / bisexual	.014	.901	.368	sexual orientation has no impact on well-being
21	Community	.019	.817	.414	valuing community has no impact on well-being
22	Parental status	.009	.541	.588	being a parent has no impact on well-being
23	Romance	-.009	-.328	.743	valuing romance has no impact on well-being
24	Democrats vs others	-.002	-.094	.925	supporting the Democrats has no impact on well-being

NB: To save space, *p* values are capped at .0001

Table 17a shows that the strongest predictors of men's mental positivity were job satisfaction, valuing health, income, age (being over 50), and relationship status (being married).

Table 18 is similar to Table 17a, but additionally shows the predictors of PMI for each US Region (Table 17b).

Table 17
Top 5 Predictors of PMI in the Total US Sample and the Four US Regions (Controlling for All Other Variables) and UK

USA; All (*N* = 5,000 – 2,887)	*t*	Northeast (*n* = 857 – 529)	*t*	Midwest (*n* = 1,085 – 634)	*t*	South (*n* = 1,827 – 1042)	*t*	West (*n* = 1,133 – 627)	*t*	UK (*N* = 1,815 – 2,000)
Job Satisfaction	21.129	Job Satisfaction	8.181	Job Satisfaction	10.950	Job Satisfaction	9.821	Job Satisfaction	12.783	Job Satisfaction
Health	6.521	Health	2.547	Aged over_50	3.917	Health	3.909	Health	3.243	Relationship stability
Income	4.575	*[Sport & Leisure]*	*1.864*	Health	2.835	Sport & Leisure	3.339	Friendship	2.975	Health
Aged over_50	4.170	*[Family]*	*1.411*	Income	2.217	Income	2.546	Income	2.438	Family
Marriage	3.504	*[Educational level]*	*1.380*	*[Military Service]*	*1.780*	Married	2.384	Aged over_50	2.029	Older age

Note: the variables in italics/square brackets are statistically non-significant at p<.05.
Note: N=5000 for 'USA - All'. For the Regional analyses, N=4902 (n=98 did not state their region), and n=2887 for the Job Satisfaction variable after removal of those who did not currently have a job, said they were unemployed, or retired.

In common with the whole of the US, the main predictors in each US Region are *job satisfaction*, *health*, and *income*.

Table 18
Which Aspects of Work Values Were the Strongest Predictor of Job Satisfaction in the Four Regions? (Those with Jobs Only, Not Controlling for Other Variables)

USA – All (*N* = 2,887)	*t*	Northeast (*n* = 529)	*t*	Midwest (*n* = 634)	*t*	South (*n* = 1,042)	*t*	West (*n* = 627)	*t*
Make an impact on company's success	7.414	Good pay	4.271	Using own unique talents	3.601	Make an impact on company's success	5.772	Having a diverse set of perspectives	2.342
Good pay	6.118	Make an impact on company's success	3.813	Chat with co-workers	2.873	Good pay	3.524	Feeling inspired by those around you	2.312
Chat with co-workers	4.820	Chat with co-workers	3.096	Continued learning	2.657	Having my opinion valued	2.379	Make an impact on company's success	2.272
Using own unique talents	3.297	Having my opinion valued	2.200	Make an impact on company's success	2.627	Promotion prospects	2.359	Good pay	2.073
Work-life balance	2.944	Express myself creatively	1.747	Good pay	2.103	Chat with co-workers	2.268	*[Chat with co-workers]*	*1.787*

Note: the variables in italics/square brackets are statistically non-significant at p <. 05.

Table 19
Which Aspects of Health Were the Strongest Predictors of PMI in the Four Regions? (Not Controlling for Other Variables)

USA – All Health (N=5000)	*t*	Northeast Health (n=857)	*t*	Midwest Health (n=1085)	*t*	South Health (n=1827)	*t*	West Health (n=1133)	*t*
Grooming routine	7.241	Grooming routine	4.063	Living longer	4.373	Exercise	4.232	Grooming routine	4.535
Healthy food	6.907	Living longer	3.276	Grooming routine	4.049	Healthy food	2.404	Healthy food	4.422
Living longer	6.527	Healthy food	2.837	Healthy food	4.007	Grooming routine	2.342	Living longer	3.132
Exercise	4.120	Mental health	2.620	*[Mental health]*	*1.662*	Living longer	2.152	*[Feeling good]*	*1.758*
Mental health	2.142	Exercise	2.428	*[Physical health]*	*1.579*	Looking good	2.072	*[Physical health]*	*1.038*

Table 20
Which Variables Were the Strongest Predictors of Income in Four Regions (Controlling for Other Variables)

USA – All (N=5000)	*t*	Northeast (n=857)	*t*	Midwest (n=1085)	*t*	South (n=1827)	*t*	West (n=1133)	*t*
Academic qualifications	20.061	Academic qualifications	8.355	Academic qualifications	11.325	Academic qualifications	10.868	Academic qualifications	8.926
Married	14.923	Employed FT	7.739	Married	8.214	Married	7.979	Married	6.299
Employed full-time	12.747	Married	6.786	Employed full-time	5.812	Employed full-time	6.469	Employed full-time	5.322
Job satisfaction	5.378	Job satisfaction	4.161	Job satisfaction	3.756	Not being a homemaker	-2.553	Not being a homemaker	-2.387
Not being a homemaker	-5.082	Being White	3.609	Being White	3.206	Being a parent	2.484	Health	2.201

NB: 'Income' indicates 'total household income', not just individual income.

Table 20 shows that Educational level is consistently the best predictor of Income, in the US overall and in each Region.

Table 21
Which Aspects of Sport and Leisure Were the Strongest Predictor of MMI in the Four Regions (Not Controlling for Other Variables)

USA – All (N=5000)	*t*	Northeast (n=857)	*t*	Midwest (n=1085)	*t*	South (n=1827)	*t*	West (n=1133)	*t*
Socialising	7	Feeling healthy	3	Feeling healthy	3	Socialising	5.372	Socialising	3
	.099		.259		.787				.547
Feeling healthy	6	Competition	2	Socialising	2	Feeling healthy	4.412	Competition	3
	.708		.915		.876				.270
Competition	5	Socialising	2	Competition	2	Competition	2.587	Feel healthy	2
	.670		.419		.876				.198
Fun	2	*[Get a good body]*	*1*	*[Being skilful]*	*1*	*[Fun]*	*1.853*	Fun	2
	.584		*.821*		*.673*				.044
Get a good body	2	*[Winning]*	*1*	*[Get a good body]*	*1*	*[Get a good body]*	*1.672*	*[Winning]*	*0*
	.309		*.393*		*.292*				*.759*

NB: The variables in italics/square brackets are statistically non-significant at $p < .05$.

Table 21 shows that when looking at the which aspects of Sport & Leisure are the most important, it can be seen that Socializing and Feeling Healthy were both similarly strong predictors of PMI.

Table 22
Which Aspects of Friendship Were the Strongest Predictors of PMI in the Four Regions? (Not Controlling for Other Variables)

USA – All (N=5000)	*t*	Northeast (n=857)	*t*	Midwest (n=1085)	*t*	South (n=1827)	*t*	West (n=1133)	*t*
Knowledge of topics	5.975	Good listener	3.301	Being fun to be with	3.739	Laughter	2.787	Knowledge of topics	4.352
Good listener	4.186	Knowledge of topics	3.221	Knowledge of topics	3.151	Protective	2.434	Good listener	3.380
Protective	3.731	Will defend to the end	2.732	Protective	2.493	*[Caring]*	*1.756*	*[Being there]*	*1.656*
Being fun to be with	3.561	*[Protective]*	*1.228*	*[Good listener]*	*1.782*	*[Supportive]*	*1.617*	*[Being fun]*	*1.568*
Being there	2.437	*[Caring]*	*0.875*	*[Laughter]*	*1.317*	*[Being there]*	*1.287*	*[Protective]*	*1.188*

Table 22 shows that the aspect of Friendship which was the strongest predictor of PMI in the US overall was Having Knowledge about Relevant Topics. It was one of the top 2 predictors in each Region, apart from the South where it was absent from the top 5 (where it was ranked 9th).

There are important clinical implications too. Men who had lower job satisfaction tended to have a less positive mindset. Occupational psychologists dealing with distressed or depressed men might encourage them towards ways to find ways of finding meaning in their work. There is evidence that Employee Assistance Programs might be less successful in the long term for men than they are for women (Wright & McLeod, 2016), so finding the factors that make male employees feel positive is important.

Relationship status

In the UK and the US, having a steady relationship is related to mental positivity. This finding echoes other research suggesting that relationships are good for mental health, and that relationship breakdown is associated with poor mental health (Barry & Liddon, 2020) and even suicide (Callanan & Davis, 2009). The findings of the present surveys imply that there is an important mental health benefit to men of having enduring relationships. Relationship counsellors and other therapists should bear this in mind when helping men going through relationship breakdown or family separation, ensure that they have a male-friendly approach. Moreover, popular narratives promoting negative views of men and masculinity should be considered themselves potentially toxic to the development of healthy, trusting relationships between men and women.

The importance of health values to PMI

Table 20 shows that *grooming routine* is the strongest of the *health values* in predicting PMI in the US overall. This holds in the Northeast and West, but in the Midwest 'living longer' is the best health predictor of PMI, and in the South 'exercise' is. Other significant findings were: Healthy food was in the top 3 for each region; living longer was in the top 4 for each region; mental health was fourth in the Northeast, but not in other regions; living longer was a predictor in the South and West; exercise was a predictor in the Northeast, but not in other regions; mental health was fourth in the Northeast, but not in other regions; looking good was a predictor in the South, but not in other regions.

How much is mental health valued compared to physical health?

Tables 6a and 6b, and 16a and 16b, show that men in the UK and US value their mental health more than their physical health. The findings were similar in both studies, except that in the UK there was a slight trend towards the youngest age group (18–29) placing the greatest degree of importance on their mental health. Table 23 shows that Being a good listener was in the top 2 in the Northeast and West US. These and other findings imply that men today are more emotionally open than the popular narrative about 'male stoicism' suggests.

Men who value their health as a way of living longer (for self and others), improving mental & physical health, and feeling good, have a more positive mindset. Health psychologists might use these four aspects as ways of motivating men to engage more in health behaviours. A change in grooming routine or a lack of grooming (looking unkempt) could be an indicator of a change in mental well-being.

Sport and leisure values

In the UK and the US, men who value *sport and leisure* had a more positive mindset. We already know that many men value sports, either to watch or play, especially team sports (Liddon & Barry, in press), and the findings of the present research underline the non-trivial benefits of such interests and activities(Holloway et al., 2018). Therefore, men should be encouraged to enjoy the aspects of *sport and leisure* that are important to them. We already know that interventions such as Walking Football in the UK (i.e., walking soccer) help the physical health of older men and provide isolated men with companionship. Sports psychology has a role in encouraging men, for whom talking therapy might be relatively unappealing (Holloway et al, 2018), to improve their mental positivity by engaging in sports (Relojo-Howell, 2019).

The importance of friendship to PMI

Social isolation is recognised as being a key factor in men's mental health (Bilsker et al., 2018), though Table 18 showed that *friendship* in the US was a significant predictor for the Western region only. Table 23 shows other values related to *friendship*, such as *having knowledge about relevant topics* was the main predictor of PMI in the US. Being a good listener was in the top 2 predictors in the Northeast and West. This suggests that men are willing to listen to their friends, as well as give advice; *being protective* was in the top 3 in the Midwest and South; Laughter was top in the South, but not significant in any other region, or the US overall; *being willing to defend your friend until the last* was significant in the Northeast, but not elsewhere; *being fun and being there* were 4th and 5th in the US overall, but only *being fun* was a significant predictor in any of the Regions (top in the Midwest).

Findings of age

It might be expected that older age brings sadness due to an accumulation of stressful life events (e.g., health problems, death of friends, etc), but research suggests that for married men negative mood decreases with age (Mroczek & Kolarz, 1998). The finding that in both of the present surveys, mental positivity increases with age is important and sends a positive message to younger men who might look to the future with pessimism. This finding supports the hypothesis that younger people see the future as being full of possibility, whereas older people see the future as being more restricted; to cope, older people orientate their lives toward maximising happiness and minimising anything else (Carstensen, 1995).

In the US study, growing older was seen in a positive light. For example, in the Midwest, it seems that men are more positive when they are over age 50. These findings may seem counterintuitive because many people see growing older as inevitably bringing increasing responsibility and ill health. However, these findings regarding the relationship between age and PMI are similar in the UK and US.

Note that few studies of happiness and ageing, are longitudinal and the apparent impact of age on happiness might be due to different attitudes of different generations i.e., so-called 'baby boomers', born between 1946 and 1964, might have throughout their youth always been happier than today's young 'millennials', for example. This is an interesting question for an ambitious longitudinal study.

Personal growth values

In the UK, men who value a spiritual aspect to their life, being authentic and true to themselves, without doing what others want them to do all the time have a more positive mindset. Although Christian men in the UK don't tend to be regular churchgoers, the free text evidence from the Study 1 suggests that spirituality (e.g., perhaps meditation or mindfulness) should be considered as part of a range of options in therapy. The same goes for finding one's true self/voice/path in life.

Family values

In the UK, men who valued a traditional paternal role ('being like my father', being authoritative) were more likely to have a positive mindset. One might speculate that, conversely, men who feel they are not living up to traditional standards for a family man might have reduced well-being. Family therapists and family courts should appreciate this when dealing with men who are criticised as being too traditional in their fathering, or 'generative parenting' (Kiselica, Englar-Carlson & Fisher, 2006).

Interpretation of PMI findings for clinical purposes

A slight difference is that the mean PMI in the US sample is 3.72 ± 0.80, which indicates good mental health on average, and is slightly higher than that found in the UK sample: 3.40 ± 0.72. This difference is not of clinical significance, though it might reflect a slightly more overt expression of positivity in the US compared to the UK.

PMI in participants who identified as other than male

Most of the US sample identified as male, but 14 identified as 'non-binary' and 10 as 'female to male transgender'. The mean PMI score for non-binary participants (3.02) and especially female-to-male transgender participants (2.63) had lower levels of wellbeing when together compared to the other participants (F = 827.60, df=2, 4997, $p < .01^{-166}$). The mean PMI in the US sample was 3.72 (0.80). If we say that the cut-off for clinical scores is one *SD* below this (i.e., 2.92), then by this definition, the transgender group are showing clinically low wellbeing and the non-binary group are borderline. Due to conditions of anonymity (detailed in the information sheet and consent form), participants with low PMI were not contactable. However, all participants have been given the contact details of the National Alliance on Mental Illness (NAMI) Helpline should they feel the need to talk to someone. By contrast to the non-binary and trans groups, the PMI scores of heterosexual (89% of participants) and non-heterosexual participants were very similar (3.7 and 3.6 respectively) and very healthy, and Table 17 shows that sexual orientation had little impact on PMI.

One interpretation of these findings is that it is difficult to be a non-binary or trans male compared to the average man. Interestingly, some of the highest PMI scores were in the small group of men (n = 94, or 2% of the sample) who were on active military duty (4.3 $\pm$ 0.82), suggesting that some types of traditionally masculine role can potentially be associated with an unusually positive mindset.

If the 24 participants with low PMI were unevenly distributed among the regions their low scores might impact the overall PMI score per region, and it might have been necessary to remove them from the analysis. However, the distribution is not significantly different across the Regions (Fishers Exact test = 9.23, $p < .115$), thus the participants retained because any impact on the overall PMI data would be unlikely to be significant.

These findings have important clinical implications for non-binary and transgender men. These are populations who, although small in number, are more likely to need mental health support.

Strengths and weaknesses

A strength of this study was the assessment of ratings of core values, which has been seldom done in previous research outside of organizational psychology research. Another strength was not imposing any modern templates of masculinity on the participants, which may have restricted participants against expressing positive aspects of themselves. This exploratory, 'bottom-up' approach, is less restrictive than much of the 'top-down' research on masculinity and allowed for inductive interpretations of the findings of masculinity. One interpretation is that the job satisfaction finding reflects the tenacity of the provider role as a key aspect of masculinity (Seager et al., 2014), possibly reflecting its adaptive value in evolutionary terms (Seager, 2019). This interpretation lends itself of course further hypothesis-driven deductive approaches too.

Another strength of this study is the use of PMI. In some ways the PMI is the ideal way to measure men's positivity: it is very brief and doesn't ask potentially off-putting questions about feelings of depression. It is likely to be a good indirect measure of mental health because it is well correlated with measures of mental illness.

A limitation is the use of bespoke questionnaires, which although were similar in both studies and replicated findings well, were psychometrically unvalidated.

CONCLUSION

The findings of this study suggest that men in the UK and US value being honest over being athletic, and they value work and relationships. Contributing to success in the workplace, and feeling connected to others in an authentic way, are indicators of mental positivity. Men's mental health is related to connecting with others through sports and connecting with friends through listening as well as giving advice.

It has become popular recently to demonise masculinity, with little consideration of the potential benefits of masculinity, nor the potential harm to boys growing up in a culture that undervalues them

(Barry et al., 2020). Efforts to reduce problematic behaviour are always welcome, but efforts to fundamentally reshape masculinity are probably futile, given the evidence that masculinity is – at least to some degree – a product of evolutionary forces as well as a product of culture (Liddon & Barry, 2021). Perhaps the key finding Harry's studies are that men today in the US and UK are people who derive their well-being from socially positive activities (such as work and relationship stability) and values (such as honesty and reliability). It seems possible that society can bring the best out in men by focusing more on these characteristics.

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Effects of expressive writing on posttraumatic stress symptoms and other traumas: Case study of male clients in therapy settings

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This paper provides a demonstration of the effectiveness and advantages of expressive writing intervention as a quick and effective way to work male clients in therapy settings, particularly those exhibiting posttraumatic stress symptoms and other traumas. The paper also offers theoretical concepts that might explain how or why the method works and what might explain its effectiveness and particularly why the effect size for the method is larger for males than females. The technique is seen as a positive and time-efficient technique as an adjunct to the more traditional techniques such as cognitive behavioural therapy as used in the brief therapy settings as offered by Employee Assistance Programme (EAP) providers and Improving Access to Psychological Therapies (IAPT) services in primary care and it can also be used by clients, particularly men, who do not have easy access to therapeutic help because, for example, they are in prison. The paper also provides implications on how it has been found that the method is particularly effective with male clients who may find it a much more acceptable treatment method.

Keywords: brief therapy; expressive writing; post-traumatic stress disorder; psychological concepts; therapy

The suicide rate for men in England and Wales in 2019 was the highest for two decades. Males continued to account for around three-quarters of suicide deaths registered in 2019 (Office of National Statistic, 2020). This would suggest that mental health services are not equally reaching the males in Britain, or the services that are being provided are not helping men with their issues.
I am not only a psychologist and psychotherapist, but I am also an expert witness. In the last few years, I have covered many kinds of cases for the courts; many of which have been men in the criminal justice system. My experience of these cases has prompted the question of how many men in prison are there because they are suffering from posttraumatic stress disorder (PTSD) and have not had the opportunity to be diagnosed and helped.

The focus of this paper is, first, to recognise that somehow men/boys are suffering because it seems that the certain issues that they are suffering from, in this case, trauma are not being addressed in a way that they can make use of. Further, even when they are seeing people, the methods used to help them are perhaps inappropriate, so they do not benefit from them and so they opt out of using the services and then maybe keeping their psychological distresses to themselves.

Alternatively, they can feel they do not know that they need help or feel the help is available, does not suit them; so they might instead act out their feelings with violent offending and end up in prison, or take out the anger on themselves and commit suicide (Atherton, 2019). Hence, it is suggested that we need to look at different kinds of help that might work better for men and boys. Thus, I want to share a method that seems to be very effective in helping people deal with their traumas, one that seems even more effective particularly with men (Smyth, 1998). This technique has become to be known as expressive writing.

Expressive writing for the treatment of posttraumatic stress disorder and other trauma among men and boys

I began to use this technique with traumatised victims of particularly traffic accidents as in my private practice I was receiving numerous referrals of this kind. The technique which I was evolving seemed to be working very successfully where clients were given, as homework, to write the story of their trauma with the feelings they have experience and are having. I also began to extend this to having clients write about their earlier traumas, including those of childhood abuse, which was often connected to, and it seems, the cause of them experiencing PTSD for events that do not cause others to experience PTSD (Liddle & Solanski, 2002).

Firstly, I want to briefly describe the definition of PTSD to differentiate it from the immediate experience that all people might feel after a traumatic event because such events do not necessarily lead to PTSD. I feel this point is important. I will also illustrate both the definition and the use of expressive writing by a case study which has been anonymised by giving him a different name and slightly changing the details, to prevent the individual be identified.

The word *trauma* is Greek in origin and means wound or injury. Traumatic events create a line of demarcation, separating lives into before and after. The event becomes the starting point of a journey to resume one's life (Richmond et al., 2000). While physical trauma has always been recognised, psychological trauma was only briefly acknowledged in the last wars (i.e., 'shell shock '). The loss of the Vietnam War led to the formulation of PTSD.

Donald[i] had a motorcycle accident. A car rammed into him while he was stationary at a zebra crossing and he was thrown into the air and his bike was wrecked. He fractured his hands and arms, injured his knees, all his joints were affected, and he suffered pain for some time afterwards. He then suffered from back pain, but nothing physically could be found to be wrong. He was experiencing flashbacks and nightmares of him flying through the air, and he could not get onto a motorbike again when, before, he enjoyed this. He felt he could have died. He could not look at the road where it happened without fear. He was now extra vigilant and had difficulty enjoying driving even a car. He was getting neck and back tensions and was taking a long time to leave his home as he had developed obsessive-compulsive disorder (OCD) where he was constantly checking the windows and doors to check there were locked. He was doing this at least 20 times and counting. From the symptoms manifested, it is suggested that this client was suffering from

PTSD. To examine whether this was the case, it may be important to clarify how PTSD is defined and what is known about the typical symptoms.

DSM-IV-TR (2000) and DSM-5 (2013) define the essential feature of PTSD as having to fulfil several criteria. PTSD is therefore defined as the development of characteristic symptoms following exposure to an extreme traumatic stressor involving the direct personal experience of an event that involves actual or threatened death or serious injury, or other threats to one's physical integrity. Other events qualifying for a criterion, known as Criterion A, include but are not limited to: (a) exposure to war as combatant or civilian; (b) threatened or physical assault (e.g., childhood physical abuse, mugging); (c) child sexual abuse; (d) sexual trafficking; (e) being taken hostage or kidnapped; (f) terrorist attack; (g) torture; (h) incarceration as a prisoner of war; (i) natural disasters; and, (j) severe road traffic accidents.

The person's response to the event must involve intense fear, helplessness, or horror (Criterion A2 from DSM-IV). The characteristic symptoms resulting from the exposure to the extreme trauma include persistent re-experiencing of the traumatic event (Criterion B from DSM-5), persistent avoidance of stimuli associated with the trauma or trauma-related thought or feelings (Criterion C from DSM-5).

Sufferers can experience two or more negative alterations in cognitions and mood associated with a traumatic event and this began with that event or worsened after the event. This is seen as Criterion D. In Criteria D there is also an inability to remember important aspects of the traumatic event due to dissociative amnesia, and often persistent exaggerated negative beliefs about oneself, others or the world e.g., 'No one can be trusted'. Thus, another client, Colin, who was suffering from PTSD after another motoring accident, believed that those about him were about to attack him, so he would attack first, thus he was getting into numerous fights with strangers, yet before the accident, he was seen as a calm and caring person. Within Criterion D there would be persistent distorted cognitions about the causes and consequences of the traumatic event leading to self-blame.

Donald believed he had to keep his children safe and it was his fault if anything happened to them, so he would repeatedly check the doors and windows were closed before leaving the home. There would be persistent negative emotional states (anger for Colin; shame for Donald). There would also be markedly diminished interest in significant activities; feeling detached or estranged from others, such as Colin's behaviour to isolate himself from everyone, believing others were a threat to him, and he had a persistent inability to experience positive emotions e.g., love and joy.

Symptoms are considered normal if experienced immediately after a trauma, if they persist up to three months they are seen as acute PTSD, and chronic if extend beyond three months. (Andrews et al., 2007; Rick et al, 1998; Williams et al., 1994). The symptoms for the above clients were present for over nine months after the event hence fulfilling Criterion F.

Sufferers can experience prolonged distress at exposure to internal or external cues resembling the traumatic event so avoid an environment that is likely to expose them to such cues (Relojo-Howell, 2020). Internal or external cues that symbolise or resemble those associated with the traumatic event can also produce marked psychological distress and/or physiological reactions. All these reactions are noted in Criterion B from the DSM-5.

Survivors experience trauma memories, trauma reminders or flashbacks and the attempt to avoid such memories or reminders can make living with a survivor feel like living in a war zone or living in constant threat of vague but terrible danger. Thus, for Colin, he made his environment into a war zone, as, he was frequently smashing his fists into the walls of his home around his girlfriend such that his girlfriend became terrified and hence the relationship did not survive. He continued to feel he was in a war with everyone around him. (van der Kolk & Fisler, 1995).

The fact that sufferers often relive trauma memories, avoiding trauma reminders, and struggling with fear and anger, results in interference with survivors' ability to concentrate, listen carefully and make cooperative decisions, so problems often go unresolved for a long time, significant others may come to feel that dialogue and teamwork are impossible, hence probably caused Colin's partner had to leave. Donald had trouble focussing on his studies and spent considerable time checking the security of his home (Foa & Hearst-Ikeda, 1996).

One of the questions concerning PTSD is about what causes the mind to process traumatic events in such a way that the symptoms of PTSD are produced. It is well to remember that while events might be objectively horrendous/traumatic not everyone reacts to such events in the same way. In my work, I regularly see people suffering from PTSD as the result of an accident. The accident itself, while being something we could all do without, some of the clients had accidents that were not necessarily extreme as accidents go, yet they experienced PTSD, while others, who may have had a similar accident, would not.

It is thought that one of the processes that people might use to cope with a traumatic event, as mentioned above, is that of 'dissociation'. Dissociation is a failure to integrate experiences/memories perceptions etc. that are normally associated, symptoms such as amnesia, depersonalisation; de-realisation & identity confusion result from 'biological response' and may serve to reduce awareness of intolerable information. There can also be for example emotional numbness; mental blanking (inability to think); inability to speak (Dell & O'Neill, 2009; Holmes et al, 2005; Kennedy et al, 2013; Kennerly, 2009; van der Hart et al, 2006).

The different types of responses to trauma are not surprising in that people's responses to stress per se will be different, in that some experience body tensions in differing part of their bodies, while others express it in moods or illness etc. Why these differences occur is one question, but the point above was that, first, there is the need to recognise that each manifestation can be an expression/symptom indicating that the client has experienced some form of trauma that was psychologically unmanageable so subconsciously they needed to find a strategy for surviving mentally, an experience that seemed life-threatening, etc. So, the clients had to find a way to process the event, frequently by dissociation. The point here is, that, to date, there has developed a considerable understanding of dissociation, but little idea about its roots or how to treat it, and it is this that I wish to address.

But first, as suggested above, clinical experience with the diagnosis of PTSD has shown that there are individual differences regarding the capacity to cope with catastrophic stress/trauma so that while some people exposed to traumatic events do not develop PTSD, other do (Keane et al., 1987). Some explanation may lie in the finding that those with previous traumatic histories may present a greater risk of experiencing PTSD as the result of a trauma (Brady et al., 2000).

The difference may be due to the different ways that the individual learnt to cope with their earlier life/childhood traumas, and this might be dependent on the age they were when experiencing the earlier trauma or, to them, life-threatening or fearful experiences. The latter may also explain how it is that men find it more difficult to find ways to process trauma as they may have been socialised, as children, not to react, or to block their feelings, about fearful experiences (e.g., 'Big boys don't cry!').

If the process for coping is a form of dissociation where the experience is not integrated into the concepts of their memories and histories, then the logical step for helping people to deal with the experience of PTSD is to find ways to help them integrate their experiences into their memories and perceptions.

An example could be my client Donald, who developed severe OCD, such that he was jeopardizing his career as he was arriving very late for work, taking so long to leave his house. But during therapy he recalled flying through the air thinking, 'What will happen to my children if they lose their father'. He was soon able to connect this thought with his own traumatic experience as a child when his father had been murdered. When Donald's father was assassinated, he was not able to grieve as he immediately had to be smuggled away from his family to safety, all alone with strangers. When he was able to record in writing for himself, for the first time, what happened for him as a 9-year-old child, the OCD behaviour disappeared. For Colin, when he was able to write an angry letter to the driver about what happened to him and what he was feeling (a letter not to be sent), his murderous feelings towards the driver disappeared.

Concerning Donald, what happened here was that I worked towards reactivation and reintegration of the compartmentalised memory of his childhood memories and that of his accident regarding the memory of the thoughts that he had had while flying (Holmes et al., 2005). This relates too, to the concept of 'working self' which is seen as one of several schemas which interpret and respond to internal and external input. The 'working self' is like 'working memory' related to the self, from moment to moment, it selects

representations of the self, based on past experiences and present context. The individual will have several working selves (Conway & Pleydell-Pearce, 2000).

Much of the 'working self' can have its origin in the concept of self we gain from childhood. Thus, it has also been found that insecure attachments in childhood positively correlate with a high risk of developing PTSD after a traumatic event in adulthood (Schore, 2002). Thus, it is suggested, the critical difference between individuals in their response to traumatic events will be the recurrence of life-threatening and other traumatic experiences particularly if the present traumatic experiences echoes (confirms) previous anxiety-provoking or traumatic experiences particularly those from very early on in that person's childhood.

In the case of another client, Bob, during his childhood, he was terrified of his father who was frequently violent towards his mother and his father's aggression was unpredictable. The suggested childhood experienced Bob would have provided him with a predisposition for reacting to traumatic events with PTSD as the present life-threatening experience would have echoed earlier anxiety-provoking/life-threatening experiences which were not dealt with. For Bob, this would have been his ongoing anxiety/fear of his father and hence his poor relationship with his father which has been correlating with a son's poor mental health resilience as an adult (Miller, 2013). One of the reasons for Bob experiencing symptoms of PTSD was that his accident echoed the life-threatening fear of his father and his lack of control generally over his life, as his father controlled what happened to him in his development. This overall feeling of lack of control would also have been a possible pre-cursor for the on-going depression and anxiety (Miller, 2013) and a diagnosis of depression and anxiety are major risk factors for developing PTSD as a result of a later trauma (Brewin et al., 2000; Halligan & Yehuda, 2000).

Studies have found that children learn their anxiety coping strategies from their parents (Eley et al., 2015). Significantly, a study in the Netherlands has found that a child's development of anxiety coping strategies, particularly for boys, is more influences by the father's responses to stress than the mother's (Moller et al., 2015). Also, children's school behaviour, again particular boy's behaviour, is strongly linked with the father's influence on that behaviour, is not only significant but may be more significant than mother's e.g. father's harsh parenting is more strongly linked to aggression than is mother's harsh parenting (Chang et al, 2003; Jaffee et al, 1990; Lloyd et al, 2003; Velleman, 2004; Wang & Kenny, 2014). Father's high involvement with their sons (as measured by reading, method of disciplinary, taking trips, etc.) is associated with fewer behavioural problems and lower criminality and substance misuse (Clark, 2009; Flouri, 2005; Lamb, 2010; Lloyd et al., 2003; Pleck & Masciadrelli, 2004; Sarkadi et al., 2008). However, in much of my working experience (working as a social worker with violent offending boys) their only experiences of their fathers would be ones where they would occasionally appear on the scene and would be aggressive and abusive to their mothers and/or to them.

Neurological underpinnings

However, given this understanding of the root of the PTSD responses, the question to ask is 'What can best help the individual to recover?'. Before exploring this, it might be useful to understand what is going on in the brain to promote ongoing fear responses. It is now established that a pathological response to stress reflects the functions of a hyper-excitable amygdala (Halgren, 1992), that fear-potentiation of startle is mediated through the amygdala, which directly projects to the brainstem startle centre (Davis, 1989), and that the memory processes of the amygdala are amplified by extreme stress (Corodimas, 1994). This amygdala-driven startle and fear-freeze responses would be, as suggested above, learnt responses often from childhood and models that the children have for coping. It was also suggested above, particularly for boys, that the most powerful models for learning how to deal with stress come from the models they had from their fathers.

The role of the amygdala in the limbic system is the monitoring of nearly all sensory stimuli and is involved in regulating fear and aggression; in charge of emotional learning in early life and somatic organisation of experience; prepares the organism for action in face of danger receiving input either via neo-cortex or from rough fast thalamic input and activating fight, flight and freeze behaviour as in PTSD. But it is the role of the Hippocampus that is critical also in the fear responses.

The hippocampus integrations and discriminations, it enables remembering of a sequence of events, converts *implicit* memory into *explicit* mental images which are important in PTSD; it i*ntegrates memories* from different sensory modalities and commits spatial and temporal dimensions to memory. Excess and chronic exposure to stress hormones (cortisol) will change synapses and dendrites in hippocampus causing: Atrophy due to traumatisation, and probably increased vulnerability to PTSD later on because of loss of coordination by hippocampus of sensorimotor systems and affective systems. Smaller hippocampal volume has been reported in several stress-related psychiatric disorders, including PTSD, borderline personality disorder and dissociative disorders which, as mentioned above are a response to trauma.

However recent studies that have focussed on the hippocampus in black cab drivers in London found that those who were successful in learning 'the knowledge' increased the size of their hippocampus and when they retired it decreased in size again. Taxi driver study indicated that the 'learning of the knowledge' caused the Hippocampus to grow in its volume of grey matter which demonstrated the plasticity of, at least, this part of the brain, knowledge of which may be important in the treatment of a client concerning their stress responses (Maguire et al., 2000).

The focus of this paper was to examine ways in which the processing of traumatic experiences can be re-routed such that the intervention of the amygdala and its triggering of neuroendocrine hormones can be inhibited. The above focussed neurologically and historically, on what sets up the preconditions which predispose the individual to react to traumatic events with repetitive fight or flight responses which are the feature of PTSD reactive responses. But the point of this paper was also to look at ways to alter that response. Thus, I would like now to connect the thinking towards the theoretical views concerning narrative therapy.

Narrative therapy

The point of narrative therapy is not about giving advice (White, 1997), is not about normative judgements or evaluations from positions of authority. As many therapists can attest people come to therapy to tell their story (McLeod, 1998) and by doing so they can, as it were, externalising the problems (Morgan, 2000; White & Epston, 1990). Through the process of communicating their problems, the client presents their story potentially laden with the experiences, attitudes, beliefs and understandings as the story is constructed via those beliefs, etc. The narrative can encourage de-construction and critical appraisal of their strong emotions/trauma. Hence it can be seen as a literate means to a therapeutic end (Foucault, 1979; White 1997; White & Epston, 1990). The process of telling the story allows them to endeavour to construct a coherence, to connect the dots, and make sense of their experiences. Focussing on their emotional responses does not allow them to do this.

When in stress mode all senses are narrowed down to survival mode making seeing the bigger picture and hence coherence, difficult to attain. The traditional models of therapy invite or reignite trauma, internalised feelings are often ignored, and the contextual element dismissed. Narrative therapy focusses on experiencing and contextualising trauma as a force outside of the person and does not seek to define the person by their experience, by creating autobiographical details can produce 80% clinical improvement in a short time (Ertl et al., 2011). People encode their narrative as coherent memories in the brain.

Psychologically-healthy individuals have meaningful, logical and vibrant self-stories whereas faulty self-narratives are synonymous with emotional difficulties. Numerous studies indicate that disarranged, unassimilated narratives of traumatic experiences lead to PTSD. Hence, finding a way to be able to construct healthy narratives of traumatic experiences corresponds to a healthy recovery process. Relating our stories in a coherent logical way changes us and hence the story has the power to heal (Mehl-Madrona, 2005).

The difficulty can be for those with multiple traumas or on-going traumas like that of child abuse. In this situation, the client is encouraged to construct a narrative of his or her whole life, from birth to the present while focusing on the detail report of the traumatic experiences. Narrative treatment methods have the potential to be effective because they make use of the persons own life story and are short-term and

hence cost-effective and seems to compare favourably with treatments such as interpersonal or CBT techniques and may require less professional training than other therapies as it revolves more around the ability to listen well to stories and to just enable the client to tell their story in a structured coherent way. The client does most of the work by telling their story over and over again until they habituate to the aroused emotional reactions that are, learning that the memories themselves are not scary.

In my practice, while I was interested in encouraging clients to tell their stories, sometimes their stories were long and could not be condensed in one hour or the limited number of sessions that they had available in the settings providing both EAP treatments and IAPT High-Intensity Treatments in the NHS (National Health Service). I also felt that even talking about their experience did not necessarily help them integrate the experience into their working memory and it was hard particularly for many of my male clients to express the emotions that went with those memories either through embarrassment concerning those feelings or their difficulties allowing themselves to feel them. But more pragmatically, I felt that they might better be able to create coherence in their story if they were able to write it in their own time where they would not have to censor themselves for fear of what I, or others, might think.

I, therefore, reasoned that writing might help those suffering from even more immediate emotionally arousing memories. I also found that speaking about the event while it helps them to rehearse what was in their minds, it was not as effective or did not have the same impact as writing. I thus began developing a protocol for getting people to use what I later discovered was being called 'Expressive Writing'.

Expressive writing, as I can now call it, is, I believe consistent with the techniques and reasoning for the effectiveness of Narrative Therapy i.e. everyone wants to tell their story. But I believe expressive writing goes further, as writing their stories gives it more coherence, order and makes their stories more concrete, and so, the suggestion is, that their story is stored more effectively.

But before I relate what I have discovered is an effective protocol for such treatment and give examples of its effectiveness, it would be well to look at what has been found in the research about the effectiveness and benefits of expressive writing in the treatment of trauma.

Expressive writing in the treatment of trauma

Over the last 30 years, there has been a considerable amount of research since the first study of Pennebaker & Beall (1986) which showed that writing about traumatic or stressful events has physical and emotional benefits. Pennebaker and Beall noted writing about traumatic experiences produced increases in short-term physiological arousal and long term mental and physical benefits. They suggested that clients could do this over several days, maybe 3–5 sessions of no more than about 20 minutes per session (20 minutes being the maximum concentration span of any individual), though the number of sessions will depend, I suggest, on the gravity or length of the traumatic experience (Pennebaker, 1994; Smyth & Pennebaker, 1999). The research showed that there were usually short-term increases in distress, negative mood and physical symptoms, but as with Pennebaker's research, my clients reported that they felt lighter and relief, even immediately after the first writing session.

Other studies found that those who had traumatic histories or post-traumatic stress disorder (PTSD) shown improvements in physical health and symptomology (Greenberg et al, 1996; Relojo-Howell & Stoyanova, 2019; Schoutrop et al., 1997, 2002; Sloan & Marx, 2004). Some studies suggested that expressive writing was detrimental for adult survivors of childhood abuse (Batten et al., 2002) though this would seem to be contrary to the comments made by writers who have written and published the stories of their abuse where they comment that writing their story had allowed them to move forward in their lives.

But it may be, as suggested above, that the researchers expected the narration of such events to be done in a limited time and for some, maybe, it can take some time to relate all the events and the feelings about those events. Interestingly, a meta-analysis found that the effects sizes were greater for males than for females (Smyth, 1998) as it seems this form of expression was more acceptable to men.

This is my experience, in that males may be more reticent to express their real emotions to others but in the privacy of their writing (in my protocol I would encourage them to keep their writing private, for their eyes only {password protected}, so that they do not censor or restrict their expressiveness, for fear of others seeing it and worrying what others would think).

Pennebaker & Beall (1986) also make the important point that the benefits are greater if the client writes about the event with the associated emotions than if they only wrote about the emotions of the events, alone. Pennebaker (1985) suggested the explanation was that the active inhibition of thoughts and feelings about a traumatic event requires physical effort and serves therefore as a cumulative stressor on the body and is associated with the increased physiological activity, obsessive thinking or rumination.

Clients come saying they are desperate to stop thinking about the event, they are desperate to forget and try to not to think about it but admit that this doesn't work as they continue to have flashback and nightmares, so they think that I am mad to suggest that as their strategy is not working (To quote Einstein: 'To keep doing the same thing and expecting a different outcome, is the definition of madness.') then we are going to do the opposite – they are going to do everything to remember!

Pennebaker suggested confronting the trauma through talking or writing about it with the associated emotions reduces the physiological work of inhibition hence lowering the overall stress on the body and translating the event into words enable cognitive integration and understanding (Pennebaker, 1985). However, I suggest here, that Pennebaker has not fully appreciated the difference between relating the events verbally and in writing. Yet, he notes, through his and other's research, that expressive writing as against verbal relating, is more effective.

Writing requires much more processing than the spoken word; it requires coherence, order and integration, and hence I suggest uses different parts of our brains, perhaps eventually bypassing the emotional brain (the amygdala). Writing and systematic memory requires processing through the hippocampus which, as discussed above, is implicated in memory, remembering a sequence of events, spatial and temporal, and integrates memories from different sensory modalities. Thus, it is suggested that expressive writing allows for a coherent narrative reflecting increasing cognitive processing of the experience (van der Kolk et al., 1996). The writing may help the writer organise and structure the traumatic memory (Harber & Pennebaker, 1992).

It is for this reason that I try to get clients to use their computers to write their story/stories, as they can restructure, as they progress, to get the order to their story, and add in the appropriate places, memories that were omitted at the time when they first recorded it; they can cut and paste if they find the memories need to be re-organised. Their instructions are to keep going until they feel nothing has been left out.

Some clients have said they feel more in touch with their emotions when they write by hand, but then they have still felt it was helpful to transcribe what they had written onto the computer to ensure its coherence. By asking clients to keep going until they feel there is nothing left also produces prolonged exposure as they have to keep reading it (another advantage of writing over talking) to check they have not left anything out (the rereading can also trigger forgotten parts of the memory of the event – often the most painful parts, the parts they try to forget – but not very successfully!).

This repeated reading and adding (I do not suggest repeated writing) may produce extinction of negative emotional responses (Lepore et al, 2002; Sloan et al., 2005; Sloan & Marx, 2004). It is suggested that to produce immediate emotional habituation requires 45-90 minutes of writing, but this view, I think, forgets that after brief writing sessions of even 20 minutes, the brain does not stop processing and further sessions over days seem to produce this effect, even if the actual sessions are for only 20 minutes, the maximum time most can tolerate the emotional arousal. However, in some instances, the clients have said once they have started, they wanted to keep going and wrote until they were exhausted but were still instructed to keep revisiting what they had written, daily, until nothing was left to write about.

Bob, Donald, and Colin revisited

Bob found the writing particularly difficult so avoided writing for quite a few sessions, but as he was getting upset that he was not able to go out to take photos, a pastime he previously enjoyed, he forced himself to write and found in the process he was able to venture out further afield on his own and the nightmares and flashbacks disappeared. He wrote not just about the accident but also his experiences at the hands of his father.

Donald spent time not only writing about what happened in the accident but also writing about what happened and how he felt, when his father was assassinated and what followed. As he progresses with writing about this, his OCD disappeared, and he was able to resume his training without risking losing his position because of arriving late for his training sessions when he was spending time checking doors and windows 20 times before he could leave. OCD is seen as avoidance behaviour, so while he was worried about the doors and windows, he didn't have to think about his real worry, which was about the security of his children, as he had not processed what had happened to his security as a child of 9 years of age and hence how his children's lives were different from his own experience as a child.

For Colin, when he was able to write an angry letter to the driver about what happened to him and what he was feeling (a letter not to be sent), his murderous feelings towards the driver disappeared.

Thus, for each of the above-mentioned clients, and many more that I have treated in this way, it has proved to be an effective brief treatment protocol. However, it is important to say that while this method is very effective in that the clients can do the hard work between sessions, this does not suggest that they do not need the support of a psychological professional to encourage them through the process and to help them to be sufficiently motivated to not put off going through the process as they had been warned that the process is very painful.

So, concerning the above example of John in prison, I encouraged him to write what happened to him, both from whilst in the army and also those traumatic events in his childhood (witnessing his twin brother being run over), while he was in prison and to ask for a forensic psychologist to support him in this process (he maybe only been able to do this using hand-writing as perhaps a laptop may have not been available to him). The support is essential as all clients would feel short-term distress during the process.

But it has been found that the short-term distress does not appear to be detrimental or pose a longer-term risk to clients thus answering those who worry about the possibility of retraumatising the clients by this procedure (Hochemeyer et al., 1999). Thus, seeing their therapist, or a supporting worker, during this process allows them also to report and make themselves aware, consciously, of the effect of the writing on their emotions and to feedback how it has allowed them to 'feel lighter' and to let go and to move forward. Further, because the main tasks are carried out in the client's own private time, then this saves time in the clinical setting, so allowing for the process to be supported by perhaps less trained staff, requiring fewer sessions and perhaps not requiring the use the traditional weekly therapy model, but allows for the use of more variable flexible frequencies. This would allow for the process to carry on using fewer sessions as used in EAP or IAPT Primary Services. Further, it should be noted that it is not perhaps accidental that the examples that I have given are all males, this is not to say it does not work with females, as it does, but these males were all males who would never normally have sought out help and came to believe that talking about what happened would not help them as all they wanted to do was to forget about what happened. Also, it should be noted, that they had not immediately sought help, e.g., Colin had tried to drink away the problem before coming; and Donald had developed OCD for some time before seeking help.

CONCLUSION

It is estimated 75% of all suicides in Britain are males, suggesting that somehow males are not gaining access to help or that the mental health help is not reaching them. Therefore, the services must think of more innovative ways to offer help. In this paper I wanted to illustrate one way that of expressive writing which seems to work well in helping people, particularly males, deal with trauma, Also, I wanted to focus on what particularly might lead sufferers of trauma to go onto experience PTSD, which I have suggested, maybe the cause of many males, for example, ending up in prison and killing themselves.

Further, the advantage of 'Expressive Writing' is that it can be used by clients in their own time and settings, perhaps with the need for less intensive input from professionals, so maybe more pragmatic in reaching those who may not have ready access to help such as men in prison, etc. The intention of this paper is not to be able to say exactly why it works, as I believe that may require more research, but to suggest what might be happening, to give perhaps a rationale as to how it is that expressive writing can be an effective tool in treating PTSD, particularly for men.

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[i] Not the real names of clients.

Loneliness, impaired well-being, and partner abuse victimisation of separated fathers in Wales

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Measures of mental well-being and social/emotional isolation were applied to a cohort of fathers seeking assistance from a Welsh charity. The fathers approached the charity predominantly with child arrangement problems after parental separation. Well-being was found to be strongly degraded – and loneliness severely increased – in this cohort compared to general populations. Associations of these dependent variables with nine predictor variables were explored, the latter being: a domestic abuse risk index, low income, allegations of abuse against the father, social services involvement with the family, refusal of the ex-partner to consider mediation, the father's concern about abuse of a child by the ex-partner or her new partner, the father's disability, the restriction of child contact, and an indicator of the father's recognition of his need for emotional support. The fathers' risk from domestic abuse was the variable most strongly associated with poorer well-being and elevated loneliness, as well as with a separate indication of depression/suicidality. The variable which was the second most strongly associated with those three dependent variables was low income, mostly due to unemployment. The findings of the study challenge the notion that serious partner abuse of men is either relatively uncommon compared with that of women, or that it is less impactful.

Keywords: domestic abuse; fathers; loneliness; parental separation; well-being

There is an extensive literature on the effects of parental separation on children. There is smaller literature on the impact of parental separation on the non-resident parent, usually the father, for example (Carlson & Turner, 2010; Köppen, et al., 2020; Nomaguchi, 2012). However, these studies do not discriminate between recent separations and those which occurred some years earlier. The participants of this study are fathers experiencing contemporaneous problems associated with parental separation. In this work, attention is focused on measures of loneliness and mental well-being obtained from this population of separated fathers, and the association of these measures with a range of independent variables, especially an indicator of domestic abuse. The association of these factors with depression/suicidality within this population is also discussed.

Private law children act cases in England and Wales: The background

Cases within the family courts of England and Wales which are brought by a parent to seek an order relating to childcare arrangements are known as 'private law Children Act cases'. There are now around 55,000 such cases per year (Ministry of Justice, 2020a). The parents in question may not be married or divorced. A roughly similar number of parental separations relate to parents who were never married to each other, though they will most often have been cohabiting. Only 38% of separating parents have recourse to the courts to make child arrangement orders (MacFarlane, 2019). The rest make their arrangements without court involvement. There are therefore nearly three times as many couples with children who separate per year in England and Wales than are seen by the courts, perhaps 145,000. With an average of 1.5 children per case, parental separation affects roughly 220,000 children per year in this jurisdiction alone.

The outcomes of these 'private law' child arrangement cases, either in terms of the court orders made or in terms of the actual child contact which transpires (the two things diverging substantially) are beyond the scope of this paper. However, what is relevant is that these outcomes are strongly associated with allegations of domestic abuse and the court's perception of the risks posed by the allegedly abusive parent (Collins, 2019). Hence, it is also pertinent to these outcomes that the incidence of domestic abuse allegations in these court cases is extremely high, while fewer than 10% of such allegations are subject to any 'finding of facts', discussed further below.

Domestic abuse in the UK: The background

For many years, the crime surveys for England and Wales have reported that 33% of adult domestic abuse or partner abuse is against male victims (Office of National Statistics [ONS], 2019). Large, international meta-analyses have indicated that partner abuse is closer to gender parity, or even that men are the majority of victims (Partner Abuse State of Knowledge Project [PASK], 2013). That men are a substantial proportion of the victims of partner abuse in England and Wales is evidenced by 25% of reports to the police of such abuse being by male victims (ONS, 2019), noting that male victims are less likely to report than female victims (ONS, 2018a). But this high level of male victimisation is diminished to very low levels of service provision, and hence minimal policy concern, in a succession of stages. In England and Wales, some 17% of victims in prosecutions for domestic abuse are male (ONS, 2017), already less than the 25% of police reports or the 33% of surveyed victims. Only 5% of cases considered by Multi-Agency Risk Assessment Conferences (MARACs) involve male victims (ONS, 2018b). Similarly, only 4% of victims accessing Independent Domestic Violence Advisor (IDVA) services are male (ONS, 2018c). Of those domestic abuse victims obtaining support in the community, such as from specialist charities, only 3.6% are men, and only 2.6% of refuge provision is provided to men (ONS, 2017).

Thus, the prevalence of male victims is vanished away via a sequence of filters at different stages of the process. The low level of male victimisation apparent at the end of this process then gives rise to misleading claims that women are the 'overwhelming majority' of victims, and even wildly incorrect claims that men are the majority of perpetrators of domestic abuse against other men, claims which are reiterated in the UK Parliament (e.g. Atkins, 2019), which then become instrumental in judicial policy (e.g., Ministry of Justice, 2020b). The result is a virtual monopoly focus on female victims, manifest in the Violence Against Women and Girls (VAWG) policies (e.g., UK Government, 2017). The significance of male victimisation is minimised in such policies based on sex alone. Despite this, the requirements of the

Equality Act (UK Government, 2010) may be claimed to be met based on the differing 'needs' of the two sexes. However, this rationalisation can be sustained only once the underlying prevalence of male victimisation has been successfully hidden by the process of filtering described above, or by claiming that the victimisation identified in surveys is misleading because men are not impacted as seriously as women by the same level of abuse. Both of these attempts to minimise the significance of male victimisation, based on either prevalence or impact, are challenged by the data presented herein.

The association between partner abuse and separation has been quantified in the crime surveys for England and Wales for many years. In 2018/19, for married couples responding to the survey, 2.3% of women and 1.6% of men reported partner abuse in the last year (ONS, 2019). Among separated people, those figures were about eight times larger at 18.1% and 12.3%, respectively. However, the prevalence of allegations of partner abuse rises still further to about 50% for cases of disputed child contact within the family courts in England and Wales (Barnett, 2020). Fewer than 10% of these claims are subject to any meaningful examination (Barnett, 2020). This is the context within which the cases providing the data used in this study arise.

METHOD

The source of participants

This study draws upon data collected from service users of the Welsh charity FNF Both Parents Matter Cymru (henceforth 'the charity') between July 2019 and July 2020. The primary role of the charity is to assist non-resident parents after parental separation to retain or obtain, a mutually beneficial involvement in their children's lives. In the UK, 92% of non-resident parents are fathers (Hunt & MacLeod, 2008), and this is reflected in the sex of the charity's service users, only a few per cent of whom are mothers. Before the COVID-19 lockdown in the UK in March 2020, most service users made the first contact with the charity via monthly meetings in each of ten locations around Wales. During the lockdown there has been no diminution in service user registration, contact now being made through a helpline, or via the charity's web site, or by referrals from solicitors and many different agencies.

There is a very strong association between parental separation and the incidence of domestic abuse, and this applies to both male and female victims (ONS, 2019). For many years this association has been a matter of daily observation within the charity. As a result, in 2018, the charity started a separate service (Aegis) for male victims of domestic abuse, which involved (before COVID-19 lockdown) weekly drop-in centres in two locations in South Wales. In practice, the association between parental separation and domestic abuse is so strong that the charity maintains a single case register which pools the two sources of service users together.

The bulk of the charity's service users are non-resident fathers who are experiencing difficulties with child contact. However, there is also a smaller, but significant, several cases in which the father seeks assistance from the charity principally around concerns about the safety of his children due to a perceived risk from the mother, or perhaps her new partner. In these latter cases, the father may or may not be content with the extent of his contact, and in a few cases, he may be the resident parent.

Data collection and ethics

The charity has been in operation since 2009, but data collection and record-keeping have been subject to maturation. In July 2019 the charity introduced a standardised six-page 'service user pack' (SUP) which records basic data about the client and his/her particular problem concerning which they have sought the charity's assistance. Invariably this involves child arrangements in some form. (Purely financial disputes are notable by their absence). The last three pages of the SUP consist of a domestic abuse risk assessment tool and measures of well-being and loneliness discussed further below. The completed SUP is uploaded to our confidential Caseworker system which also houses all other documentation, correspondence, etc., relating to the case. Strict adherence to confidentiality rules in terms of access to these data is essential, both for GDPR reasons and also because the documents mostly relate to living family law cases, to which legal restrictions apply.

The SUP includes the service user's agreement to the charity's confidentiality and data protection policies, and the possible usage of data in fully anonymised form for research purposes, such as this paper.

Completion of the SUP is partly a supervised process and takes typically 45 to 60 minutes. Before COVID-19 lockdown, this was done as a face-to-face exercise, but it has necessarily been done by 'phone and internet during the lockdown. Usage of the full SUP and associated recording within the caseworker system came about gradually from July to October 2019 and was fully embedded by November 2019. However, for logistical reasons or service user preference, not all cases achieve a fully completed SUP.

Between 1st July 2019 and 19th July 2020, the charity registered 418 new cases, of which 271 (65%) had a SUP within Caseworker and the service user was a father. Due to the slow start in July to September 2019, the SUP data relates to an equivalent of about 10 full months operation of the charity.

Demographics

The charity's client base is not an unbiased cross-section of the Welsh population. This is inevitable given the charity's main function in terms of assisting separated parents. Marriage has become markedly less popular over the last 50 years, but this is strongly demographic related (Benson & McKay, 2015). In the highest-earning demographics, marriage has become only marginally less popular. In contrast, in the lowest income demographics, the reduction in marriage has been dramatic, for example only 25% of new mothers in the lowest quintile of income are married (Benson & McKay, 2015). The decline of marriage in these demographics has led to an increased prevalence of cohabitation. But cohabiting couples separate at several times the rate of married couples (Benson, 2017). Consequently, services for separated people will inevitably be skewed to the lower socioeconomic classes. This is further exacerbated by the withdrawal of legal aid from civil court cases since April 2013 (UK Government, 2012), which leads to low earners, and those on benefits, seeking free assistance from charities such as FNF Both Parents Matter Cymru.

As a result, 56% of the charity's service users are unemployed, and 70% have an income of less than £12,000 pa. At least 6% are BAME and 18% report a disability. This report is confined to male service users. 8% of these fathers did not have formal parental responsibility (PR). It is noteworthy that 92% of fathers did have PR, despite being unmarried in many cases.

Loneliness and well-being measures

The Well-being of Future Generations (Wales) Act 2015 adopts a range of indicators of well-being for the Welsh public (Welsh Government, 2019). Two of these are, (1) the average mental well-being of the Welsh people, and (2) the percentage who are lonely. The measures adopted by the Welsh government were the Warwick-Edinburgh mental well-being scale, and the de Jong-Gierveld loneliness scale. The charity has adopted these same measures.

For mental well-being, the shorter Warwick-Edinburgh scale has been used (WEMWBS Resource, 2018). This asks seven questions, such as 'I have been feeling optimistic about the future,' and similar questions relating to feeling useful/relaxed/close to others, dealing with problems well, thinking clearly, or 'able to make up my mind.' The scale uses a five-point scoring system from 'never' (score 1) to 'always' (score 5). Hence the possible scores range from 7 to 35, with higher scores indicating better well-being. (Tennant, et al., 2007) have shown that the WEMWBS showed good validity/reliability with a Cronbach's alpha of close to 0.9.

For loneliness, the longer de Jong-Gierveld scale has been used (de Jong-Gierveld & Kamphuls, 1985). This combines both the social loneliness and the emotional loneliness sub-scales. Only the combined score will be used here. It consists of eleven questions, which variously may be positively phrased (e.g., 'There are enough people I feel close to') or negatively phrased (e.g., 'I often feel rejected'). Each question scores either 0 or 1, (see Middlesbrough Voluntary Development Agency [MVDA], 2020), so the total score lies in the range 0 to 11 with higher scores indicating greater loneliness. The de Jong-Gierveld loneliness measure was originally developed to meet the criteria of a Rasch scale (de Jong-Gierveld &

Kamphuls, 1985), and has been shown by (de Jong-Gierveld and Van Tilburg, 2006) and (Iecovich, 2013) to be valid/reliable with a Cronbach's alpha of around 0.86.

The last page of the SUP contains the Warwick-Edinburgh and de Jong-Gierveld questionnaires and is handed to the service user to complete independently (or the electronic equivalent). The resulting Warwick-Edinburgh and de Jong-Gierveld scores will be treated as dependent variables in regressions.

Depression and suicidality

A further dependent variable was defined according to the service users' self-reporting of depression and/or suicidality. The variable was defined as self-reported depression = 1, suicidal ideation = 2, suicide attempt = 3, none of these = 0.

Domestic abuse risk index (RIC score)

Pages 4 and 5 of the SUP consist of the Safelives Dash domestic abuse Risk Identification Checklist, or RIC (Safelives, 2020). This is the same tool which is virtually universal within the female domestic abuse sector in the UK. It consists of 24 questions with yes/no/don't know responses. Example questions are, 'has the current incident resulted in injury?,' 'Are you very frightened?', 'do you feel isolated from friends/family?', 'does the abuser try to control everything you do?'. Each 'yes' scores one point. The higher the score, the greater the assessed risk. A score of 14 or more is taken to indicate a high risk of abuse, a level which may suggest referral to a MARAC. Use of the RIC tool requires supervised completion by a trained person. The national manager of the charity is trained as an IDVA. The RIC score will be treated as an independent (predictor) variable in the regressions, together with a range of other independent variables (defined next).

Other independent variables

Ordinary linear regressions were carried out based on nine independent (predictor) variables, with nicknames and definitions:

- *RIC* is the domestic abuse Risk Identification Checklist score normalised by 14, so that RIC ≥ 1 indicates high risk.

All the remaining variables are binary, taking values 0 or 1, as follows:

- *Income*: If the service user's income is less than £12,000 pa then Income = 1
- *Allegations*: If allegations of domestic abuse were made against the father then Allegations = 1
- *Buddy*: If the service user requested to join the charity's 'Buddy' scheme then Buddy = 1. (The charity's Buddy scheme provides emotional support, so this variable is an indication of the service user's recognition that he needs emotional support).
- *Services*: If social services were already involved with the family when the service user registered with the charity then Services = 1
- *Mediation*: If the partner/ex-partner has refused formal mediation then this variable is set to 1
- *Child DV*: If the partner/ex-partner or her family or new partner were reported by the service user as having been abusive to a child then Child DV = 1
- *Disability*: If the service user self-reports a disability then Disability = 1
- *Contact*: If the service user's contact with his child(ren) was being prohibited or unduly restricted than Contact = 1

Statistics

Analysis of the data was carried out in Python and cross-checked in Excel data analysis. This included calculating Pearson correlations between pairs of variables and ordinary, multivariate, linear regressions between the dependent variables and the full set of independent variables (unstandardised). Linear regressions were also carried out based on a subset of independent variables chosen as those with the larger correlations. The full dataset had $N = 271$ but many SUPs were incomplete, so for the well-being

and loneliness data *N* = 220, for the RIC data *N* = 173, and regressions which required both well-being and RIC had *N* = 156. The significance of relationships between variables may be judged from the p values quoted below and derived from the regressions.

RESULTS

Loneliness data

Figure 1 displays in histogram form the distribution of de Jong-Gierveld loneliness scores from the charity's male service users. Table 1 compares these scores with a large scale survey of the general adult male population of England (ONS, 2018d), in ranges which correspond with the verbal descriptions used in that source. Figure 1 is starkly distinct from the general population, the mode of the distribution being at the maximum possible loneliness, compared with the general population for which the mode lies in the 'hardly ever lonely' range. 40% of the charity's service users are severely lonely ('often/always') compared with only 5% in the general adult population. 67.7% of the charity's service users are lonely more often than 'occasionally', compared with 19% of the general adult male English population (ONS, 2018d), or 16% of the general adult male Welsh population (Welsh Government, 2018). A Mann–Whitney U test confirms that the distribution of measured loneliness is significantly different from the general population ($p < 0.00001$). The extreme degree of social/emotional isolation evident in this cohort of separated fathers is one of the main observations of this study.

Figure 1
De Jong-Gierveld Loneliness Score (Percentage of Service Users Who Completed the Assessment, N = 220)

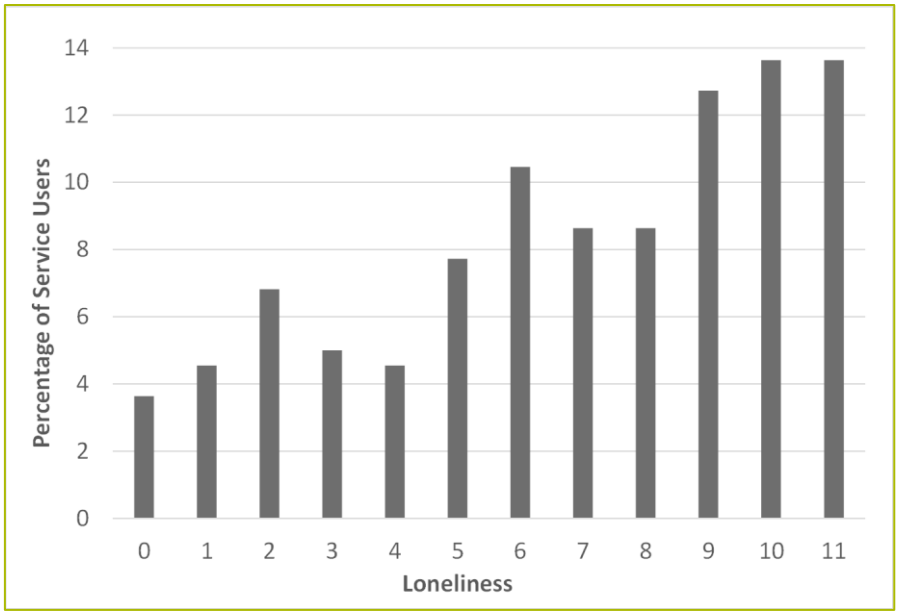


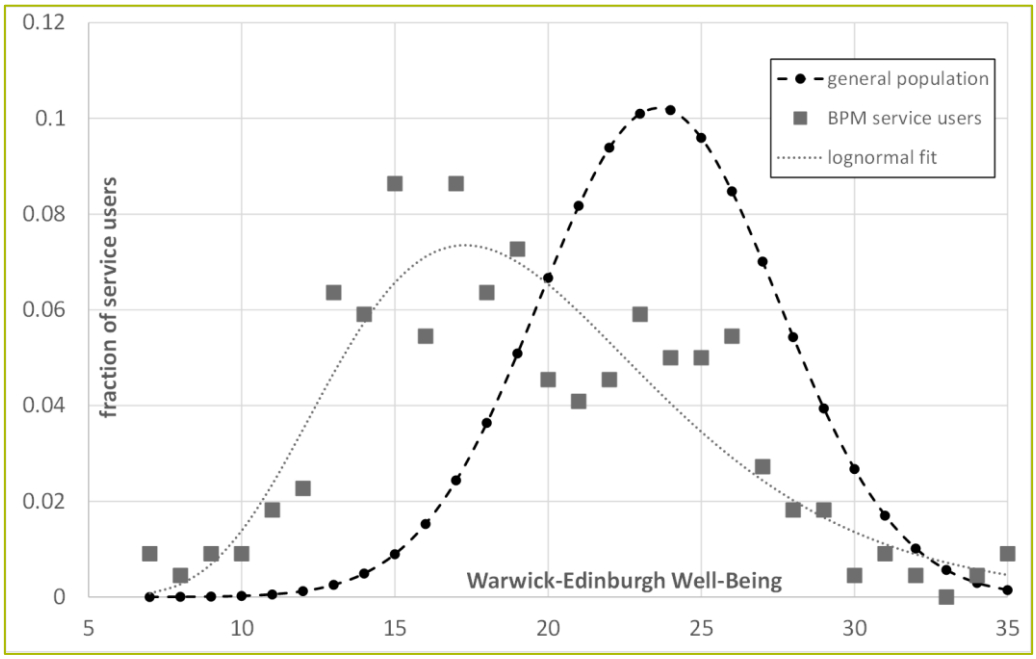
Table 1
Loneliness of the Charity's Male Service Users Cf. General (English) Adult Male Population

Loneliness score	Decription	General population	Present study
0	Never lonely	27%	3.6%
1–2	Hardly ever lonely	32%	11.4%
3–5	Occasionally lonely	22%	17.3%
6–8	Lonely some of the time	14%	27.7%
9–11	Often/always lonely	5%	40.0%

Well-being data

Results of the Warwick-Edinburgh mental well-being assessments are plotted in Figure 2 in comparison with the general adult population of England (WEMWBS Resource, 2011), where the latter is represented by a normal distribution with a mean (or median) of 23.6 and a standard deviation of 3.9. To aid visualisation the best lognormal fit to the service user data is also plotted in Figure 2. The median is 18.9 and the mode is 17.4. It is clear from Figure 2 that the separated fathers have mental well-being skewed to abnormally poor levels, the median being shifted down by 4.7 points. 78% of these separated fathers have poorer well-being than the mean of the general population. 28% of the separated fathers have a well-being score of 15 or lower, which has a prevalence of less than 2% in the general population. A Mann–Whitney U test confirms that the distribution of measured well-being is significantly different from the general population ($p < 0.00001$).

Figure 2
Shorter Warwick-Edinburgh Mental Well-being Cf. the General Population of England (Fraction of Service Users Who Completed the Assessment, N = 220)



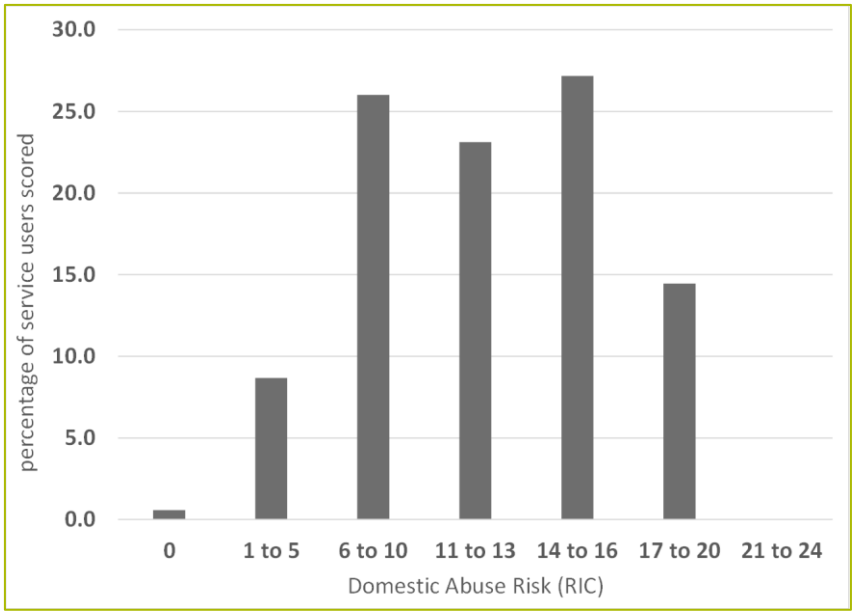
Domestic abuse and RIC scores

From the dataset of 271 male service users, 196 (72%) either self-reported being the victim of domestic abuse, or this was apparent from the domestic abuse risk index. 173 (64%) completed a supervised RIC assessment. 138 service users with a completed SUP (51%) reported that allegations of domestic abuse had been made against them by their partner/ex-partner. 33 cases (12%) involved child protection issues other than any risk posed by the father, almost all associated with the father claiming that the mother had abused the child(ren). In 63 cases (23%) social services were already engaged with the family at the time the service user registered with the charity.

The results of the RIC assessments are displayed in histogram form in Figure 3. The median RIC score was 12. 41% of service users with a RIC assessment were assessed in the 'high risk' category, having a RIC score of 14 or greater. In 23 cases (13% of assessed cases) the charity's IDVA judged the risk sufficient to motivate a MARAC referral. The average RIC score for these 23 cases was 16. However, few of these were referred to MARAC. It is no longer the charity's policy to do so. The reason is several experiences with breaches of security within the MARAC process which led to the abuser discovering the victim's

address and thereby furthering the abuse. The charity no longer regards the MARAC process as a safe recourse for men.

Figure 3
Domestic Abuse Risk Index (RIC Score) for the Separated Fathers (Percentage of Service Users with an RIC, N = 173)



Correlations

Pearson correlations between the loneliness scores and the independent variables, where significant ($p \leq 0.05$), are given in Table 2 together with their p values. Correlations with the mental well-being scores are also given. Note that the correlations align with expectation in terms of the sign, i.e., those for loneliness are positive while those for well-being are negative. Note that the correlations with domestic abuse victimisation of the father are most significant, while low income (mostly unemployment) is the second most significant.

Table 2
Pearson Correlation Between Loneliness or Well-being and the Independent Variables, Where Significant (No Correlations Significant for Variables Child DV, Disability, or Contact)

Variable	Loneliness (deJong-Gierveld)		Well-being (Warwick-Edinburgh)	
	Correlation	*p*	Correlation	*p*
RIC	0.23	0.004	–0.26	0.001
Income	0.23	0.001	–0.19	0.007
Allegations	0.14	0.045	n/s	> 0.05
Buddy	0.14	0.044	–0.18	0.013
Services	n/s	> 0.05	n/s	> 0.05
Mediation	n/s	> 0.05	–0.18	0.01

Regression

Ordinary linear regressions for the dependent variables, loneliness and well-being, were carried out in terms of the nine independent variables. The resulting unstandardised (or 'b') coefficients are given in

Table 3. The linear fits accounted for 40% of the variation in the well-being measure and 44% of the variation in the loneliness measure. Also included in Table 3 are the coefficients obtained when variables which do not have a significant correlation with the dependent variable are excluded from the regression. The salient feature of all fits is that the dominant predictor variable is the domestic abuse index (RIC score) in each case, and this is significant at the 97% confidence level or better. The only other variable which is significant at the 95% confidence level is the refusal of the ex-partner to agree to mediation (in respect of degrading well-being, see Table 3).

Table 3
Regression 'b' Coefficients and Their P-Values for Loneliness and Well-being (for Cases Where All Variables Were Known, N = 156)

DV	Loneliness				Well-being			
	Coeff.	*p*	Coeff.	*p*	Coeff.	*p*	Coeff.	*p*
Intercept	4.88	<0.001	4.79	<0.001	22.95	<0.001	22.97	<0.001
RIC	2.09	0.02	1.88	0.03	−4.86	<0.001	−3.95	0.003
Income	0.7	0.2	0.65	0.25	−0.54	0.5	−0.15	0.8
Allegations	0.15	0.8	0.14	0.8	0.52	0.5	0	–
Buddy	0.15	0.8	0.23	0.6	−0.48	0.5	−0.34	0.7
Services	0.64	0.27	0	–	0.61	0.5	0	–
Mediation	0.75	0.17	0	–	−1.69	0.05	−1.74	0.03
Child DV	0.43	0.5	0	–	1.55	0.16	0	–
Disability	0.89	0.15	0	–	1.73	0.07	0	–
Contact	−0.68	0.25	0	–	−0.11	0.9	0	–

Depression and suicidality

The Pearson correlation of the variable representing self-reported depression/suicidality with the nine independent variables was calculated and found to be significant ($p < 0.05$) only for three variables: *RIC*, *income*, and *disability*. These correlations are given in Table 4. The strongest correlation was with domestic abuse victimisation of the father, and the second strongest was with low income, as was found for loneliness and well-being (Table 2). However, the significant correlation between disability and depression/suicidality is new and specific to this dependent variable.

Also shown in Table 4 are the correlations between depression/suicidality and loneliness or well-being. Not surprisingly there are significant correlations with both, and with the anticipated sign. The negative correlation between the shorter Warwick-Edinburgh well-being measure and client reported depression/suicidality is the largest correlation identified in this study.

Ordinary linear regression for depression/suicidality against the nine independent variables yields the "b" coefficients given in Table 5. The dominant regression term is again that for domestic abuse victimisation of the father (RIC), but Disability is also significant. This fit accounts for 49% of the variation in the dependent variable. Also given in Table 5 are the regression coefficients when only the variables with significant correlations are included (*RIC*, *income*, and *disability*).

Table 4
Pearson Correlations Between Depression/Suicidality and the Independent Variables, Where Significant, and Also with Loneliness and Well-being

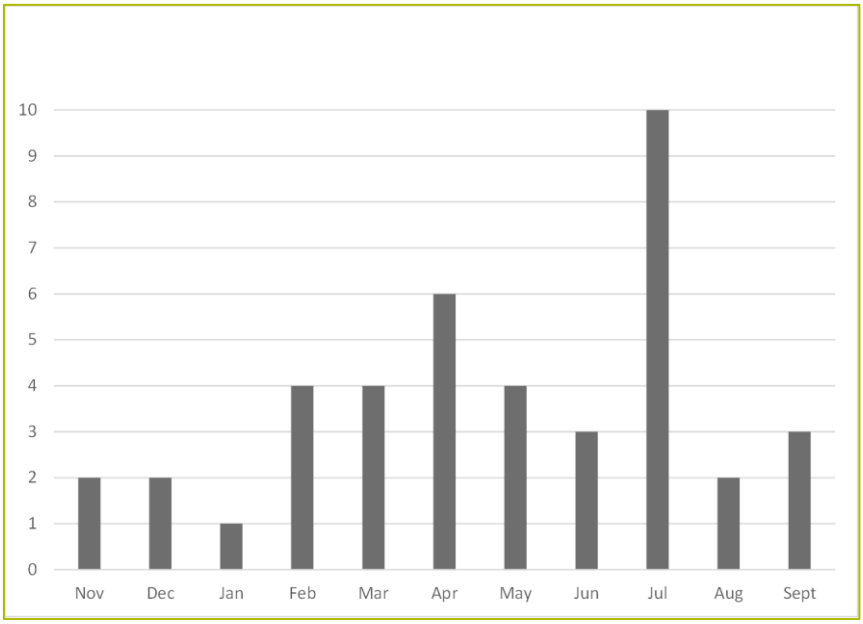
Variable	Depression/Suicidality	
	Correlation	*p*
RIC	0.32	0.0001
Income	0.22	0.005
Disability	0.20	0.012
Loneliness	0.26	0.0002
Well-being	−0.35	10^{-6}

Table 5
Regression 'b' Coefficients and their P-Values for Depression/Suicidality (for Cases Where All Variables Were Known, N = 156)

Independent Variable	Depression/Suicidality			
	Coeff.	*p*	Coeff.	*p*
Intercept	0.19	0.34	0.28	0.11
RIC	0.71	0.001	0.66	<0.001
Income	0.23	0.10	0.22	0.11
Allegations	−0.15	0.27	0	–
Buddy	0.09	0.48	0	–
Services	−0.04	0.77	0	–
Mediation	0.01	0.94	0	–
Child DV	−0.01	0.97	0	–
Disability	0.3	0.04	0.26	0.07
Contact	0.12	0.40	0	–

Of the 173 service users who addressed the question during the period of this study, 39 (23%) had recently experienced suicidal ideation, of which 8 (5%) had attempted suicide. These prevalence are substantially elevated compared with the general population. However, the statistics are too sparse to identify any trends over time (Figure 4).

Figure 4
Number of Service Users Reporting Suicidal Ideation or Past Suicide Attempts by Month (November 2019–September 2020



DISCUSSION

The experience of the staff and volunteers working with the charity is that most service users are in a state of considerable distress. Consequently, it is no surprise that the measured mental well-being of these separated fathers is skewed to substantially lower levels than the general population. However, it is of concern that such extremely poor well-being scores are so common in this population, 28% having a well-being score of 15 or lower, which has a prevalence of less than 2% in the general population.

It is also no surprise that the charity's service users have elevated loneliness scores. The charity knows that social isolation is frequently a service user's principal difficulty. This comes about because men's social circle tends to focus on just two centres: work and family connections. As most of the charity's service users are unemployed, after separation both centres of social contact have failed, leaving the man without social support at a time when it is most needed. Despite being readily explicable, it is still rather alarming to find that the degree of loneliness is so marked that the mode of the distribution lies at the maximum measurable loneliness. 40% of the charity's service users are severely lonely compared with only 5% in the general adult population.

In view of the service users' markedly reduced well-being and commonly severe social isolation, it is to be expected that suicidality would have an elevated prevalence. This was borne out by 39 of those asked the question (23%) having recently experienced suicidal ideation, of which 8 (5%) had attempted suicide. The link between separation and men's suicide is well known, though perhaps not as well established by UK data as it might be. (Collins, 2019) analysed data referenced in (Samaritans, 2012) and (Evans et al., 2016), none of it from Great Britain, and concluded that separation increases the suicide rate for both sexes, but more so for men than for women. The suicide rate for men after separation was estimated to be 8 to 12 times higher than for women in the general population. To the effect of separation must be added the effect of domestic abuse in elevating suicide rates further, and again this is more marked in men than in women. In 2017/18, in England and Wales, 11% of male victims of partner abuse tried to take their own lives compared to 7.2% of female victims (ONS, 2018b).

As regards associations with the independent variables, the elevated loneliness, the reduced well-being, and the elevated prevalence of depression/suicidality were all most strongly correlated with the men's domestic abuse victimisation (RIC score). This variable was also clearly dominant in the regressions. The

greater significance of the fathers' victimisation by domestic abuse than any of the other eight independent variables is one of the main findings of this study.

The second most significant independent variable was low income, less than £12,000 pa (generally due to being unemployed), and this was again the case for all three dependent variables: loneliness, well-being and depression/suicidality. Other independent variables were significant for some dependent variables but not all, namely allegations against the father, the man's recognition of his need for emotional support, refusal of the ex-partner to consider mediation, and, in the case of depression/suicidality, the man's disability.

An initially surprising finding was that the variable representing frustrating contact with children was not significant, because the anecdotal experience is that child contact issues are a major source of fathers' distress. On reflection this is less surprising because our dataset does not contain contrasting data: essentially all service users were having some form of child arrangement problem. Whilst 65% were experiencing prohibited or restricted contact, the rest had other concerns which invariably focussed on their children, typically anxiety about potential abuse by the ex-partner or her family or new partner. Consequently, the lack of statistical significance of variable 'contact' most likely indicates that both types of case are equally distressing. The effect of prohibited contact could only be isolated by comparison with a control group experiencing no child arrangement problems, but the charity has no such control group.

There continues to be a political and judicial adherence to the notion that domestic violence is overwhelmingly about female victims and male perpetrators. This is exemplified by the outcome of a recent family justice review (Ministry of Justice, 2020b). The final report, literature review and implementation plan resulting from this judicial review, amounting to some 406 pages, presents a perspective which is not so much biased as a monoculture of concern. That partner abuse of men, and fathers, in particular, is relatively uncommon is not supported by the fact that 72% of the charity's service users have been identified as experiencing such abuse. Nor can any claim that the impact of such abuse on men is minor be sustained in the light of the present findings. 41% of service users subject to risk assessment were assessed in the 'high-risk' range, with a RIC score of 14 or higher (26% of the whole population in the study). But perhaps most revealing is that it is the domestic abuse risk index (RIC) which, out of the nine independent variables examined, is most strongly associated with loneliness, well-being and depression/suicidality. Add to these findings from this study the national crime survey findings that male domestic abuse victims are more likely to attempt suicide than female victims (ONS, 2018b), and it ceases to be credible to argue that partner abuse is a less serious issue for men than women, either in terms of prevalence or impact.

Much has been written this year about increases in domestic abuse resulting from the COVID-19 lockdown. There has also been an immediate effect on non-resident parents' contact with their children. A survey conducted by the charity in April/May 2020 indicated that 61.5% of fathers responding to the survey had no contact, or only indirect contact, with their children during the lockdown, a huge increase from 14% which prevailed before lockdown. In comparison, 27% of women responding to the survey had no contact, or only indirect contact, with their children after lockdown, an increase from 9% before lockdown. The long-term effects of the lockdown remain to be seen, but it is already apparent that the severe economic downturn is likely. The potential for a simultaneous marked increase in both domestic abuse and unemployment, the two most significant variables, presents a worrying prognosis for increasing levels of isolation and suicidality among the demographic of separated fathers.

CONCLUSION

Separated fathers accessing the services of charity FNF Both Parents Matter Cymru were found to have: (1) substantially degraded mental well-being, 28% having a well-being score of 15 or lower, which has a prevalence of less than 2% in the general population; (2) highly elevated social and emotional isolation, 40% being severely lonely compared with 5% in the general adult population; (3) markedly elevated prevalence of suicidality.

Of nine independent variables investigated, the variable which had the dominant association with degraded well-being, elevated loneliness, and the increased prevalence of depression/suicidality was the

fathers' victimisation by partner abuse. In each case, the second most significant variable was an income less than £12,000 p.a. (generally due to being unemployed).

Acknowledgement

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Child contact problems and family court issues are related to chronic mental health problems for men following family breakdown

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It is known that family breakdown and divorce are stressful for all parties. There is evidence these can even lead to suicide, especially in men. However it is not known how much various factors – such as child access restrictions and family court issues – cause stress, and whether the levels of stress change over time. The present study surveyed the experiences of 29 men who had separated from their partners. Participants submitted multiple reports (n = 408 for the whole sample) over a 12-month period. It was found that these reports included 358 stressful experiences related to child access problems, and 229 stressful experiences related to family court issues. Men's mental well-being, measured using the Positive Mindset Index, was continuously low – just above clinical levels on average – throughout the 12-month period. Mental well-being was strongly negatively correlated to problems with child access (rs = –.571) and family court issues (rs = –.448). These correlations can be interpreted in the context of free text responses, which indicate that child access issues and family court issues had a negative impact on men's mental well-being. Physical health problems were frequently reported too. Implications of these findings for the long-term mental health and physical health of men experiencing family breakdown are discussed in relation to the need for the family courts, and associated services, to recognise the chronic stress experienced by many men who find themselves in this predicament, and to ensure that court processes are resolved as swiftly as possible.

Keywords: child access; chronic stress; family breakdown; family court; a longitudinal study

The distress of family breakdown can lead to mental health problems and even suicide (Sullivan, 2019). A review of suicide research in the US found that the two most common reasons for suicide are relationship/family discord (22% of suicides) and relationship dissolution (a further18% of suicides) (Callanan & Davis, 2009).

Family breakdown is usually stressful for all concerned, though mothers and fathers tend to experience the related stressors differently (Köppen et al., 2020). For example, men in this situation are twice as likely to experience depression compared to women, possibly in part due to men's greater reliance on their spouse's network for social support than vice versa (Rotermann, 2007). Compared to married men, divorced men are significantly more prone to depression, suicide, substance abuse and heart disease (Felix et al., 2013). An estimate based on a large US database is that divorced men are at nine times higher risk of suicide than divorced women, even after taking into account age, education and income (Kposowa, 2003).

There is some evidence that loss of contact with one's children is a contributor to parental suicide (Shiner et al., 2009), but many aspects of the contributing factors are uncertain. There is evidence however that family breakdown can harm children, for example, delinquent behaviour (Juby & Farrington, 2001). Conversely, children who grow up in intact families tend to experience advantages in some aspects of physical health, emotional health and cognitive ability (Mariani et al., 2017).

Family breakdown can be considered a chronic stressor, but the degree of distress experienced at the different stages of breakup (e.g. initial separation, family court, long-term separation etc) have not been measured systematically. It is well recognised that divorce is linked to a reduction in health (Sbarra & Coan, 2017), suggesting that for many people the chronic stressors associated with family breakdown impact their physical as well as mental health. A national study of over 7000 adults in the US found that people who are widowed, separated, or divorced had a higher allostatic load – a profile of biomarkers indicating chronic stress - than those who were married or living with a partner (Chen et al., 2014).

In the case of men going through the family court process, this for many is a long-term stressor, and it is not known whether this relents once problems are resolved. In general, men under stress tend to prefer to deal with the problem that is causing the stress rather than deals with their feelings regarding the stressor (Holloway et al, 2018), so it is more likely that resolution of stress for men in the family court process will be 'solution-focused' i.e., stress will be resolved when the problem is resolved.

Currently, there is a lack of clear data on how stressful specific experiences can be, nor whether men and women experience these stressors differently. Therefore, the present study aimed to identify the degree to which different types of stressors are related to different levels of distress following family breakdown.

METHODS

Design

This study was a longitudinal online survey analysed using correlations and *t*-tests. The main outcome was mental positivity, and the other variables were: *demographics* (age, gender, UK region of residence); *features of the relationship and family* (months since separation [aka 'split'] from the partner, years in the relationship before separation, number of children, duration of separation from children; *recent stressful issues* (stress of family court issues, stress of arguments regarding family court issues, stress of child access issues, stress-related to mental health issues, stress of physical health issues, stress of work-related issues, stress of relationship issues, stress of substance abuse issues, and housing issues).

Materials

Features of the relationship and family

Participants were asked: *How long ago (approximately) did you split from your ex?; How many years, approximately, were you in your relationship before the breakup?; Please state the number of children with your ex.; How many of these children are you separated from, and for how long?*

Recent stressful issues

Participants were asked: *Please state how stressful any of the following have been for you in the past two weeks: family court issues; arguments related to family court issues; child access; mental health; physical health; work; relationships; substance abuse (alcohol, drugs); and housing.* These were answered on a scale from 1 to 5, where 1 = not at all stressful; 2 = slightly stressful; 3 = moderately stressful; 4 = very stressful; 5 = extremely stressful. There was also an option with each question to identify when there were no issues to deal with.

Positive Mindset Index (Barry et al., 2014)

The PMI consists of six items (happiness, confidence, being in control, emotional stability, motivation, and optimism), and uses a 5-point Likert scale. Previous work (e.g., Male Psychology Network, 2020) has observed that this scale shows good internal reliability (Cronbach's alpha = 0.926) and good concurrent validity a range of other validated instruments measuring constructs such as psychological health (r= .678), suicidality (r = –.539), happiness (r = .689), and self-esteem (r = .766).

Two platforms were used for the questionnaire (as per Stoet, 2010; 2017: Qualtrics (from November 2018 – January 19), then PsyToolkit (from February 2019 to April 2020). The survey questions were unchanged on the platforms, apart from removing the need to re-enter demographic information in the second version of the survey.

Participants

Participants were people registered with Families Need Fathers (FNF), a UK-based organisation for those facing difficulties in family breakdown. Due to the impact of UK family court laws on fathers, the membership mostly consists of men, though women are welcome too, and around a third of followers of the FNF Facebook page are women. The inclusion criteria were: being aged over 18 and with some experience of family breakdown and the family court system.

Procedure

The study was launched at an FNF conference in London in October 2018, and thereafter participants were recruited via the FNF newsletter, mailing list and social media. The contact point was JB, and potential participants who contacted JB were emailed the information sheet and consent form. Once they had consented, the participant received a personal identity code to use when filling in the survey. Every two weeks they were prompted by email to fill in the survey.

Data analysis

The distribution of most scores, which the exceptions of (age, number of children, and PMI), were positively skewed. Statistical adjustments were applied where possible (e.g., *t*-tests without equal variance assumed), or otherwise nonparametric tests applied (e.g., Spearman's rho, r_s).

RESULTS

Participants

Thirty-three participants (29 men and 3 women) consented to participate. All participants met the inclusion criteria, so all were included. All participants submitted the minimum required information, so all data were included. The median number of responses during the study period from the male participants was 13, with the highest number being 30 and the lowest being 1. For the three women, the median number of responses was 18, with the highest number being 22 and the lowest being 8. The median duration taken to fill in the survey was 3 minutes (minimum = 1 minute; max = 103 minutes). One man withdrew after three months due to finding the process of reporting his feelings and experiences too upsetting and was referred to the FNF support phone line. Of the three women, one was a grandmother

alienated from her grandchildren addressing difficulties with her son's wife, a situation which is not directly comparable to the other two women, who were mothers seeking access to their children. Unfortunately, the number of women in the sample was too small for statistical analysis, and because findings from such a small group would be difficult to make generalisations from to other women, these data were withdrawn from further analysis.

Table 1 shows the information (demographic, relationship/family, *Stressful recent life experiences)* given at baseline (i.e., the first time filling in the survey). It can be seen that most participants were from London or the South East of England, possibly due to the study being launched at an FNF conference in London, which would have been attended mainly by people from London and the surrounding area. The sample had an average (median) age of 47, around 3.5 years since their split, had been in that relationship for about 9 years, had three children, who had been separated from for around two years. On a scale of 1 to 5, where 5 indicated the highest level of stress, the experience that caused the most stress was child access (median 5) and family court issues (median 5). The median PMI scores of 2.8 (0.82) were lower than the average for men in the UK 3.40 (*SD* = 0.72). The threshold for clinically low levels of mental positivity is around 2.7, so the mental positivity of the men in the FNF study was on average only just above levels that would indicate a problem that required psychological intervention. The median PMI scores across the study (408 observations) were 2.77 (0.82), which suggests a fairly consistently low level of mental positivity (see also Figure 1). The UK norm for the percentage of men scoring 2.7 on the PMI is 12.1% (Barry, 2020). In the present study, at baseline, 46% (13 of 28) scores were below the 2.7 thresholds, and 44% (10 of 26) were below this threshold at the time of their last rating in the study. These scores show that across the 12 months of the study, clinically low mental well-being scores were almost four times more common than would be expected.

Table 1
Baseline Information Regarding Demographic Characteristics, Relationship/Family, and Stressful Life Experience Scores of the Respondents

		Men (*N* = 29)	χ^2
Age, median (min - max)		47 (27 – 60)	
Region	London & SE	19 (63%)	8.397
	SW England	3 (10%)	
	Scotland	5 (17%)	
	Other	3 (10%)	
Months since split		42 (2 – 156)	
Years in relationship before split		9 (1 – 36)	
Number of children		3 (1 – 5)	
Months separated from children		24 (2 – 108)	
Family court issues		5 (2 – 5)	
Arguments of family court issues		4 (2 – 5)	
Child access		5 (2 – 5)	
Mental health		4 (2 – 5)	
Physical health		3 (1 – 5)	
Work		3 (1 – 5)	
Relationships		3 (1 – 5)	
Substance abuse		1 (1 – 3)	
Housing		4 (1 – 4)	
Positive Mindset Index (PMI)		2.8 (0.82)	

NB: Apart from region which shows percentages, and PMI which shows mean (± SD), values are shown as medians (and highest – lowest scores), analysed using Chi Square (χ^2).
SE = South East England; SW = South West England
χ^2 with Fisher's Exact correction

Table 2 shows the correlations between scores on the PMI and the relationship/family variables and stressful recent life experiences variables. It can be seen that three events are strongly correlated with worse PMI: child access, mental health stress, and family court issues/arguments. Notably, child access issues were the most frequent problem, being identified in 92.8% of the reports as being at least 'slightly stressful' or worse. This is much more frequent than family court issues (59.3% of occasions) or arguments about family court issues (68.3% of occasions).

Table 2
Correlations (Spearman's rho, r_s) Between PMI and Other Variables for the 29 Male Participants and 408 Reports

Variable	Correlation with PMI	% of Times this issue arose	Sig.
Months since split	−.032	–	ns
Years in relationship	−.064	–	ns
Number of children	.177**	–	.001
Months separated from children	.140**	–	.005
Family court issues	−.448**	59.3%	$.05^{-19}$
Arguments about family court issues	−.439**	68.3%	02^{-17}
Child access issues	−.571**	92.8%	05^{-33}
Mental health issues	−.547**	86.8%	05^{-30}
Physical health issues	−.365**	91.3%	04^{-13}
Work-related issues	−.253**	89.5%	02^{-7}
Relationship issues	−.307**	84.3%	02^{-10}
Substance abuse	−.185*	33.9%	.001
Housing issues	−.318**	67.3%	03^{-11}

NB: The number of times each issue arose throughout the study varies for each variable, depending on whether the participant had experienced an issue with a particular issue or not.

Correlations with physical health

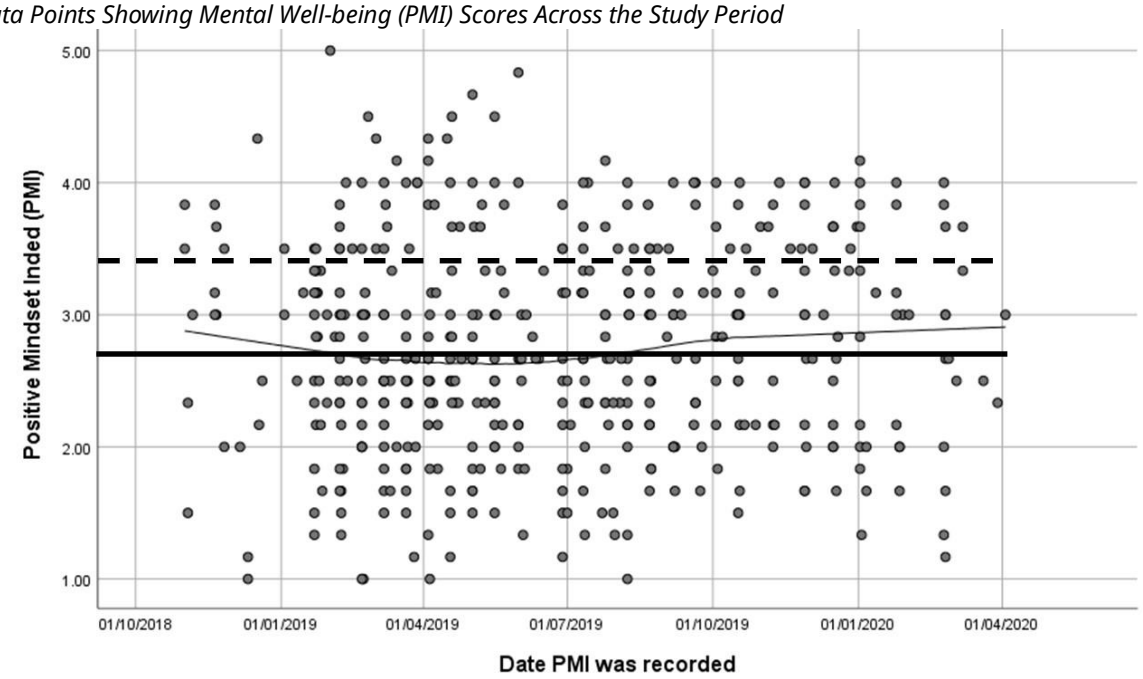
There were significant positive correlations (not shown in Table 2) between physical health problems and other variables: child access problems (r_s = .389, n = 388, $p < .02^{-13}$), family court issues (r_s = .383, n = 388, $p < .05^{-13}$), and arguments over family court issues (r_s = .275, n = 388, $p < .04^{-6}$).

Table 3
Quotations from some of the participants, capturing the core issues experienced

Variable	Quote from participant
Months separated from children	*Every day, I am reminded that I have no contact with my daughters.*
Family court issues	*Constantly shocked by the bias in the Family Courts against men*
Arguments of family court issues	*Frustrated at my ex partners attitude and with the family court.*
Child contact	*Most stress now comes from having to continue contact with my ex, and from not having as much contact with the kids as I did.*
Physical health	*I was admitted to hospital with severe chest pains and breahting issues. I had a number of tests done all of which came back clear. It became apparent that all this issues where related to stress and anxiety caused by family court issues and contact failing.*
Work	*Work is quiet stressful and seams to get into my time with my child... I desperately need exercice but my work takes a lot of my energy.*
Relationships	*Trying to have hope in the impossible of a normal relationship with one's child is so so difficult.*
Substance abuse	*I have realised that alcohol can be dangerous and have now gone 5 nights without*
Housing	*I'm still waiting for my new home (new build) to be completed, and it is increasingly strained for my son and I to continue living with my mum.*

Figure 1 shows the relationship between the PMI score and the date that the PMI score was recorded. It can be seen the time of year does not appear to have an impact on PMI. To test this, the PMI scores for men recorded at three periods during the year were compared: the Xmas period (mean PMI = 2.9), the new year period (mean PMI = 3.2), and the rest of the year (mean PMI = 2.8). One-way ANOVA found no significant difference in the PMI scores, F (2, 396) = 1.474, p < .230.

Figure 1
Data Points Showing Mental Well-being (PMI) Scores Across the Study Period



NB: The heavy dotted line shows the norm wellbeing score for men in UK; the heavy black line shows the threshold for clinically relevant scores; the lighter curved line (Loess curve) shows PMI scores in this study were consistently close to the clinical threshold across the duration of the present study.

Stress-related to child access or family courts

Three men were dealing with child access, but not via the courts at any point during the survey. Taking all measurement occasions into account (75 for the no-court group vs 323 for the others), the mean PMI of these three men was significantly higher than the PMI of those who were involved in the family court process (3.5 vs 2.6; $t(df = 150.08) = 12.187$, $p < .05^{-32}$).

Impact of resolution of family court issues

Although there were only two examples of the resolution of family court issues during the period of the study, which is not a sufficient number to apply statistical analysis, some free text responses suggest that resolution led to considerable relief from stress. In his final submission to the survey, one man said his wife had called off-court action and wanted to restart their relationship; in this post, his PMI was 3.0, a marked improvement to his previous mean PMI score of 2.4 during the period of separation.

DISCUSSION

This longitudinal survey assessed the mental positivity of 29 men over 12 months, identifying the issues that predicted distress about their family breakdown experience. It was found that problems with accessing their children, and family court issues, were strongly correlated with chronic levels of, on average, almost clinical levels of distress.

Stress due to child access and family courts

It is known that the distress of family breakdown can lead to distress and even suicide (Sullivan, 2019). Indeed relationship dissolution accounts for 18% of suicides (Callanan & Davis, 2009). The Positive Mindset Index is known to be well correlated with suicidality and other indexes of mental health, and in the present study, the median PMI scores across the 12-month study period (Figure 1) were 2.77 (0.82), demonstrating a chronic low level of mental positivity, being in just above the threshold (PMI of 2.7) for clinically relevant scoring. The fact that PMI wasn't significantly lower over the winter holiday period might be explained by the reduced activities of the family courts over this period, so although many fathers may not have had access to their children over this time, any sense of loss might have been compensated by at least not having to cope with family court issues over this time. At the start of the study, 46% (13 of 28) of scores were below the PMI clinical threshold of 2.7, and at the end of the study, 44% (10 of 26) were below this threshold. Therefore across the 12 months of the study, clinically low mental well-being scores were almost four times more common than would be expected in adult men in the UK. Table 1 shows that the duration of time since separation, which ranged from two to 108 months, was not correlated with the degree of stress, which indicates the chronic and unrelenting nature of the stress experienced by the men in this study.

Previous research suggests that loss of access to one's children is a contributor to parental suicide (Shiner et al, 2009). The correlations (Table 2) suggest that that child access was the variable most related to low mental positivity ($r_s = -.571$). The effect size of this correlation is strong ($r = .5$ is a strong correlation). Almost as strongly related to PMI were family court issues ($r_s = -.448$), and arguments related to the family court issues ($r_s = -.439$). Correlation does not prove causation, but the free-text responses (Table 3) support the interpretation that issues connected to child access and family courts were the cause of men's stress.

There were two other sources of evidence that family courts caused stress. Firstly, the three men who did not use the family court process had significantly higher PMI scores than men using the family courts (respectively, PMI scores of 3.5 vs 2.6, $p < .05^{-32}$). Secondly, two men came to a resolution of family court issues during the period of the study, which although is not a sufficient number for statistical analysis, experienced considerable relief from stress, as shown not only by PMI changes but by their free-text responses. In his final submission to the survey, one man said his wife had called off-court action and

wanted to restart their relationship; in this post, his PMI was 3.0, which is a clinically significant increase from the mean of his previous posts, which was 2.4.

Impact on physical health

Previous research has found that individuals who are divorced or separated are more prone to health problems related to chronic stress (Chen et al., 2014). Divorced men are significantly more prone to depression, suicide, substance abuse and heart disease than married men (Felix et al., 2013). In the present study, physical health problems were moderately correlated (r_s between .3 and .5) with child access problems, family court issues, and arguments over family court issues. Free text comments from participants (examples in Table 3) suggest that stress directly related to family courts and stress due to arguments about family court issues increased health problems. Table 2 shows that men mentioned health issues in 91.3% of their reports and that health issues were moderately related to PMI (r_s = –.365). Table 3 gives an example of a man who was hospitalised with severe chest pains due to the pressures of his family breakdown issues. The longer-term consequences of stress on health could not be assessed in this study, which followed men over only 12 months. However the frequency of reports of health issues is a red flag for long-term consequences, and this needs to be the subject of further research.

Strengths of this study

This was a longitudinal study which assessed changes in stress levels over time, and the impact of various court experiences and life experiences over time. This research design means that the results can't be explained by individual differences e.g. due to demographics or personality type. Though only a pilot study, the project amassed a lot of data – with over 400 reports throughout the study. The study highlighted the unrelenting stress associated with family breakdown, the key roles of child access and family court problems, and how these issues impact health. This study also showed that although family court issues and arguments about family court issues raise roughly similar levels of stress, the frequency of stress-related to arguments about family court issues was greater (68.3% of reports) than the frequency of stress-related to family courts (59.3% of reports), suggesting that family court issues created additional stressful arguments. The findings of this study have identified which issues are the most stressful, thus should help to identify the people going through these experiences who would most benefit from support.

Limitations of this study

The number of participants was relatively small, though having said this, the number of observations (> 400) was large enough to detect statistically significant effects. However, a larger sample would have allowed for a greater range of statistical tests e.g. multiple regression. Also, it would have been very useful to have a comparable sample of women for the study, to see whether there were gender differences in experiences and sources of distress. We recruited two mothers, but unfortunately, this is not a sufficient number to allow statistical analysis.

Implications and future research

Future research could be improved by recruiting more effectively a sample of mothers. Research suggests there are sex differences in the impact of family breakdown, often with mothers experiencing more dissatisfaction with post-breakdown finances, and men – with reduced access to their children - experiencing more dissatisfaction with post-breakdown family life (Köppen et al., 2020). Although mothers are more likely to be given the retention of children by the family courts, there is anecdotal evidence recognised in FNF that when mothers are denied access to children, this can be extremely stressful for the mother.

Although coping strategies were not assessed in the present study, futures studies might study the degree to which different coping strategies (e.g., emotion-focused vs solution-focused) might impact the levels of stress experienced about family breakdown (Holloway et al., 2018). The reduction in PMI in those participants who resolved their family breakdown issues implies that a solution-focused approach works i.e. addressing the cause of the stress rather than addressing the stress itself. A future study should collect

more detailed data on the health impact of going through the family court process. This would need a long-term study, over several years at least.

CONCLUSION

The finding of unremittingly low levels of mental well-being across the course of this study has serious implications for the long-term health of men following family breakdown. It is recommended that the family courts should consider the mental health impact of going through the family court process and make the resolution of cases as fair and rapid as possible. It is anecdotally suggested (see Table 3) by men going through such proceedings that, as fathers, they are viewed much less sympathetically than mothers. Such a state of affairs is not only unfair on the father but unfair to the children who are deprived not only of their father's presence in the home but deprived of any access to a happy father. The fact that this situation has not already been recognised by the authorities or acted upon might be a sign of gamma bias, a widespread cognitive distortion that makes problems less visible when then impact men than when the same problems impact women (Seager & Barry, 2019).

In conclusion, these findings underline the urgent need for support for men going through family breakdown, especially those seeking access to their children, and those going through the family court process. Perhaps the family courts could look into their proceedings and – after consultation with men who have experience of these proceedings – identify modifications which would make the process less stressful. In the meantime, family courts should also actively make men who are using their services aware of sources of mental health support e.g. the FNF counselling helpline.

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Male broodiness: Does the desire for fatherhood affect men?

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The objective of this study was to assess the level of the desire for parenthood (broodiness) in childless men compared to non-parents and parents. Parenthood brings a high social status. The majority of studies examining reproductive intentions and behaviour have concentrated on women and couples. However, there are very few studies exploring men's desire for fatherhood. This study is a sequential quantitative-qualitative mixed-methods online survey on the influences, motivations, and reasons for men and women's desire for parenthood. The quantitative data was analysed using descriptive, univariate and bivariate techniques. Qualitative data were analysed using a latent thematic analysis. Recruitment was by the snowball email method. The sample was formed of 232 respondents with a mean age of 41.37 years (*SD* = 10.83), a central tendency of female, the majority were White British, degree educated, professional, and heterosexual. The main finding identified non-parent females and males showed similar levels of desire for parenthood with females scoring slightly higher than males. A higher number of childless men desired parenthood (51.9%) than did not (25.9%). For non-parents economic and social factors were the main influences on the decision for parenthood. Female and male parents demonstrated an equal desire not to repeat parenthood. The results from this study did not support the hypothesis (and common belief) that men are not interested or affected by the desire for parenthood. Compared to equivalent women, childless men may experience higher levels of depression and isolation.

Keywords: childless; depression; isolation; male broodiness; parenthood

This paper is based on my MSc study (Hadley, 2009a) which examined the responses, motivations and reasons associated with, and incidence of, the desire for parenthood in females and males, parents and non-parents. The results from my MSc were integral to a poster (Hadley, 2013a) presented at the 2013 British Sociological Associations Annual Conference. The finding that childless men were more depressed and isolated than equivalent women received much international press attention (Hadley, 2013b; Hodgekiss, 2013; Kafcaloudes, 2013; Lerner & Bratt, 2014). This piece provides further details of the study.

In 2015, there were approximately 141 million babies born worldwide and the projection for 2020 is 140.66 million. Nonetheless, the global total fertility rate has fallen from an average of 5 children per mother in 1965 to below 2.5 in 2015 (Ritchie, 2019; Roser, 2014). In addition to the decline in fertility, there has been a global trend of increased longevity, which has resulted in growing populations that are increasingly ageing and without children (Greulich, 2018; Organisation for Economic Co-operation and Development, 2018). However, in the vast majority of societies, biological parenthood is a structurally embedded, highly valued, and atypical and expected part of the life cycle (Neugarten, 1969, p. 125). For example, the pronatalist ideal of parenthood is exemplified in religions and other sociocultural practices and structures (Monach, 1993). The vast majority of societies have expectations linked to age/stage transitions across the life course with attendant roles and meanings surrounding each phase (Becker, 1999; Goldberg, 2014) with the transition to parenthood one of the most significant people make (Eggebeen et al., 2012). Indeed, Becker (1999) argues that not becoming a parent is a 'non-transition' that has to be negotiated just as has a transition. Moreover, many studies demonstrate the majority of younger people report the intention to become parents (e.g., Acharya & Relojo, 2017; Riskind & Patterson, 2010; Sylvest et al., 2018; Thompson & Lee, 2011).

Lampic et al. (2006) investigated the fertility intentions, issues and attitudes of 222 female and 197 male Swedish university students with a mean age of 24 years. Results indicated that the majority of childless students (both female and male) wanted to have children at some point. However, females expressed unease about balancing childcare and work and indicated concern regarding the effect of motherhood might have on their career. Interestingly, the authors noted that one of the limitations of the study was the low response rate of males. Contemporary studies have highlighted that gay men and lesbians are interested in parenthood (Smith et al., 2019). In a study of gay (n = 628) and heterosexual (n = 638). Kranz et al. (2018) found that 89.7% of heterosexual men and 76.4% of gay men expressed a wish for fatherhood. In a study of gay and lesbian youth in New York, 86% of the men (n = 83) and 98% of the women (n = 50) expected to become parents in the future (D'Augelli et al., 2007).

The demographic changes resulted in the development of models that would detect and calculate the influences on people's fertility intentions (Hoffman & Manis, 1979; Schoen et al., 1997; Schoen, et al., 1999). Initially, studies concentrated on structural items such as the social value (costs and benefits) of children to parents and social and economic categories (Hoffman, 1975). However, the cost-benefit analysis approach was criticised for reflecting the parent's decision to stop having children rather than people's intention to become parents (Hoffman & Manis 1979). Later, van Balen and Trimbos-Kemper (1995) proposed that costs did not deter childless couples. Additionally, Bagozzi and Loo (1978, p. 318) argued that 'to accurately predict fertility one must examine the attitudes and social relationships of families'. Subsequently, studies that included attitudes and intentions items proved that fertility outcomes were reliably predicted by measuring fertility intentions (Langdridge et al., 2000; Schoen et al., 1999). A study of infertile Dutch couples found happiness, parenthood and well-being were the highest motivators while women showed a stronger desire for parenthood than men (van Balen & Trimbos-Kemper, 1995). Langdridge et al. (2000) study of expectant and Assisted Reproductive Technology (ART)-ready British couples found three core motivators for parenthood: 'give love', 'receive love', and 'become a family'. Nevertheless, many scales were criticised for employing different items and measurements, lack of generalisability, and unacknowledged sociocultural commonalities and differences (Armitage & Conner, 2001; Langdridge et al., 2005; Purewal & van Den Akker, 2007).

To consolidate scales, Langdridge et al. (2005, p. 125) developed the *Reasons for Parenthood Scale*. Uniquely, this study included the fertility ideations of both female and male 'intenders' and 'non-intenders' (Langdridge et al. 2005, p. 125). The sample consisted of White British, married, childless couples (men, n = 393; women, n = 481), aged 18–40. The main reasons the 'intenders' cited were 'aspiration', 'bond with child', 'bond between parents', 'centrality of the family', and 'give love'. Female and

male non-intenders cited that 'other things' were more important than parenthood. Male non-intenders listed 'career', 'freedom', and 'responsibility'; while female non-intenders cited 'partners wishes' as their main reason (Langdridge et al., 2005, p. 128). The intention to become parents decreased with age and length of marriage increased (Langdridge, et al. 2005, p. 131). Importantly, all respondents emphasised the significance of their partner's attitude in fertility decision-making (Langdridge, et al. 2005, p. 131). Moreover, European research demonstrated that age, ethnicity, and gender differences influenced fertility intentions (Bos et al., 2003; Rooij et al., 2006). Critics of quantitative fertility behaviour scales argued that the inherent deterministic foundations did not account for people's subjective experience and relational processes (Purewal & van Den Akker 2007, p. 79).

The historical attitude that fertility and family formation are relevant only to women led to the observation there was a relative paucity of data on men's fertility intentions and history (Dykstra & Keizer, 2009; Murphy, 2009). For example, many sociological studies concentrated on measuring women's marital status, experiences, fertility intentions, age at first birth, and family size (Dykstra & Keizer, 2009; Murphy, 2009). Inhorn et al. (2009, p. 1) argued men have been marginalised as the 'second sex' in all academic fields relating to reproduction because of the false assumption that men are not interested and disengaged from reproductive ideation and outcomes. Following their systematic review of international academic literature Hammarberg et al. (2017), found there were few population studies on men's desires, expectations and hopes of fatherhood. Their examination of 47 papers from 14 countries revealed the majority of men want and expect to become fathers, view parenthood as crucial for lifetime contentment and fulfilment and wish for at least two children. Also, they found that men have an equivalent desire for parenthood as women and as with women, the most common reason for men remaining childless was not finding a partner (Hammarberg et al., 2017, p. 478). In addition to finding a suitable and willing partner, men's requirements for parenthood included career and financial stability and being at the right age/stage. Consequently, there has been a growing recognition that the majority of research literature and public media concerning parenthood has focused on women and couples with little interest on the impact of fatherhood or male childlessness (Eggebeen & Knoester, 2001; Fisher & Hammarberg, 2017; Hadley, 2019b; Hadley & Hanley, 2011; Throsby & Gill, 2004).

Historically, fatherhood has only been measured as a component of the cultural, legal, and societal structure that dictated 'rights, duties, responsibilities and statuses' (Hobson & Morgan, 2002, p. 11). However, from the 1990s onwards, there has been an increased interest in fatherhood, fathering and fathers (Dermott, 2008; Eggebeen & Knoester, 2001; Hadley, 2019a; Lupton & Barclay, 1997; Miller, 2010). In the US, Eggebeen and Kester's (2001, p. 392) analysis of data (n = 3088) from two waves of the National Survey of Families and Households found that 'Fatherhood can profoundly shape the lives of men'. Moreover, they found strong evidence that men who made the transition to fatherhood behaved differently to non-fathers. Eggebeen and Knoester (2001) identified that fatherhood led improved well-being, and increased social involvement concerning familial interactions, community activities and work hours.

Keizer and Ivanova (2017) studied the impact of childlessness in relationships of 326 childless individuals in 163 couples aged 40 and over. Their findings revealed that the 'implications of childlessness are no less significant for men than for women' (p. 314). For example, childless men were more strongly affected by relationship conflicts than childless women and more at risk of physical and mental ill-health than childless women (2017, pp. 324–327). Zhang and Hayward (2001) discovered that compared with women in similar circumstances, divorced, never married and widowed, childless men reported higher rates of loneliness. Divorced and widowed childless men also revealed higher rates of depression than comparable women did. In the Netherlands analysis of the Health and Living Conditions of the Population of the city Eindhoven and surroundings found that compared to men who have fathered two or more children, childless men have a higher risk of mortality (Keizer et al., 2012). Likewise, analysis of the Norwegian Central Population Register and the education register demonstrated that compared to equivalent fathers, childless men in late mid-life had higher mortality (Grundy & Kravdal, 2008). Similarly, Weitoft et al., (2004) study of Swedish Census, Health, Multi-Generation, and Death registers found that compared to resident fathers, lone childless men and lone non-custodial fathers had a greater risk of death through addiction, external violence, injury, lung and ischemic heart disease, poisoning and suicide.

HYPOTHESIS

The review of the literature highlights the absence of data on men's reproductive motivations. One of the central issues raised in my previous study (Hadley, 2008) was the prevalence of male broodiness. Biological yearning, nurturing, and parenting are mostly associated with women. Consequently, it is considered natural and socially acceptable for women to desire (biological) parenthood (Gillespie, 2003). How do males and females compare in terms of broodiness and what factors influence the decision to the parent (or not)? For those already in the parous state, what factors influence the decision to repeat parenthood? Therefore, areas to be examined include the following research questions: (1) How widespread is male broodiness in childless men? (2) What is the incidence of male broodiness compared to female broodiness? (3) What factors influence the decision to parent? (4) Is there a difference between those with and those without children? (5) What are the reactions associated with broodiness?

These questions contribute to previous research and therefore this study tests five hypotheses: (1) It is predicted there will be a difference between the numbers of childless men who desire parenthood and those that do not. (2) It is predicted that there will be a difference in the desire for parenthood between non-parents and parents, both female and male. (3) It is predicted that parents and non-parents, both male and female, will have different factors that influence the decision to parent. (4) It is predicted that there will be differences in the reasons that influence the decision to parent between non-parents and parents. (5) It is predicted there will be differences in the reactions associated with broodiness, between non-parents and parents, both male and female.

METHOD

To examine the issues surrounding the desire for parenthood mixed methods approach was chosen. Mixed methods are particularly suited to understanding complex phenomena as studies 'delve below the surface' and 'seeks to explicate the behaviours, rituals, language, symbols, values and social structures' (Newman et al., 2003, p. 178). This reflects the aims of this study to understand the incidence and consequences of men's desire for parenthood. Mixed methods are founded on pragmatism (Rorty, 2000) and use diverse approaches via 'logical and practical alternative' (Johnson & Onwuegbuzie, 2004, p. 17). For example, in mixed methods research, Teddlie and Tashakkori (2003) argue that the research question has greater significance than either the theoretical framework or the underpinning method (Hanson et al., 2005).

Setting

The setting was online, and recruitment was via email and snowball method.

Design

A sequential exploratory mixed-methods quantitative-qualitative design was selected as it is a well-established method that is 'suited to explaining and interpreting relationships' (Teddlie & Tashakkori, 2003, p. 227).

The study conformed to the University of Manchester ethical policy and approved by the course director. The ethical structure used was framed by the ethical research policies of the British Association for Counselling and Psychotherapy (BACP, 2009), the British Psychological Society (BPS, 2006) and the British Educational Research Association (BERA, 2004).

Data collection

An online survey questionnaire was used to measure the influences, motivations, and reasons that may affect the decision to parent. Surveys are a popular form of research instrument as they potentially access a large sample. As the survey had a limited time for the deployment period, an online instrument was chosen and was delivered by email. Online-based surveys are relatively cheap to administer and have the advantage of anonymity being easily built into the design. Malik & Coulson (2008) found the anonymity of a web-based message board led men to reveal more of their concerns regarding matters surrounding

their infertility. The survey is in the form of a self-report questionnaire. A non-experimental method, surveys do not control variables to study change and affect (Punch, 2003).

The survey was created using the default option of the University of Manchester's Select Survey ASP software package. Respondent access was via embedded web-link in an email message: the respondent only had to select the link to connect with the survey page. Security level allowed only a single entry; multiple entries from one individual were not possible. Included in the instrument was a unique item attempting to measure the reactions associated with broodiness. Open questions were integrated into the survey to provide detail of the respondent's life experience and, also, aid validity by providing feedback on the survey. The exclusion criteria were included: not completing the mandatory questions ('informed consent agreement', 'What is your gender?', 'Are you a parent?'), being under 16 years old, not agreeing to the consent form, and not completing the whole survey.

The survey was based on two pilot surveys and the works of Muijs (2004; 2008), Oppenheim (1992), Keith Punch (2003; 2005) and Robson (2002). Given the sensitive nature of the subject, respondents were given the response-option of 'choose not to answer'. The response-option of 'other, please specify' was used with several items and provides information for the further development of the study. Concerning the language used in the survey, items and response-options were drawn from various sources; my previous study (Hadley, 2008), the pilot study (Hadley, 2009a), Lampic et al. (2006), Langdridge et al. (2005), Thompson and Lee (2008). The survey comprised of three elements over six pages: (1) introductory statement and informed consent agreement question; (2) questionnaire; and (3) information.

Introductory page

The first page of the survey introduces a statement that outlines the purpose, reasons, and background of the study. It is common practice for surveys to offer inducements to potential participants, therefore I informed readers that due to the self-funding status no reward would be offered (Muijs, 2004). This was followed by a 'snowball' request to forward the link onto other parties. The statement concludes with a declaration regarding ethical issues such as confidentiality and data storage. The statement was followed by the mandatory informed consent 'Yes/No' agreement (question one). On selection of 'Yes', the respondent was taken to the questionnaire element. Selection of 'No' or not selecting, terminated the survey.

Questionnaire

The questionnaire element of the survey comprises of 29 questions in a variety of formats: dichotomous, open, and scaled. The use of different formats aids retain the participants' attention and also acts as a form of validity check (Punch, 2003). The questionnaire was divided into five modules:

- Attitude to becoming a parent/parenthood.
- Attitude to becoming a parent for non-parents
- Attitude to repeating parenthood.
- A few more facts about you.
- Finally

First module: Attitude to becoming a parent/parenthood

The first page of the questionnaire entitled 'Attitudes to becoming a Parent/Parenthood' consists of a brief guide to the survey followed by five items, with mandatory questions two ('what is your gender?') and six ('are you a parent?'). Questions - three, four, and five were to 'relax' the respondent so they are not trying to give the 'correct' answer. Here respectfully, data on the participant's age, employment and religion were gathered. The response-options for question four, 'How would you classify your employment' were developed from Langdridge et al. (2005) and the Office for National Statistics (ONS, 2008). Question 6, 'Are you a parent?' filtered the respondents into those without children from parents using a yes/no answer. Those without children are automatically taken to the page 'Attitudes to becoming a parent for non-parents' consisting of questions seven through to twelve. Parents are taken to the page 'Attitudes to repeating parenthood' comprising of questions 13 to 19.

Second module: Attitude to becoming a parent for non-parents

- Question 7 (dependent variable): 'Do you wish to become a parent?' Five response-options: Yes / No / Don't know / Undecided / Choose not to answer. The following four items measured the level of 'wish' and influences on intention to parent.
- Question 8: 'How much do you want to be a parent?' Response-options: Not at all / Not bothered / A little / A lot / Not at all / Don't know / Choose not to answer. The scaling order was switched to retain participant attention.
- Question 9: 'Which of the following may influence your decision to become a parent?' Against items: 'Accommodation' / 'Age' / 'Career' / 'Finance' / 'Own health' / 'Health of others'.
- Question 10: 'Do any of the following influence your decision in becoming a parent?' Against items: 'Biological urge' / 'Cultural/societal expectation' / 'Family expectation' / 'Personal desire' / 'Religious/spiritual belief' / 'Global population issues.'
- Question 11: 'Which of the following reasons may influence your decision in becoming a parent?' Against items: 'Children complete a relationship' / 'Continue the family name' / 'Current relationship' / Ex - relationship' / 'Feel parent - child bond' / 'Future relationship' / 'Give love and affection' / 'Give my experience of childhood to my children' / Improve on my experience of childhood' / 'I want a child' / 'I do not want a child' / 'Parent(s) want to be grandparent(s)' / 'Please family' / 'Receive love and affection' / 'Religious beliefs.'
- Question 12 was an open question, 'Please add any comment you wish to make in the box below. For example, if your situation is not represented.'

Third module: Attitude to repeating parenthood

In this module, the focus is on those who are already parents.

- Question 13 asks the respondent to select what type of parent they are: Biological parent / Non-biological parent / Foster-parent / Step-parent / Other, please specify.
- Question 14 (dependent variable): 'Do you wish to become a parent again?' Response-options: Yes / No / Don't know / Undecided / Choose not to answer. These response-options were used against the following four items and were identical to the response items in the non-parent module.
- Question 15: 'How much do you wish to have another child?'
- Question 16: 'Which of the following may influence your decision in becoming a parent again?'
- Question 17: 'Do any of the following influence your decision in repeating parenthood?'
- Question 18: 'Which of the following reasons may influence your decision in becoming a parent again?'
- Question 19 (repeat of Question 12): was an open question 'Please add any comment you wish to make in the box below. For example, if your situation is not represented.'

Fourth module: 'A few more facts about you'

This module sought reactions to 'broodiness' and indicators of the respondent's ethnicity, faith, level of education, employment type, and sexual orientation. Research has not investigated 'broodiness' but focused on the intentions to become parents or the effects of infertility.

- Question 20: 'To what degree have you had any of the following reactions to broodiness?' This query was located at this point for three reasons. First, the respondents would have connected to their experience of broodiness. Second, this module encompassed those without and parents in this module. Third, should respondents choose not to answer any of the questions at least some data would have been collected? Aware of the sensitivity surrounding the subject I adapted the wording of the response-option, and the scaling was also switched. The response-options 'Unsure' and 'Does not apply' replaced 'Don't know' and 'Not bothered.' The replacement response-options were drawn from previous pilot studies (Hadley, 2009). This question was set against eleven items: 'Anger' / 'Denial' / 'Depression' / 'Elation' / 'Guilt' / 'Isolation' / 'Jealousy' / 'Relief' / 'Sadness' / 'Yearning' / 'Withdrawal'.

The remaining five questions describe the representativeness of the sample:

- Question 20: 'How would you describe your ethnicity?' The ethnic categories were drawn from the ONS (2006). On selecting the box, a list of various ethnicities appears, and the respondent can either select the most appropriate or supply their own. The survey was designed for respondents from outside of the UK to complete the item.
- Question 22: 'What faith are you' had six response-options mainly drawn from the ONS (2003): Agnostic / Buddhist / Christian / Hindu / Muslim / Jewish / Other, please specify. The first response-option was included following pilot study feedback. This question formed a validity check with question five.
- Question 23: 'What is your highest level of educational qualification?' Response-options based on ONS (2005) criteria: 'O' level GCSE/ 'A' level GCSE / Degree (or above) / Skill (National Vocational Qualification, City and Guilds etc.) / Other, please specify.
- Question 24: 'How would you classify your employment?' This item formed a validity check with question four and consisted of eight response-options: Clerical / Homemaker / Managerial / Manual / Professional / Skilled / Student / Other, please specify. Response-options were drawn from the ONS (2008) and Langdridge et al. (2005).
- Question 25: 'How would you describe your sexual orientation?' This item consisted of six response-options: Bisexual / Gay / Heterosexual / Lesbian woman / Choose not to answer / Other (please specify). These response-options were drawn from research by King et al. (2008).

Fifth module

This module consists of five questions to generate information for a future study.

- Question 26: 'If a further study takes place would you be interested in participating via one or more of the following methods?' This item had six response-options: Diary / Email contact / Focus group / Personal interview / Telephone interview / Web site chat room/discussion board / Other, please specify. These options were drawn from Punch (2005) and Robson (2002).
- Question 27: 'Please let me know how you found completing the survey.' This item consisted of five response-options: I had no problems / I had a few problems / I had a lot of problems / Some questions were vague / Some answers were vague. I included this item as a validity check on the survey as a whole and as development aid for a future study.
- Question 28: 'Please supply the problem(s) you encountered in this box.' This item enabled the respondent to give details of any issues they had had in completing the survey.
- Question 29: 'Please supply any further comments you would like to add.' The aim was to encourage engagement in the hope new items and categories would be revealed.
- Question 30: 'I would be grateful if you would forward this survey on. If you do so, please indicate the number of people you have passed it on to in the box below. This will help me estimate how many people have received the survey.' Here the request to 'snowball' the survey was repeated and an explanation for the request supplied to aid 'ballers'.

The survey concluded with an information module that reiterated the purpose of the study, ethical policy, and use of the material in publications. Contact details of the researcher, the research supervisor and the course director were supplied.

Sample

Only adults over 16 years of age were requested to complete the survey as this is the legal age for consensual sex in Great Britain (Public Helath England, 2015). No respondents indicated they were under the age limit. An estimated 2,000 requests to participate were sent. Forty-two respondents reported 'snowballing' approximately 160 requests. In total, two 298 responses were initially generated. Sixty-six were incomplete and removed from the study. A final dataset of 232 responses was produced from the Select Survey material. This was composed of 167 females and 65 males, giving a central tendency mode of 'female'. The study had a mean age of 41.37 years (*SD* = 10.83) with one participant not completing the age item. The youngest respondent was aged 20 years old and the oldest 65 years giving a median central tendency age of 40 years old with a range of 45 years (Field, 2009). Two hundred and 25 respondents

indicated their ethnicity with the majority of those being 'White British' (83.5%). The ONS (2003) criteria for 'White British' include those who indicated White followed by British, English, Scottish, or Welsh. The majority of participants were heterosexual (90.2%), white-British (83.3%), Christian (52.4%), held a degree or higher qualification (68.9%), professional (69.8%), and worked full-time (68%).

ANALYSIS

Quantitative analysis

The quantitative data were analysed using the Statistical Package for Social Sciences, Version 16 (SPSS, 2007). The statistical methods employed include parametric (descriptive statistics) and non-parametric tests (distribution-free tests): Mann-Whitney and Spearman's Rho. Parametric tests were used to test two the first and fifth hypotheses (respectively):

The first hypothesis, 'That childless men will have a similar level of broodiness to childless women'
The fifth hypothesis, 'There will be differences in the levels of reactions between parents and non-parents, both male and female.'

Non-parametric tests are based on the frequency of occurrence or ranking of the data and the analysis applied to the ranks, rather than the raw data (Field, 2009). Due to size and distribution issues and the type of variables, Mann-Whitney and Spearman's Rho tests were applied to the data. These tests indicate the strength and direction of the relationship between items but not causality (Muijs, 2004). The Mann-Whitney test is a 'non-parametric version of the independent *t*-test' (Field, 2009, p. 540). This method was used to test the second hypothesis:

'There will be a difference between parents and non-parents, both male and female, in the incidence in the desire for parenthood.'

Spearman's rho calculates the correlation coefficients of ordinal variables and is recommended for 'small participant numbers...use Spearman's rho' (Dancey & Reidy, 1999, p. 524). This method was used to test the third and fourth hypotheses (respectively):

Fourth hypothesis, 'That parents and non-parents, both male and female, will have different factors that influence the decision to parent.'

The fifth hypothesis, 'There will be differences in the reasons that influence the decision to parent between parents and non-parents.'

Qualitative analysis

An inductive thematic analysis (Braun & Clarke, 2006) was deployed. This method of analysis is not associated with any specific theoretical framework and therefore fits the pragmatic approach of this study. However, the objective of the analysis is focused on emerging themes, the analysis ends at stage four 'review themes' of the six stages. Coding of the data followed Rennie et al. (1988) method where the text is divided into categories of 'passages or meaning units' (Rennie, 2006, p. 67). Most replies are only a line or two long and these were carefully studied before being assigned into a category code. Codes were generated from my interpretation, previous studies and 'in-vivo codes' (Glaser & Strauss, 1967). The initial categories were then examined and compared and grouped into high order categories (Rennie, 2006). As categories were formed those with the greatest number of meaning units were selected for further examination. Following this, the high order categories were further refined, and themes identified. The coding was performed by hand, using scissors and envelopes labelled with the appropriate codes.

RESULTS

In this section, the results of the analysis of both the quantitative and qualitative data are presented. Due to space restrictions, the focus of this section will mainly be on female and male non-parent's male and only summaries of the parent's responses will be supplied. To facilitate between-group comparisons

Questions 9, 10, 11, 16, 17 and 18 (Table 1). First, the desire for parenthood is explored. This is followed by an examination of the environmental, urges and beliefs and statements categories. Third, the broodiness item is examined, and the final section is a summary of the findings from the thematic analysis.

Table 1
Category Labels Applied During Creation of the Dataset

Question	Category label
Q 9: Which of the following may influence your decision to become a parent? Q16: Which of the following reasons may influence your decision to become a parent again?	*Environmental*
Q 10: Do any of the following influence your decision in becoming a parent? Q 17: Do any of the following influence your decision in repeating parenthood?	*Urges and Beliefs*
Q 11: Which of the following may influence your decision in becoming a parent? Q18: Which of the following may influence your decision in becoming a parent again?	*Statements*

Both non-parent items of 'environment' and 'statements' had high reliability, Cronbach's α = .76 and Cronbach's α = .70, respectively. However, the 'urges and beliefs' item had a low reliability, Cronbach's α = .55 (discussed later). All the parent items 'environment' 'statements' and 'urges and beliefs' had high reliability, Cronbach's α = .79, Cronbach's α = .80, and Cronbach's α = .83, respectively. The 'broodiness' scale had a high reliability, Cronbach's α = .92.

The desire for parenthood in non-parents and parents

The sample size and distribution for some items prevented the use of Pearson's Chi-Square and phi. Therefore, a Mann-Whitney test was applied. The analysis for 'Do you wish to become a parent?' (M = 1.00 [Yes]), U = 995.000, z = –.688, p = .492, and r = –0.06 shows no significant difference between female and male non-parents and a weak effect. 'How much do you wish to become a parent?' (M = 2.00 [A little]), U = 817.000, z = –1.934, p = .053, and r = –0.18 shows the borderline significance and weak effect size. The analysis for both female and male parents for the item 'Do you wish to become a parent again?' demonstrated no significant difference and a weak effect: (M = 2.00 [No]), U = 1479.000, z = –1.047, p = .295, and r = –0.09. Similarly, for the item 'How much do you wish to have another child?' there was no significant difference and a weak effect: (M = 4.00 [Not at all]), U = 1561.500, z = –.318, p = .751, and r = –0.02.

The majority of non-parents wished to become parents (58.9%) with 48.1% indicating the maximum response level of 'A lot'. Of the females (n = 81) in the non-parent group (n = 107), 61.2% wished to become parents with the majority of those indicating the maximum response level of 'A lot' (51.9%). Males within the non-parent group (n = 27) indicated slightly less desire to become a parent (51.9%) than female non-parents. Female and male parents indicated an equal desire *not* to repeat parenthood.

Factors that influence the desire for children follow with results given in descending order of significance and effect. Noting the sample size issues with cross-tabulations, and with the type of the variable being ordinal, Spearman's rho was selected for the next analysis.

Environmental factors
Question 9, 'Which of the following may influence your decision to become a parent?' examined environmental factors that may influence the desire to become a parent for non-parents. The non-parents demonstrated a range of significant outcomes and effect sizes, indicating positive relationships. Tables 2 and 3 show the influences for non-parent males and females, respectively.

Table 2
Environmental Influences on the Non-Parent Males in Deciding to Become a Parent

Influences	Rho	*p*
Career and finance: Significant and a moderate effect	.683	.000
Finance and others health: Significant and a moderate effect	.681	.000
Career and others health: Significant and a moderate effect	.587	.001
Career and accommodation: Significant and a moderate effect	.522	.005
Own health and others health: Significant and a modest-moderate effect	.446	.020
Career and own health: Significant and a modest-moderate effect	.438	.022
Accommodation and others health: Significant and a modest effect	.394	.042
Accommodation and own health: Significant and a modest effect	.388	.046

Table 3
Environmental Influences on the Non-Parent Females in Deciding to Become a Parent

Influences	Rho	*p*
Accommodation and finance: Significant and a moderate effect	.685	.000
Career and finance: Significant and a moderate effect	.556	.000
Accommodation and own health: Significant and a modest-moderate effect	.421	.000
Career and accommodation: Significant and a modest-moderate effect	.416	.000
Own health and other health: Significant and a modest effect	.379	.001
Finance and own health: Significant and a modest effect	.319	.004
Career and age: Significant and a modest effect	.303	.007
Age and own health	.266	.019
Accommodation and others' health: Significant and a modest effect	.259	.023
Career and own health: Significant and a modest effect	.246	.029

The results for non-parent males and females indicated significant and moderate to modest strength interactions across most constituent items for the group. 'Career and finance' was the most common link. However, the males showed a disposition towards health, with six out of eight items relating to health. Four of those six items concerned the health of others. Moreover, the males tended to put others before themselves. Females indicated health in five items, with three of those concerning their health.

The equivalent question (16) for parents was 'Which of the following may influence your decision to become a parent again?' Results indicated significant and moderate to modest strength interactions across most constituent items. The most common links were 'Own health' 'other health' and 'Age'. Differences between female and male parents were slight: females recorded 'Own and other health' and 'accommodation and finance' in first and second place. Male males placed 'own health and age' and 'career and finance' in first and second place.

Urges and beliefs

Question 10, 'Do any of the following influence your decision in becoming a parent?' explored the relationships between urges and beliefs that may influence the desire to parent. The non-parents demonstrated a range of significant outcomes and effect sizes, indicating positive and negative relationships. The results for male and female non-parents are shown in Tables 4 and 5, respectively.

Table 4
Urges and Beliefs That May Influence the Desire to Parent for Male Non-Parents

Influences	Rho	*p*
Family expectation and cultural/societal expectation: Significant and a very strong effect	.909	.000
Religious belief and cultural/societal expectation: Significant and a moderate effect	.526	.005
Family expectation and religious belief: Significant and a modest-moderate effect	.417	.030
Personal desire and biological urge: Not significant and a modest effect	.365	.061*

**This result is included for comparison purposes.*

Table 5
Urges and Beliefs That May Influence the Desire to Parent for Female Non-Parents

Influences	Rho	*p*
Family expectation and cultural/societal expectation: significant and a moderate effect	.474	.000
Personal desire and biological urge: significant and a modest-moderate effect (	.418	.000
Culture/societal expectation and global issues: Significant and a modest effect	.353	.001
Family expectation and religious belief: Significant and a modest effect	.348	.002
Personal desire and family expectation: Significant and a modest effect	.299	.007
Personal desire and religious belief: Significant and a weak-modest effect	.243	.032
Religious belief and global population issues: Significant and a weak-modest effect	.231	.041
Personal desire and global population issues: Significant and a weak-negative modest effect	.222	.049

The results for Question 10 demonstrated significant and modest to moderate strength interactions across most constituent items for the group. 'Family expectation and cultural/societal expectation' was the most common link. Male non-parents demonstrated a very strong response to the influence of 'family expectation' and 'cultural/societal expectation'. Compared to the female group 'desire and biological urge' was not significant. However, it was the fourth rated item, and this indicates some males have both a 'personal desire' and a 'biological urge'. Moreover, the relatively small number of male respondents may have influenced this result. Female non-parents showed a disposition towards 'personal desire' with 'personal desire' and 'biological urge' showing the highest relationship, albeit with a moderate effect. 'Personal desire' and 'global population issues' highlighted a significant and negative relationship, suggesting that the two are not compatible.

The equivalent question (17) for parents was 'Do any of the following influence your decision in repeating parenthood?' Results indicated significant and modest to moderate strength interactions across most constituent items. Combinations of 'family expectation' 'cultural expectation' 'societal duty' and 'religious/spiritual belief' items were the most common link. Female and male parents gave similar responses. However, a disposition towards 'biological urge' was apparent with females recording it in the last four of 10 results. Males gave fewer results –just four - with the last incorporating the 'biological urge' and 'societal duty'.

Statements

Question 11, 'Which of the following reasons may influence your decision in becoming a parent?' and question 18, 'Which of the following reasons may influence your decision in becoming a parent again?' examined reasons that may influence the desire to become a parent or repeat parenthood. Due to the number of responses, only the first 15 results are provided. The results for non-parents are shown in Table 6.

Table 6

Urges and Beliefs That May Influence the Desire to Parent for Female Non-Parents

Influences	Rho	*p*
'Feel parent-child bond' and 'give love and affection': Significant and a moderate effect	.636	.000
'I do want a child' and 'Feel parent-child bond': Significant and a moderate effect	.544	.000
'I don want a child' and 'give love and affection': Significant and a moderate effect	.534	.000
'Feel parent-child bond' and 'receive love and affection': Significant and a moderate effect	.500	.000
'Children complete a relationship' and 'continue the family name': Significant and a moderate effect	.444	.000
'Parents want to be grandparents' and 'give love and affection': Significant and a modest-moderate effect	.415	.000
'Receive love and affection' and 'give love and affection': Significant and a modest effect	.410	.000
'Children complete a relationship' and 'give love and affection': Significant and a modest effect	.390	.000
'Give love and affection' and 'give my experience of childhood to my children': Significant and a modest effect	.384	.000
'I do want a child' and 'receive love and affection': Significant and a modest effect	.372	.000
'Children complete a relationship' and 'future relationship': Significant and a modest effect	.356	.000
'Children complete a relationship' and 'Parents want to be grandparents': Significant and a modest effect	.344	.000
'Continue the family name' and 'give my experience of childhood to my children': Significant and a modest effect	.326	.001
'Feel parent-child bond' and 'give my experience of childhood to my children': Significant and a modest effect	.321	.001
'Feel parent-child bond' and 'I do not want a child': Significant and a negative modest effect	–.334	.001

For non-parents, the relationships between 'Which of the following reasons may influence your decision in becoming a parent?' indicated significant and modest to moderate strength interactions across most constituent items. The response-options 'feel parent-child bond', 'give love and affection', 'I do want a child' and 'children complete a relationship' was the most common link.

For the parents, the results from Question 18, 'Which of the following reasons may influence your decision in becoming a parent again?' indicated significantly and approaching a strong to modest-moderate strength interactions across most constituent items. Combinations of 'feel parent-child bond' 'receive love and affection' and 'give love and affection' items were the most common link. However, 'improve on my childhood experience' appeared on four results compared to twice for 'give my experience of childhood to my children.'

Broodiness

Question 20, 'To what degree have you had any of the following reactions to broodiness?' was used to establish the level of reactions associated with broodiness for non-parents and parents. A visual examination revealed a central tendency median of 4 ('Not at all') for the majority of the responses except for the 'Yearning' response. This response had a central tendency median of 2 ('A little'). Therefore, I used this latter response to examine the differences between male and female parents and non-parents.

Yearning

Assessing the cumulative per cent of the first two ranks ('A little' and 'A lot'), female non-parents and parents showed a similar level of yearning 58.4% and 61.2% respectively. Using the same criteria, the non-parent males exhibited a higher rate of yearning 40.7% compared to male parents 33.3%. Although the male results are in the minority, they indicate a record of male yearning. This finding supports 'the desire for parenthood' results for male non-parents reported previously. A further visual examination of each category's frequency statistics demonstrated several trends across the subset for those who had indicated 'A lot' and 'A little' responses. The subset of results for Question 20 comprised of the option-responses 'a lot' and 'a little' using the valid and cumulative percentages given by the SPSS statistic output. Table 7 gives the responses with the cumulative percentage of total emboldened.

Table 7
Subset of Question 20 Comparing Group Cumulative Total

Emotional response	Frequency	Male Non-parent (%)	Male Parent (%)	Female Non-parent (%)	Female Parent (%)
Anger	Total	18.5	8.1	17.9	21.2
	A lot	14.8	2.7	6.4	15.0
	A little	3.7	5.4	11.5	6.2
	Not at all	77.8	59.5	64.1	65.0
Denial	Total	18.5	10.8	20.5	19.8
	A lot	-	2.7	2.6	1.2
	A little	18.5	8.1	17.9	18.5
	Not at all	77.8	54.1	47.4	59.3
Depression	Total	26.9	11.1	25.6	18.8
	A lot	23.1	5.6	2.6	2.5
	A little	3.8	5.6	23.1	16.5
	Not at all	73.1	63.9	59.0	60.0
Elation	Total	29.6	33.3	17.9	40.0
	A lot	7.4	13.9	5.1	15.0
	A little	2.2	19.4	12.8	25.0
	Not at all	66.7	41.7	60.3	43.8
Guilt	Total	–	11.1	15.4	17.4
	A lot	–	8.3	2.6	1.2
	A little	–	2.8	12.8	16.2
	Not at all	88.9	63.9	65.4	61.2
Isolation	Total	29.6	19.4	26.9	16.2
	A lot	3.7		5.1	1.2
	A little	25.9	19.4	21.8	15.0
	Not at all	63.0	58.3	56.4	67.5
Jealousy	Total	29.6	17.1	37.2	38.3
	A lot	3.7	2.9	2.6	3.7
	A little	25.9	14.3	25.9	34.6
	Not at all	66.7	62.9	46.2	45.7
Relief	Total	7.4	16.7	20.5	25.0
	A lot	–	5.6	2.6	3.8
	A little	7.4	11.1	17.9	21.2
	Not at all	88.9	61.1	57.7	57.5
Sadness	Total	29.6	22.2	43.6	37.5
	A lot	11.1	8.3	9.0	6.2
	A little	18.5	13.9	34.6	31.2
	Not at all	63.0	55.6	37.2	47.5
Yearning	Total	40.7	33.3	58.4	61.0
	A lot	14.8	11.1	22.1	30.5
	A little	25.9	22.2	36.4	30.5
	Not at all	55.6	41.7	24.7	20.7

Most male non-parents gave higher responses compared to male parents except for the item's 'elation' 'guilt' and 'relief'. The females in both groups exhibited similar responses; non-parent females gave slightly higher responses to the 'isolation' and 'sadness' items. Compared to parents, non-parents were more affected by 'yearning' 'sadness' and 'depression'.

Qualitative data analysis

Qualitative data was gathered to support and highlight any gaps in the quantitative survey data. Therefore, the survey included open questions for the respondents to complete should they wish. An inductive thematic analysis (Braun & Clarke, 2006) was performed on the responses to questions 12, 19, 28, and 29. Overall, the results revealed clarification of respondents' circumstances and the structure of the survey. The results illustrated non-parents and parent's narratives in areas such as age, health and relationships. The theme of 'family' emerged as a major thematic difference between parents and non-parents. A theme of 'motivation' highlighted parent's unwillingness to repeat parenthood compared to the non-parent's emphasis on desire and plans. The last two questions illustrated the respondent's opinions and issues concerning style, format and presentation of the survey.

DISCUSSION

This study aimed to discover how do males and females compare in terms of desire for parenthood (broodiness) and what factors influence the decision to the parent (or not)? For those who are parents what factors influence the decision to repeat parenthood? Two hundred and thirty-two respondents (n = 165 female and n = 67 male) from a range of educational, ethnic, familial situations, gender, religious and sexual orientations completed an online survey. Descriptive, univariate and bivariate statistical analysis was used to examine the dataset to answer the research questions:

1. *What is the incidence of broodiness in childless men?* Most the study's childless men (51.9%) signalled a desire for parenthood compared to those who did not (25.9%).
2. *What is the incidence of broodiness in females and males and those with and without children?* Most non-parents showed a similar desire for parenthood with the females indicating a slightly stronger wish. Both female and male parents highlighted an equal desire not to repeat parenthood.
3. *What factors influence the decision to parent?* The results show a difference between the non-parents and parents in the factors that may influence the decision for parenthood. For non-parents 'economic' and 'social' were the strongest factors compared to 'health' and 'age' for parents. Non-parents exhibited greater differences between males and females, with the males indicating 'others health' and 'own health' as concerns. Differences between female and male parents were minimal.
4. *What reasons influence the decision to parent between those with and without children?* The results indicated some similarities between the non-parent and parent groups in the reasons that influence decisions regarding parenthood. The two groups show commonality in 'cultural' and 'family expectations' factors. Also, the parent group highlighted 'societal duty' and 'religious/spiritual belief' with little gender divide across items. Non-parents exhibited greater differences between males and females. The males indicated a strong influence of 'cultural' 'societal' and 'family expectations', with the possible suggestion of 'personal desire' and 'biological urge' being a factor. Females indicated that 'personal desire' was a major influence. The results illustrated a similarity between the non-parents and parents in the items 'feel parent-child bond' and 'give love and affection'. However, parents highlighted 'receive love and affection' and 'improve on my childhood experience'. For non-parents, the items 'I do want a child' and 'children complete a relationship' were more prominent. Religious and spiritual beliefs were associated with cultural and family expectations across all groups, with a greater influence in the parent group. Several items were not major factors in the overall results: 'global population' 'parents want to be grandparents' and 'please family' seldom occurring.
5. *What are the levels of reactions associated with broodiness?* The levels of reaction to broodiness demonstrated most respondents did not associate with most of the option-responses provided. The exception was the 'yearning' item. Non-parents were more affected by 'yearning' 'sadness' and 'depression' compared to parents. Females from both groups had similar response levels on most items, with non-parent females recording higher responses in 'isolation' and 'sadness'. Compared to male parents, male non-parents recorded higher in the majority of option responses with the exceptions of 'elation' 'guilt', and 'relief'.

The research questions resulted in five hypotheses being tested:

1. *It is predicted there will be a difference between the numbers of childless men who desire parenthood and those that do not.* This hypothesis is supported. This study to a degree, follows Lampic et al. (2006, p. 599) where 97% of the childless males responded 'Yes' to the question, 'Do you plan to have children?' The difference in the sample may account for this. Lampic et al (2006) study the mean age of the childless male 23.7 (*SD* = 3.7) compared to the mean age of 37.37 years (*SD* = 10.15) in this study. Likewise, Lampic et al. (2006) latter study sample were solely undergraduate university students, whereas in this study non-parent males were mainly professionals (55.6%) with degrees (74.1%).
2. *It is predicted that there will be a difference in the desire for parenthood between non-parents and parents, both female and male.* This hypothesis is partially supported by the differences highlighted between the non-parent and parent groups and the differences between female and male non-parents. Most of the non-parents strongly wished to become parents, with females (61.2%) indicating a somewhat greater desire than males (51.9%). Previous research demonstrated that childless females had a greater desire for parenthood (30%) than childless males (Langdridge et al., 2000; van Balen & Trimbos-Kemper, 1995). However, those studies used participants that were in various stages of fertility treatment (Langdridge et al, 2000) or had received infertility treatment (van Balen, 1995). The strength of the desire for parenthood between female and male non-parents, compared to other studies, may be related to the non-specific sample of this piece (see Lampic et al., 2006; Langdridge et al., 2000; Langdridge et al., 2005). Most of the parent group, female and male, exhibited a similar response of not wanting another child. This finding may support criticism of the child cost-benefit model; parents can identify the cost-benefit reality of having a child; the childless can only speculate what the cost-benefit will be (van Balen & Trimbos-Kemper, 1995).
3. *It is predicted that parents and non-parents, both male and female, will have different factors that influence the decision to parent.* The hypothesis that different influences affect the decision to parent is therefore partially supported. Non-parents signalled that matters surrounding career, finance and accommodation were the common influences. However, female and male non-parents differed, with the former following the group trend, whereas the latter highlighted the 'health of others' as being a central influence. The parent group differed in indicating that 'health' and 'age' were the commonest influences, with little difference between female and male. The qualitative data reflected 'age' 'health' and 'socio-economic' were themes for both non-parents and parents.
4. *It is predicted that there will be differences in the reasons that influence the decision to parent between non-parents and parents.* This hypothesis is partially supported, showing the difference between the non-parent and parent groups, and generally indicating divergence between female and male non-parents and agreement among parents. Reasons that influence the decision to parent followed a similar pattern to the previous hypotheses. Both non-parents and parents demonstrated that 'family expectation' 'cultural expectation' 'feel parent-child bond' and 'give love and affection' were the most influential reasons. This result is consistent with other studies (Langdridge et al., 2000; Langdridge et al., 2005; van Balen & Trimbos-Kemper, 1995). For example, Langdridge (2005, p. 131) found there was 'a strong emphasis on values concerned with 'primary group ties and affection' (give love and make family)'. The non-parent results are in line with previous research, as are the parent group response of 'receive love and affection' (Lampic et al., 2006; Langdridge et al., 2000; Langdridge et al., 2005; van Balen & Trimbos-Kemper, 1995). The items 'improve on my childhood experience' and 'give my experience of childhood to my children' originated from the pilot study. Several interesting issues arose from these results. First, only the parent group selected that item. By comparison, the item 'give my experience of childhood to my children' was selected only twice by both parents and non-parents. Second, why only parents? Does the experience of parenting expose the deficiencies of their own formative experience? Is there a cost-benefit that has not been previously identified? Contrary to most other studies (Lampic et al., 2006; Langdridge et al., 2000; Langdridge et al., 2005; van Balen & Trimbos-Kemper, 1995) religious and spiritual reasons were demonstrated as being somewhat influential, more so in the parent group. Again, this may be related to this particular sample - there were a relatively high number of respondents (38.5%) that indicated a religious belief.
5. *It is predicted there will be differences in the reactions associated with broodiness, between non-parents and parents, both male and female.* The hypothesis is partially supported, with males showing more divergence and females more agreement. The main category associated with broodiness was

'Yearning' where females from both groups recorded similar levels, whereas non-parent males recorded a higher rate than male parents (40.7% compared to 33.3%). An investigation of a subset of the other items revealed that overall non-parents were more affected by 'yearning', 'sadness', and 'depression' than parents. Interestingly, a word search for 'yearning', 'sadness', depression', and 'elation' in the papers commonly referred to in this piece (Lampic et al., 2006; Langdridge et al., 2000; 2005; Purewal & van Den Akker, 2007; Schoen et al., 1999; 1997; van Balen & Trimbos-Kemper, 1995). Only 'depression' was once referred to and that was in the context of being associated with infertility treatment (Langdridge et al., 2000). van Balen and Trimbos-Kemper (1995) used 'Happiness' as a motivator in the desire for parenthood; 'Happiness denotes the expected feelings of affection and happiness in the relationship with children' (p.139). Critical here is the word 'expected' as van Balen and Trimbos-Kemper (Ibid) suggest that the cost-benefit model measures 'factual' costs and benefits, which are only apparent post-birth. Thus, childless individuals have 'expected' cost-benefit choices. However, neither 'factual' nor 'expected' cost-benefit models seem to reflect the 'actual' desire for parenthood.

Strengths

This study has several strengths. The lack and evolutionary nature of research into the desire for fatherhood mean there are few directly comparable results with this study. Most quantitative studies use those in either pre or post infertility treatment as a criterion for involuntary childlessness (see Lechner et al., 2007). However, this policy avoids an alternative source of data; as one of the respondents to this study noted, 'What kept me from being a parent was not having the right "constellation of circumstances".' (Hadley, 2009b, p.58). The Langdridge et al. (2005) study was one of the few that accessed and measured the fertility intentions of childless couples, excluding anyone pre or post infertility treatment. However, the difference between male intenders and non-intenders was not published in any detail.

Limitations

The sample (n = 232) consists of female and male non-parents and parents. However, there were relatively few male respondents (non-parent, n = 27; parent, n = 38). Compared to the ONS (2005) data, and similar to Langdridge et al. (2005, p. 126), the sample is not in line with social trends and might generalise across populations. This may reflect an issue with the sampling technique: it is possibly more representative of the researcher's network than the population. Disadvantages of this form of the survey include the exclusion of sectors of the population that have no digital access. Similarly, the ubiquity of surveys may influence the willingness to participate (Couper, 2000).

Future studies

There is a lack of material regarding the desire for parenthood in men. Therefore, this field is open to further research in many areas. Specifically, there is even less work on childless men who yearn to be a father. However, I believe that further exploration of that area would provide invaluable insights into the mental health, behaviour, and social identity of men who yearn for fatherhood. Weitofr et.al. (2004) demonstrated the higher mortality rates for childless men and lone non-custodial fathers.

CONCLUSION

The results indicated several findings that answered the research questions and partly supported the proposed hypotheses. Most childless men wanted to become fathers, female non-parents showed a slightly higher desire. Parents were equally sure of not repeating parenthood. Common reasons influencing parenthood were cultural and family expectations, 'feel parent-child bond' and 'give love and affection'. 'Yearning' was the item most associated with broodiness. Analysis of a subset found that, compared to parents, non-parents were more affected by 'Yearning' 'Sadness' and 'Depression' with male non-parents having the highest reactions to 'Depression' and 'Isolation'. The hypotheses were, in the main, concerned with predicting the differences between the female, and male, parent and non-parent groups. The first hypothesis was supported. Three of the remaining hypotheses were partially supported, the main differences being between female and male non-parents, while female and male parents

displayed very similar responses. The final hypothesis revealed more divergence between males and more agreement between females. The results indicate that male non-parents do get 'broody' and consequently may suffer from some reactions including depression and isolation.

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‘Men say that he shall come again, and he shall win the holy cross’: Gender differences in shared-religion bias in identifying with fictional characters

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This experimental research investigated if men and/or women have an own-religion bias in their strength of identification with fictional characters. Past research on this topic in psychology, literary studies, and game studies is limited and the expectations from identity theory are unclear. A hypertext fiction story game was used as an experimental stimulus, slightly modified for different participant groups. Almost 400 participants took part and ANOVA analysis carried out. The novel surprising results found no strong evidence of own-religion bias in identification for either gender but did produce good evidence of gender bias in identification. This reveals new complexities in identification research and suggests models from social identity theory may not generalise to identification, with practical application for informing literary creation.

Keywords: Arthurian; gender; fiction; hypertext; identification

Identification is the process by which a person recognises similarities between themselves and something else, such as another person, a group, or a fictional character. Identification has been discussed across the humanities, but as Cohen (2001) notes these ideas lack conceptualisation or testing. In the social sciences identification was discussed by Holt (1950) and Freud (2010, originally published 1923), but neither addressed identification with fictional characters.

Identification is an interesting and worthwhile topic in that a deeper understanding can inform artistic creation. A further real-word implication is an understanding of how to shape identification may help reduce prejudice as discussed by McLaughlin et al. (2018). Beyond these applications, a better understanding of identification may generalise to provide insight into identity, a topic that is difficult for practical reasons to research experimentally. Burke and Stets (2009) explained that identity can either be a role in society (as defined by Stryker, 1980), a group membership as understood by social identity theory or a set of personal characteristics; identities based on characteristics are a particularly under-researched topic.

Social identity theory (SIT) was originally developed by Tajfel (1970), who used an experimental design based around participants assigning points to other people. Tajfel found evidence of in-group bias, even with temporary group membership arbitrarily assigned by the experimenter. Rudman and Goodwin (2004) also looked at gender differences and found across multiple SIT experiments that women generally have a stronger in-group bias than men.

Klimmt (2009) studied games and claimed that identification occurs when the player sees attributes of their character as part of themselves. This position was supported empirically by Blake (2012), who found that identifying with video game characters increases enjoyment and transforms self-perception for at least a short time after play. There are also several studies on identification with game avatars including Martin (2005) and Bessière (2007). However, an avatar is merely a virtual object – a digital playing piece – and not a literary character. Survey research by Yee (2017) found that three-quarters of female gamers considered inclusion of female protagonists as 'very or extremely important', compared to only a quarter of male gamers, which could be considered an indication of in-group gender bias in identification.

Previous research by Hook (2019) into identification with fictional characters presented a new experimental method to study identification with fictional characters by using a hypertext fiction (HF) story game (Montfort, 2005), also called 'choose-your-own -adventure', as a stimulus which could be modified slightly for different groups. The reader reads each page and chooses a hyperlink to decide what the protagonist does. Examples of this medium include the computer game *Depression Quest* (Quinn, 2013) and the *Fighting Fantasy* book series, such as *The Warlock of Firetop Mountain* (Jackson & Livingstone, 1982). Aarseth (1997) provided an in-depth academic discussion of HF and made the case that the reader is an active player compared with the observer status of a reader of traditional fiction. Green and Jenkins (2014) discussed how the user control in HF increases enjoyment and engagement, of which they consider identification to be a facet. Hook (2019) discovered a gender difference in levels of identification: women displayed an own-gender bias in that they identified more strongly with female characters than male characters, but men did not display this bias and identified equally with characters regardless of gender.

This finding posed a question of whether this gender difference in in-group identification bias is specific to gender identity or whether it also applies to other identities. To put it another way, do men and/or women identify more strongly with characters that share a particular characteristic other than gender with themselves? The current paper attempts to answer this question using religion as the second identity.

While there has been some research into religious identity as a group identity from a SIT perspective; it should be noted this has not been strictly about identification. Cairns et al. (2010) found in-group bias researching Protestants and Catholics in Northern Ireland, with particularly strong bias found among Protestants and those who strongly identify with their faith. Johnson et al. (2012) found evidence of Christians having negative attitudes to various out-groups (atheists, Muslims, and gay men) but it was not clear whether they acted in a biased way because of this. On the other hand, Hunter (2010) found no

evidence that Christians experience a self-esteem boost from the positive or negative evaluations of Christians or Atheists.

Ben-Ner et al. (2009) used a conventional SIT experimental design and reported in-group bias for most identity categories they investigated, with family/kinship being the strongest, followed by political, religious, sports-team and music-preference based groups. Strangely, they reported no significant findings based on gender. Ysseldyk (2010) discussed how religious identity is both a group membership and also a worldview belief system and differs from other social groups in offering a membership regarded as eternal.

Some particularly fascinating experiments into religious bias were reported by Różycka-Tran (2017). Using staged real situations such as trying to get a seat on a train while wearing religious dress, they found signs of helping behaviours being directed more towards those presenting as having a shared religion. This was consistent with Ahmed (2007) who argued that bias comes not from hostility to outsiders but favouritism towards in-group members.

Religion and gender are considered as group identities, especially by those researching group identity using SIT. However, they can both also be considered as personal characteristic based identities; someone physically stranded apart from all other people and so cut off from their group will likely still identify by their religion and gender. Indeed, people may turn to religion in times of such distress. Hence, religious identity is not simply a group membership-based identity but also a personal characteristic identity. The present study therefore directly addresses the shortfall in studies on personal characteristic identities (Burke & Stets, 2009) by investigating participants' identification with religious and non-religious fictional characters.

Based on the conclusions of SIT research such as Ben-Nur et al. (2009) it was expected that participants would identify more strongly with characters who shared their religion. An interaction with gender was also expected, with women showing a stronger in-group religious bias than men (Rudman & Goodwin, 2004).

METHODS

Participants

Participants were recruited by posting adverts on social media in gaming, roleplaying, Arthurian and religious groups. It ran online for two weeks in April 2019, and a total of 393 responses were recorded.

Most (75%) of the participants identified as male, followed by 21% who identified as female and the remaining 4% who either identified as non-binary or preferred not to say. In terms of religious identity, 62% were of no religion and 26% were Christian, with the remaining 12% selecting other religions. Most of the participants were native English speakers (85%), aged 25–50 (71%); from Europe (59%) or North America (33%). Typically they held at least one degree (73%), had a lot of prior exposure to Arthurian fiction (68%), had played more than ten interactive fiction games (53%), had more than a year of experience of tabletop role-playing games (52%), but very little or no experience with live-action role-playing (81%).

Materials

The stimulus used for this experiment was a custom written HF story game; the researcher's qualifications include creative writing. The story game details an Arthurian knight on a quest, broadly in the literary tradition of *Le Morte d'Arthur* (by Sir Thomas Malory, first published 1485, from which the quote in the title of this article derives) and the tabletop role-playing game *Pendragon* (Stafford, 1985). The participants had seven binary choices to make during the story about the decisions of the protagonist. Use of a setting far removed from everyday life avoided chancing upon the character having

other identities shared by the player, since it was relatively unlikely that a participant would identify as a knight.

Design

This experimental design was inspired by the method described in Hook (2019) and coded using the Twine software tool for creating HF. Participants were randomly assigned to one of two groups by the software. The only difference in the stimulus between the two groups was the character briefing screen at the start of the story. In one group, the protagonist was described as 'a pious and faithful Christian knight' and in the other as 'a knight with little interest in religion.' Christianity was chosen here due to the expectation that this would be the most represented religious identity among the participants.

The dependent variable of identification with the character involved two seven-point Likert-type items: 'How strongly did you identify with [character name]?' and 'How strongly were you able to take on the role of [character name]?'. The responses were averaged to lessen any influence of precise question wording.

Procedure

The story game was presented as a series of webpages, which enabled the experiment to be run online. This enabled a wide and diverse set of participants from across multiple countries and increased ecological validity in that participants used their own devices in their everyday settings.

Data was collected at the end of the story using a form and participants gave consent by completing the form and clicking submit. Participants were welcome to simply play through the story game and not take part by not completing or not submitting the form though it is unknown how many may have done this. An email address was given in case participants wished to withdraw later and no one made contact for this purpose.

On the form participants were asked two identification questions (as detailed above) and what religion they were, using the same categories as the Office for National Statistics, which are: no religion, Christian, Muslim, Jewish, Hindu, Buddhist, Sikh, other religion. Participants were also asked for their gender, with the options: male, female, 'other / non-binary' and 'prefer not to say', to be consistent with Hook (2019).

Additional questions covering topics such as the participant's broad geographic identity, education level, distractions while taking part, and past exposure to the King Arthur setting were also included asked for background and possible secondary analysis. Names and other identifying data were not requested so all data was anonymous. Data was stored with appropriate security, and ethical review and approval for this research obtained from the first author's university ethics committee.

RESULTS

The primary analysis conducted was a three-way independent ANOVA, with character religion, participant religion, and participant gender as the independent variables and the average of the two identification questions as the dependent variable. For the purposes of this analysis, all non-Christian participant religions were merged into a single category titled 'all other religions.' In addition, nine non-binary participants and five who preferred not to disclose their gender were excluded from the analysis, leaving 379 participants in the sample.

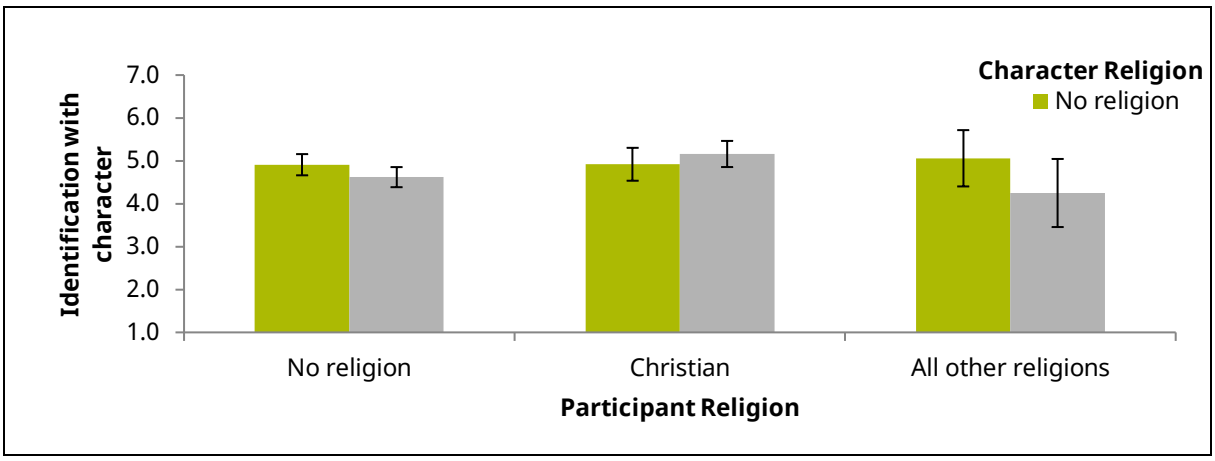
The main effect of participant gender was highly significant, F (1, 367) = 13.00, $p < .001$, $\eta^2p = .03$, with men showing a higher level of identification with the character than women. However, there were no other significant effects, including the hypothesised two-way interaction of participant religion by character religion, F (1, 367) = 0.42, $p = .655$, and the three-way interaction, F (1, 367) = 0.54, $p = .585$. Means and standard deviations for all conditions are shown in Table 1.

Table 1
Means (Standard Deviations) and Numbers of Participants in Each of the Groups Present in the Main Analysis

	Men		Women	
Participant religion	Character with no religion	Christian character	Character with no religion	Christian Character
None	4.91(1.15) *N* = 83	4.62 (1.19) *N* = 99	4.29 (1.16) *N* = 24	3.97 (1.41) *N* = 30
Christian	4.92 (1.19) *N* = 37	5.16 (1.03) *N* = 44	4.50 (1.41) *N* = 11	4.09 (1.46) *N* = 11
All other religions	5.06 (1.34) *N* = 16	4.25 (1.62) *N* = 16	3.92 (1.07) *N* = 6	3.50 (0.71) *N* = 2

Due to the large percentage of men in the sample (75%), combined with the highly significant main effect of gender, post hoc two-way analyses of variance were conducted on the data from men and women separately. The results for men showed weak evidence for an interaction between participant and character religion, F (2, 289) = 2.57, p = .078, η^2p = .02. Figure 1 suggests that while the character of no religion was identified with equally by all male participants, when the character was Christian, there was higher identification by Christian participants and lower identification by participants of other religions. The main effects of participant religion, F (2, 289) = 1.87, p = .156, and character religion, F (1, 289) = 2.69, p = .102, did not reach significance.

Figure 1
The Interaction of Participant and Character Religion on Identification with Character for Male Participants Only



Nine out of the 16 men following non-Christian religions who viewed the Christian character selected 'other religion' (M = 4.17); two selected Muslim (M = 4.50); one selected each of Buddhist, Hindu and Jewish (M = 5.30); and two preferred not to say (M = 2.75).

The same two-way ANOVA on the identification of women with the character showed no significant effects of participant religion, F (2, 78) = 0.47, p = .624, character religion, F (1, 78) = 0.82, p = .367, nor an interaction, F (2, 78) = 0.01, p = .990.

Exploratory analysis

A stepwise linear regression was performed on the data from participants who viewed the Christian character. Predictors made available to the model were age, gender, religion (seven dummy codes), importance of religion (7-point Likert item), country (six dummy codes), degree (three dummy codes), device (two dummy codes), and distractions. Using an entry criteria of $p < .100$, seven predictors were added to the model, the coefficients of which can be seen in Table 2. The directions of the coefficients suggest that the Christian character was identified with more highly by men, by participants who rate religion as important to them, and by people who follow the Hindu religion. On the other hand, lower identification with the character was found among participants who used a mobile phone for the story-game, by following other religions or the Jewish religion, and by those who stated that experiencing a good story with strong narrative or drama is the most important aspect when role-playing.

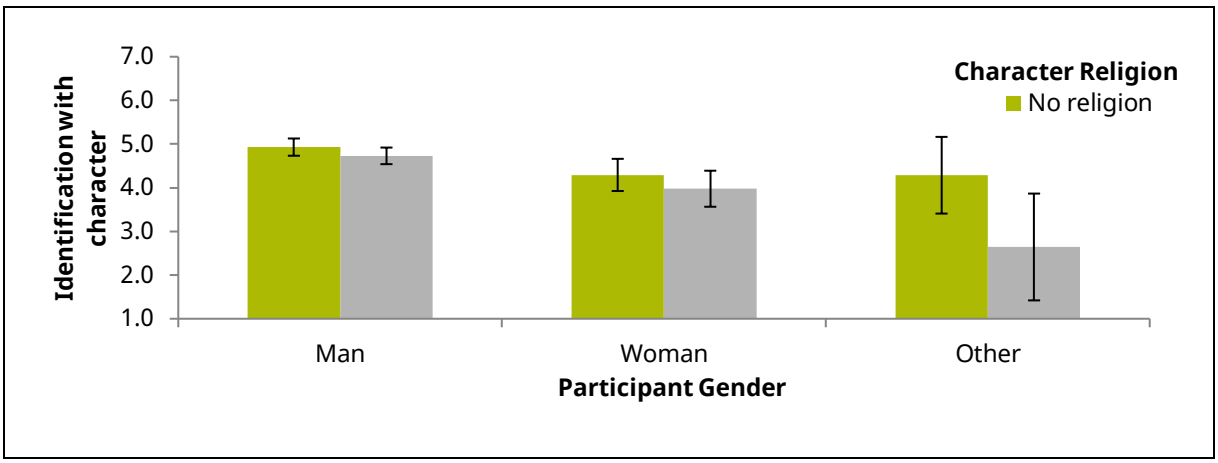
Table 2
Predictors of Identification with the Christian Character

Predictor	*B*	*SE B*	β	*T*	*p*
(Constant)	4.069	0.254		16.023	<.001
Importance of religion	0.177	0.041	0.288	4.350	<.001
Gender	0.629	0.205	0.200	3.068	0.002
Hindu	2.840	1.186	0.155	2.395	0.018
Device Phone	−0.378	0.170	−0.145	−2.218	0.028
Other Religion	−0.706	0.368	−0.124	−1.921	0.056
Jewish	−2.434	1.201	−0.133	−2.027	0.044
RPG Narrative	−0.336	0.173	−0.127	−1.940	0.054

The final stage of the exploratory analysis was to look at the participants who were previously excluded due to being of non-binary preferring not to disclose their gender identity. None of these 14 participants identified as Christian, an association which was statistically significant, $\chi^2(4) = 16.11$, $p = .003$.

A two-way ANOVA (ignoring participant religion) was conducted which resulted in significant main effects for both gender, $F(2, 387) = 16.97$, $p < .001$, $\eta^2p = .08$, and character religion, $F(1, 387) = 8.97$, $p = .003$, $\eta^2p = .02$. There was weak evidence of an interaction, $F(2, 387) = 2.31$, $p = .101$, $\eta^2p = .01$. Figure 2 suggests that this was due to low identification with the Christian character by participants who were either non-binary or preferred not to disclose their gender.

Figure 2
The Interaction Between Participant Gender and Character Religion on Character Identification



Discussion of results

While there was some weak evidence of differences in identification on the basis of religion for males, the overall lack of evidence was somewhat surprising. This implies a general lack of in-group bias in identification on the basis of religion. This was unexpected as religious group bias is well documented both other research and familiar in everyday experience. The lack of shared-religion bias was consistent with the previous research by Hunter (2010). In contrast, Cairns et al. (2010) did find in-group bias among Christian groups, but these findings may be particular to their Northern Ireland research context with a long history of conflict.

One possible explanation is that identity functions differently to identification with fictional characters and the concepts from Social Identity Theory do not generalise well to identification with fictional characters. As discussed above religion can be considered a personal characteristic identity (Burke & Stets, 2009) rather than a social group identity. This might also explain why the predictions from Social Identity Theory did not seem to apply here.

Hook (2019) found that women but not men display in-group bias in identification on the basis of gender identity. This raised the question of whether this finding would generalise to other identities. By finding no evidence for in-group bias in identification on the basis of religious identity, this experiment implies that Hook's findings do not generalise to religious identity. This highlights the importance of avoiding assumptions that findings about one identity generalise to another. For this reason, future discovery of underlying general principles of identification may prove extremely difficult.

Leaving aside the topic of religious group bias, there was strong evidence here for a gender difference in identification; women identified less strongly with the male character than men did. While this was not a full replication, this is consistent with the findings of Hook (2019). This pattern of results demonstrated the importance of analysing genders separately when researching identification, especially if the weak evidence for an interaction between participant and character religion in the male participant data but not the female is considered as an indication of gender differences in the variables that affect identification.

While the evidence was weak, the results were suggestive that that men who follow non-Christian religions identified less with a Christian character than other men did. Examination of the means suggested that this was especially the case for those who selected the 'other religion' category (which includes 'pagan' faiths). One speculation is that this reflects participant religions which were historically persecuted by Christians.

Reflection on the method

This experiment built upon a new experimental method first published in Hook (2019). As noted above it generated further evidence in support of those findings and extended the understanding of those results. From a psychology perspective, this research shows how a game can be used as an experimental stimulus. The digital nature of many games lend themselves to the experimental method and efficiently support recruiting a much larger pool of participants than would otherwise be practical. Modern tools make it relatively easy to create a small novel game for research purposes. Arguably, the use of game-like elements in experiments is nothing new. Hook (2012) discusses how many classic psychology experiments could be considered game-like.

From the perspective of the game studies discipline, this continuing strand of research brings the rarely used experimental method into a relatively new discipline, in contrast to research that draws on the traditions of other disciplines. It demonstrates how concrete hypotheses can be tested to create evidence-based insights. Methodologies that game studies derive from other disciplines have an important role in forming concepts and generating hypotheses, but there is certainly more need for formal definition and testing of these hypotheses in game studies.

Practical applications of the findings

One practical application of this finding is in informing artistic creation. Identification is believed to increase audience engagement (Green & Jenkins, 2014) and enjoyment (Blake, 2012), so for media concerned with telling stories about characters such as novels, films and some games this finding is relevant. It informs us that the character's religion is unlikely to affect audience engagement positively or negatively. A central protagonist being Christian does not appear to alienate non-Christian readers. This might be particularly important commercially if the target audience is in a particularly secular country. This might also apply to other fields where identification with a character is a design goal, such as advertising and marketing (e.g., celebrity brand management).

Implications for future research

Given the repeated results of finding a gender difference in identification, a key point for future research is to control for this difference by considering different genders separately when researching identification. It may also be worth recording religious group in future experiments, even if only for secondary analysis purposes to see if there is further support for the weak evidence found for male participants.

Given the findings of differences in identification bias comparing gender identity and religious identity, an important message is that findings about one identity should not be assumed to generalise to other identities. This makes developing generalised rules about the mechanisms of identification extremely challenging.

One outstanding research question to explore is what extent findings about identification ('I identify with…') generalise to identity ('I identify as…'), and vice versa. While Ben-Ner et al. (2009) found in-group bias based on religion but not on gender, experiments with identification found in-group bias for gender but not religion, and only for one gender identity. This suggests findings do not generalise across the topics as might have been assumed.

Another more modest extension of this research would be to repeat it with different identities. Given that men have not shown any bias in identification based on gender or religion, further research might be particularly interesting to shed light on when men do display shared-identity bias in identification.

Replications of experiments such as this with a graphical computer game rather than a text story-game would be interesting to see how the results generalise across different kinds of media. Another option would be comparing an interactive stimulus such as HF with a conventional short story to see if the addition of agency changes the pattern of identification.

CONCLUSION

This research has further tested a new experimental design and producing surprising results suggestive of no identification bias on the basis of religious identity and good further evidence of identification bias on the basis of gender identity. This exposes the complex nuances of the process of identification and has practical implications for literary creation.

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Adults are expected to take responsibility for their problems, especially when those problems are congruent with traditional gender role expectations

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Some research suggests that we attribute responsibility differently for men and women. For example, Reynolds et al. (2019) found women are more easily typecast as victims and men as perpetrators. The present study was a cross-sectional online survey of 408 male and female adults aged 18 to 65, stratified by UK region. Participants saw 14 vignettes depicting a wide variety of scenarios featuring either a male or female character (a man or woman, or a boy or girl), about which participants were asked to make attributions. The gender of the vignette character was randomly assigned for each vignette. There was no overall difference in total internal attribution of responsibility to boys compared to girls (Cohen's d = –0.01, p < .862). For the vignettes about adults, there was a non-significant overall trend towards total internal attribution being higher for male characters (d = 0.061, p < .065). However, in terms of each vignette separately, participants agreed more strongly that: boys were more responsible for how depressed they feel (p < .013), and men were more responsible for avoiding workplace accidents (p < .002) and finding work (p < .003). Girls were attributed as more responsible for being physically fit (p < .034), and women attributed as more responsible for making sure their children don't have a playground accident (p < .034). Findings of this exploratory study are discussed about attributions of responsibility being based on traditional gender role expectations. Implications for social issues, for example, encouraging help-seeking for mental health problems by boys, are discussed.

Keywords: attribution of responsibility; gamma bias; sex difference; traditional gender roles; victim-blaming

Some previous research has noted sex differences in attribution of responsibility to individuals in various circumstances, but there is not a comprehensive body of work covering the variety of social contexts in which this occurs. Although research on the factors that affect the attribution of responsibility to men compared to women is far from complete, there are some interesting examples. In the context of health, a study presented participants with vignettes (short scenarios) about a 'positive thinking' strategy used by a hypothetical patient with bone cancer, and it was found that a male patient was seen as more responsible than a female patient if they continued to have cancer (Ruthig & Holfeld, 2016). In another study using vignettes, undergraduate nursing students were randomly allocated to reading material emphasizing either sociocultural or biological causes for the development of anorexia nervosa (Crisafulli et al., 2008). Participants who were exposed to the biological explanation were less inclined to blame people with anorexia than those exposed to the sociocultural explanation.

It could be that the more salient the gender of the protagonist is compared to other characteristics in the vignette, the more participants will be inclined to make attributions based on gender rather than other characteristics, such as their social class (Baron et al., 1995). If this is the case, then research that makes gender salient, or describes situations that are typically thought of as gendered, might be more likely to elicit judgements based on gender. For example, men are more likely than women to commit a violent crime, and although a small minority of men commit most of the violent crime (Falk et al., 2014), the association of men with violence appears to influence our judgements of male criminality. In support of this hypothesis, experimental studies by Reynolds et al. (2019) found women are more easily typecast as victims and men as perpetrators, even in cognitive tasks where animated shapes instead of people were shown perpetuating harm. Because of attitudes to gender, we would expect scenarios that are based on situations that evoke gender norms to invoke attitudes based on these norms.

It seems that even when we are presented with information that is contrary to our assumptions about gender, our judgements may still be interpreted according to our expectations if the situation is seen as gender-typical. One example is domestic violence, an issue that tends to be seen more as a problem faced by women, though around 30% of victims are male (Powney & Graham-Kevan, 2019). A study using vignette methodology to manipulate perpetrator and victim sex found that compared to female victims, violence against men was seen as less serious and more justified, and male victims were seen as more blameworthy than female victims (Erickson et al., 2017). The authors suggested that this victim-blaming was due to traditional gender role attitudes.

Apart from gender, other facts might make a difference in how much responsibility we attribute to someone's actions. For example, the law in most countries has a threshold 'age of responsibility', and perpetrators under this age are held less responsible for their actions (Cipriani, 2016). Similarly, those with severe mental health issues at the time of committing a crime may be seen as having 'diminished responsibility' (Catley, 2019). Thus, as well as gender, other variables might impact our attribution of responsibility.

Apart from attributes of the individual (such as gender, age, mental health etc), details of the context in which the individual finds themselves can influence attributions of responsibility. The classic finding of the *fundamental attribution error* was that we tend to believe that other people's behaviour (though not necessarily our own) is caused by their personality rather than their context (Jones & Harris, 1967). Thus, when a person is having problems, observers tend to blame the person, rather than the person's context, for their problems. It has been found that non-Western people are more likely to blame the context than are Western people, possibly related to how collectivist a culture is (Miller, 1984).

The existing evidence base on sex differences in responsibility attributions is relatively sparse, so the objective of the present study was to explore, in a wide variety of hypothetical situations, how responsibility is attributed differently depending on the age and sex of the character (or protagonist) in a vignette.

METHODS

Design

This was a cross-sectional online survey during which participants saw a series of vignettes, each vignette featuring either a male or female character, about which they were asked to make attributions of responsibility. The survey included a manipulation such that for each vignette, half of the participants were randomly allocated to see a female character and half saw a male character, allowing a between-group comparison by gender of the vignette character.

Participants

Participants were recruited from the research panel of *Lightspeed* (now called *Kantar*), a data collection company who are certified by the British Healthcare Business Intelligence Association. Adults aged 18 to 65 were a quota sample by gender and age and stratified by UK region.

Procedure

During June–July 2017 a quota sample of potential participants who met the inclusion criteria was identified by *Lightspeed* from their online panel of thousands of people across the UK. Invitations were sent and potential participants were told they would be asked to look at and comment on several short scenarios. After giving consent they accessed the survey via a link. Participants were first asked for some demographic details and then asked to rate, for each of 14 vignettes, how much responsibility the characters have for their predicament, and how much responsibility society has for their predicament. The main objective of the study was to examine how attributions differed according to the gender of the vignette characters. For each vignette half, the sample saw a male character and half a female character. At the end of the survey, the debrief form told participants that the age and gender of the characters had been varied so that their ratings wouldn't be influenced by the character's age or gender. The survey used Qualtrics survey software Version 4.2.

Measures

Participants were first asked to give their age, gender, ethnicity, educational level and relationship status. Following this, they were presented with 14 vignettes (fully described in Table S1). The vignettes covered a wide variety of topics, reflecting the exploratory nature of this study. The situations were described in a way that meant that the most obvious features of the protagonist were the gender and their age. The order of the vignettes was randomised and whether the participant saw a male or female character(s) depended on which pattern they were randomly allocated to (see Table S2). For each vignette, participants were asked to respond how much they agreed with a statement indicating that it was the individual concerned who was responsible for fixing it. They were then asked to respond how much they agreed with a statement indicating that the context needed to change.

An example of one of the 14 vignettes is:

A health spokesperson recently stated that the depression rate had increased for girls [or boys] aged 10-12 and that it was time that we started taking depression in girls [or boys] more seriously.
How much do you agree with the following statements?
Girls [or boys] should take more responsibility for how depressed they feel.
The government should do more to reduce depression in girls [or boys].
[Scored as 1 = Totally disagree to 6 = Totally agree]

The first statement was designed to measure the degree of responsibility attributed to the person or people affected, thus a high score indicated higher attribution of responsibility to the individual or individuals concerned. The second statement was designed to measure the degree of responsibility attributed to the context, thus a high score indicated higher attribution to external factors. From these, an additional measure was calculated by subtracting the context attribution score from the individual

attribution score, as is common in studies of attribution (Kouabenan et al., 2001). This variable was called 'total internal attribution' and has a possible range of values of −5 to +5.

Five of the vignettes focused on children or adolescents (girls or boys as characters in each vignette) and covered mental health (depression, as shown above), physical health (fitness), isolation (having no friends) and academic issues (confidence in maths/science and grades). Nine vignettes focused on adults (men or women as characters in each vignette) and covered workplace issues (obtaining a sales job and causing workplace accidents), adverse effects of internet usage, crime (being mugged and the home being robbed), physical health (liver cancer in a drinker and emphysema in a smoker), homelessness and a playground accident. Details of all the vignettes can be found in Table S1.

Ethics

Participants gave their informed consent to participate in this study, and the guidelines of the Declaration of Helsinki were followed. As is usual when panel members complete a survey, participants were paid a small fee for participation. Contact details were given at the end of the survey for those who might need further information or support from Samaritans (a UK helpline). Ethical approval was granted by University College London's Research Ethics Committee (REC Reference: 4075/012).

Statistical methods

For each vignette and each of the three attribution measures, effect sizes for the difference between male and female vignette characters were calculated and *t*-tests performed. Following this, ANOVA was used to examine whether the difference by gender of the vignette character changed after adjusting for participant age (categorised as 18–34; 35–49; 50+), gender (categorised as male, female), ethnicity (categorised as white or Black or Asian Minority Ethnic Group [BAME] and educational level (categorised as nongraduate, graduate). That is, this analysis examined whether the characteristics of the participant confounded the results. ANOVA was used to examine whether participant age, gender, ethnicity, or educational level modified any differences by vignette character gender. As this was an exploratory study, all significance values were two-tailed. Statistical analysis was conducted using SPSS statistical software for Windows, Version 25. Overall standardised effect sizes for adults, children and adults plus children were calculated by combining the standardised effect sizes for each vignette using a fixed-effects meta-analytic method in Stata, Version 16 (Statacorps).

Sample size

The sample size was calculated to give 80% power to detect an effect size (Cohen's *d*) of 0.25 for the difference between genders at the 5% level of significance. Using these criteria G*Power v3.1 (Faul et al., 2007) produced an estimate of 199 in each group requiring a minimum overall sample size of 398. A sample of 414 individuals consented to participate and completed the online questionnaire. A summary of participant's demographic characteristics can be found in Table 1.

RESULTS

Table 1
Demographic Characteristics of Participants

Characteristics	*N*	% (Non-missing)
Gender		
Male	186	44.9
Female	228	55.1
Age		
18–34	152	36.7
34–49	120	29.0
50+	142	34.3
Ethnicity		
White	353	85.3
BAME	61	14.7
Academic qualification		
No qualification	7	1.7
GCSE or lower qualification	124	30.5
NVQ/BTEC	129	31.8
A Level; higher NVQ/BTEC	113	27.8
Undergraduate	33	8.2
Postgraduate	8	–
Missing	–	–
Relationship status		
Single	144	35.5
Married/engaged/cohabiting	234	57.7
Widowed/divorced	28	6.9
Missing	8	–

Table 2

Difference in Scores Between Male and Female Vignette Characters for the Three Types of Attribution

	Individual(s) responsible Male minus female scores[a]					Context need to change Male minus female scores[b]					Total internal attribution Males minus female scores[c]				
	M	*SE*	*t*(412)	*p*	*d*	*M*	*SE*	*t*(412)	*p*	*d*	*M*	*SE*	*t*(412)	*p*	*d*
Children															
Depressed children[d]	0.20	.129	1.57	.117	.15	−0.21	.120	−1.74	.083	−.17	0.41	.165	2.49	.013	.25
Unfit children[c]	−0.13	.101	−1.31	.190	−.13	0.11	.098	1.08	.280	.11	−0.24	.112	−2.13	.034	−.21
Children with no close friends[e]	0.08	.124	0.64	.522	.06	0.28	.128	2.21	.027	.22	−0.20	.198	−1.02	.306	−.10
Low confidence in science/maths[d]	0.10	.102	0.98	.328	.10	−0.03	.087	−0.34	.738	−.03	0.13	.105	1.23	.219	.12
Poor academic grades[e]	−0.08	.104	-0.74	.459	−.07	0.07	.127	0.55	.582	.05	-0.15	.154	−0.96	.340	−.09
Adults															
Getting into sales jobs[d]	0.04	.126	0.35	.723	.03	−0.42	.134	−3.13	.002	-.31	0.46	.154	3.02	.003	.30
Workplace accident[e]	0.71	.138	5.15	<.001	.51	0.14	.123	1.12	.263	−11	0.57	.188	3.05	.002	.30
Adverse effects of social media[d]	0.00	.106	0.05	.963	.00	−0.21	.128	−1.68	.095	−.16	0.22	.166	1.32	.187	.13
Being mugged[d]	0.31	.151	2.02	.044	.20	−0.06	.113	-0.53	.594	−.05	0.37	.197	1.86	.063	.18
Being burgled[e]	0.10	.139	0.75	.451	.07	0.13	.123	1.01	.312	.10	−0.02	.203	−0.10	.920	−.01
Emphysema among smokers[d]	−0.01	.156	−0.06	.953	−.01	−0.16	.118	−1.39	.165	−.14	0.15	.203	0.76	.447	.07
Liver cancer among drinkers[e]	−0.04	.153	−0.27	.786	−.03	0.25	.113	2.25	.025	.22	−0.30	.199	−1.49	.138	−.15
Where homeless can sleep[e]	−0.08	.151	−0.56	.578	−.05	0.10	.158	0.63	.526	.06	−0.18	.255	−0.72	.469	−.07
Playground accident	−0.21	.133	−1.57	.118	−.15	0.12	.108	1.16	.247	.11	−0.33	.158	−2.11	.035	−.21

[a] Positive sign indicates stronger attribution to the individual(s) concerned when the character(s) of the vignette were male

[b] Positive sign indicates stronger attribution to the context when the character(s) of the vignette were male

[c] Positive sign indicates stronger total internal attribution when the character(s) of the vignette were male

[d] 209 participants saw male vignette character(s); 205 saw female vignette character(s)

[e] 205 participants saw male vignette character(s); 209 saw female vignette character(s)

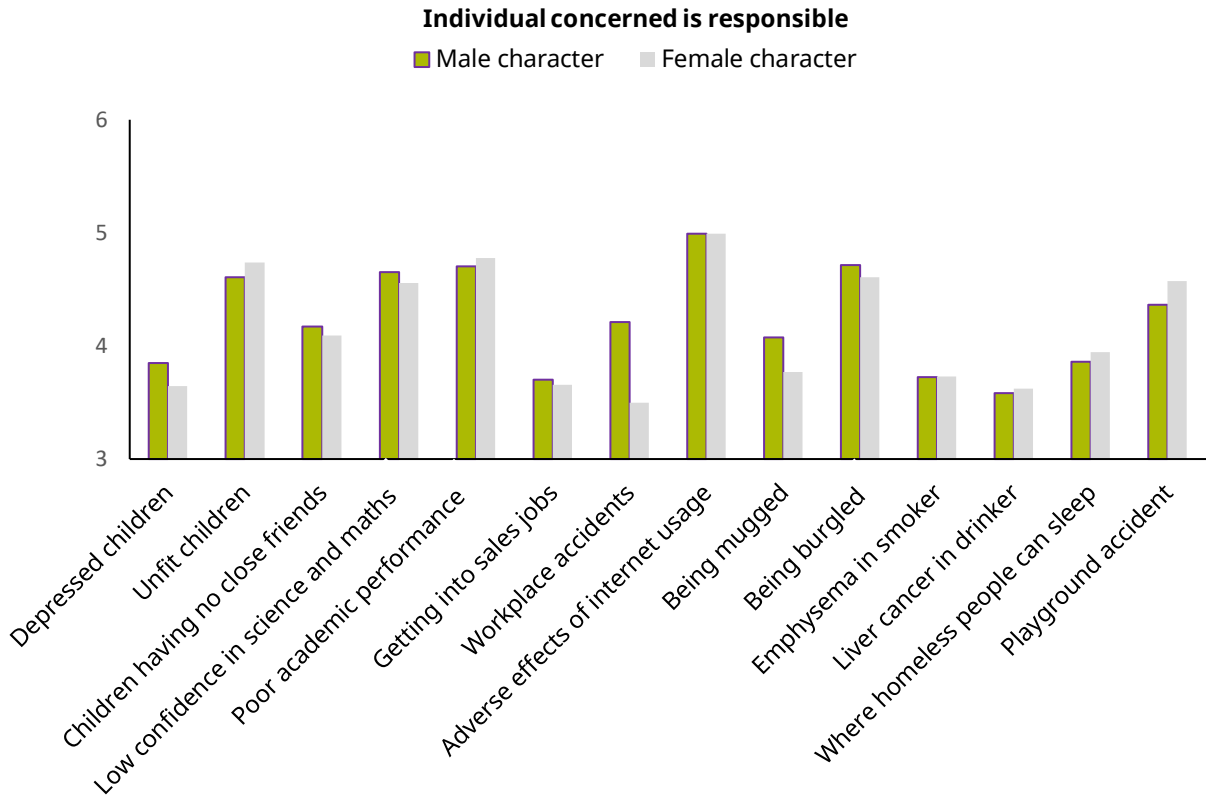
Table 3
Means by Gender of Vignette Character Shown for Different Levels of Effect Modifiers

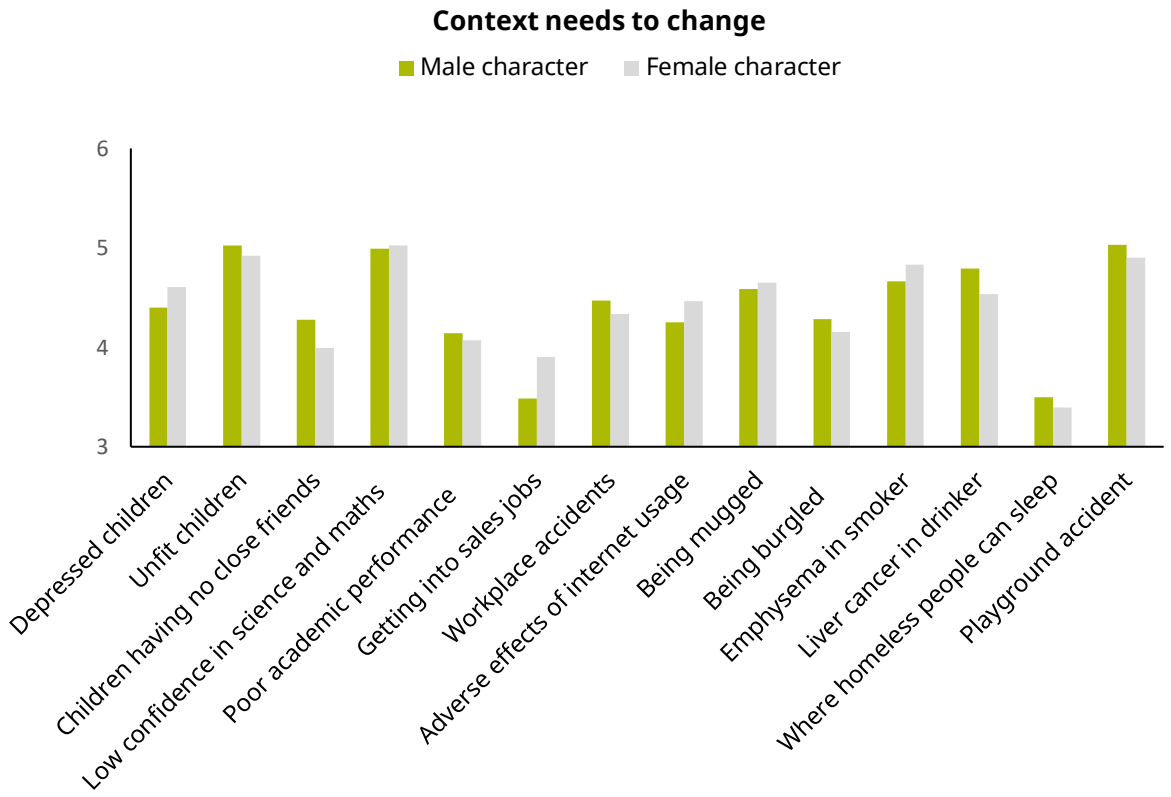
Attribution	Effect modifier	Gender of vignette character						$F_{(1,398)}$	*p*
		Male			Female				
		n	*M*	*SE*	*n*	*M*	*SE*		
	Ethnicity of participant								
Depressed children (individual responsible)	White	178	3.88	.101	169	3.53	.100	6.97	.009
	BAME[a]	28	3.77	.249	31	4.38	.236		
Depressed Children (total internal attribution)	White	178	-.53	.131	169	−1.07	.129	3.92	.049
	BAME[a]	28	-.64	.320	31	−.25	.304		
	Gender of participant								
Workplace accident (individual responsible)	Male	83	4.43	.164	99	4.01	.162	4.61	.032
	Female	117	4.25	.146	107	3.24	.152		
	Age of participant							$F_{(2,397)}$	*p*
Getting into sales jobs (individual responsible)	18–34	75	4.03	.157	72	3.67	.157	3.56	.030
	35–49	61	3.89	.177	57	3.73	.138		
	50+	70	3.66	.180	71	4.08	.175		
Home robbed (total internal attribution)	18–34	72	−.28	.252	75	.35	.251	3.75	.024
	35–49	57	.56	.292	61	−.18	.284		
	50+	71	.51	.280	70	.67	.289		
Playground accident (individual responsible)	18–34	72	4.55	.163	75	4.27	.163	3.85	.022
	35–49	57	4.01	.190	61	4.61	.184		
	50+	71	4.61	.182	70	4.94	.187		

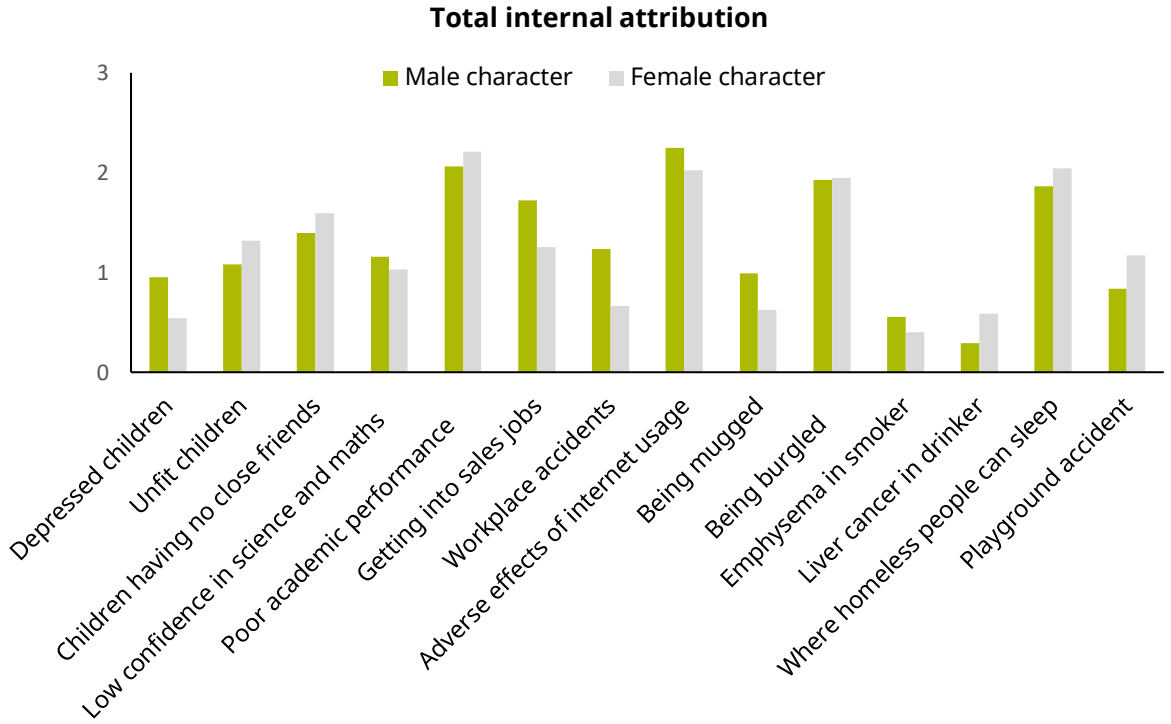
[a] BAME: Black or Asian Minority Ethnic Group

Figure 1 shows mean scores by gender of vignette character for each of the vignettes and each of the three attribution outcomes. Table 2 shows effect sizes for the difference in scores between male and female vignette characters, along with the *p*-value from the t-test. Table S3 shows a similar table but with the results adjusted for participant demographic characteristics. Table 3 shows summary statistics where significant effect modification by participant demographic characteristics occurred.

Figure 1. Mean attribution scores by gender of vignette character(s) for each vignette. The top graph shows the how much responsibility was attributed to the individual (protagonist). The middle graph shows how much responsibility was attributed to the context in which the protagonist was placed. The bottom graph shows the difference between these two scores, calculated by subtracting the context attribution score from the individual attribution score, yielding a 'total internal attribution score'.







Note: 1.5 was added to the total internal attribution scores to make them all positive for ease of interpretation of the graph.

Vignettes with children as characters

The mean scores illustrated in Figure 1 show that overall, participants agreed more strongly that boys should take responsibility for how depressed they feel. They also agreed more strongly that the Government should do more to reduce depression for girls. Table 2 shows that this translated into a significant difference between genders (p = .013) with higher total internal attribution for boys (d = .25; a small effect size). This difference remained after adjusting for potential confounders (p = .017). However, there was significant moderation by ethnicity (p = .009 for individual responsibility; p = .049 for total internal attribution) with those of white ethnicity attributing more individual responsibility for boys while those in the BAME group attributed more individual responsibility for girls (Table 3).

Figure 1 shows the opposite overall pattern for physical fitness, with participants agreeing more strongly that girls should take responsibility for improving their physical fitness while health promotion should be given in schools to help boys improve their fitness. This translated into total internal attribution being significantly higher for girls (p = .034) with a small effect size (d = .21). However, this effect weakened after adjusting for potential confounders (p = .058) and there was no effect moderation.

Figure 1 and Table 2 show that there was little difference in the attribution of individual responsibility for having no close friends between girls and boys but that participants agreed more strongly that outreach programmes are needed for boys (p = .027, d = .22, small effect size). This effect remained after adjusting for potential confounders (p = .037).

For the two vignettes about academic achievement (low confidence in maths/science and poor grades), there was little difference in attribution between the male and female vignette characters.
The meta-analytic approach used to combine effect sizes across vignettes showed that there was no overall difference in total internal attribution of responsibility attributed to boys compared to girls (Cohen's d = −0.01, p < .862).

Vignettes with adults as characters

In the context of the workplace, Figure 1 and Table 2 show that participants agreed more strongly that sales jobs should be created for women than that sales jobs should be created for men (p = .002, d = .31, a small effect size). This translated into significant differences in total internal attribution (p = .003, d = .30, small effect size). However, there was some moderation by age (p = .030). Table 3 shows that participants younger than 50 years old agreed more strongly that men were responsible for getting themselves sales jobs whereas older participants (aged 50 or more) agreed more strongly that women were responsible for getting themselves sales jobs.

Looking at attribution for workplace accidents, Figure 1 and Table 2 show that participants agreed more strongly that men need to be more careful to avoid workplace accidents (p < .001, d = .51, a medium effect size). This translated into a significant difference for total internal attribution (p = .002). Table 3 shows that there was some moderation by gender of participant (p = .032) in that while both male and female participants were more likely to say men needed to be more careful to avoid accidents, the difference was more marked for female participants.

For the vignette on what is needed to avoid the adverse effects of internet usage, there was little difference between male and female vignette characters in individual responsibility for the amount of time they spend on the internet or whether more research is needed (context).

For the vignettes on crime, participants agreed more strongly than male victims of mugging should have taken more care of their belongings than when the victim was a woman (p = .044; d = .20, a small effect size). The effect for total internal attribution was weaker (p = .063) but became stronger after adjusting for demographic characteristics of the participants (p = .020). For the other crime-related vignette - a person's home being robbed after they accidentally left the door ajar - there was little overall difference in the attribution of responsibility. However, there was some moderation by age (p = .024) in that in the youngest participant age group (18–34 years) total internal attribution was highest for females whereas in 35–49-year-olds it was highest for males. In over 50s it was similar for both genders.

For the health-related vignettes, there was little difference between the genders in attributions about emphysema in a smoker. However, for the vignette on liver cancer in drinkers, participants agreed more strongly that outreach should be provided to prevent alcoholism in men (p = .025, d = .22, a small effect size) although this effect weakened after adjusting for demographic characteristics of participants (p = .078).

For the vignette about where homeless people should be allowed to sleep there was little difference in attributions for male or female homeless people.

Figure 1 shows that in the case of a playground accident, participants agreed more strongly that mothers should have focused more on their child rather than chatting with a friend than when it was fathers. Figure 1 also shows that participants agreed slightly more strongly that playgrounds should be made safer for children when the accident occurred under a father's supervision. These translated into significantly higher internal attribution of responsibility for playground accidents for mothers (p = .035, d = .21, a small effect size) although this weakened after adjusting for participant demographic characteristics. There was also some moderation by age of the participant in those younger participants (18–34 years) attributed slightly more individual responsibility to fathers in contrast to those 35 who attributed more responsibility to mothers.

The meta-analytic approach combining effect sizes over vignettes showed that there was a non-significant overall trend towards total internal attribution being higher for male characters (d = 0.061, p < .065).

DISCUSSION

This exploratory survey of over 400 men and women found that when presented with vignettes of male and female characters in similar situations, there was a trend towards attributing more responsibility to male characters for their predicament (d = 0.061, p < .065), though the effect size is very small and was not statistically significant. However, some of the sex differences in attribution of responsibility in the individual vignettes were significant (Table 2). There was no evidence of overall gender differences regarding the responsibility of boys and girls, with the total internal attributions for all vignettes being statistically nonsignificant (d = –0.01, p < .862), though again some of the sex differences in the individual vignettes were significant (Table 2). Interestingly, attributions of responsibility tended to fall along the lines of traditional gender roles, with men be ascribed more responsibility for male-typical situations, and women for female-typical situations. For example, men's greater responsibility for workplace accidents can be seen as related to the traditional provider role (see the section below on *Male and female traditional gender scripts*).

Table 3 shows that demographic differences in participants made little difference in scoring. Apart from workplace accidents, responsibility scores did not appear to be significantly different in male or female participants. Apart from depression in children, responsibility scores did not appear to be significantly different by ethnicity. The main demographic difference was by age, where the responsibility scores were significantly different according to the age of the participants for vignettes about the sales jobs, burglary and the playground accident.

Vignettes with children as characters

There is a popular notion that 'children are innocent', and children are generally held less responsible than adults for their actions, even when these actions are criminal (Cipriani, 2016). This may go some way to explaining the overall lack of sex difference in the attribution of responsibility for their predicaments (d = 0.01). However, there were some interesting contrasts in some of the individual vignettes e.g. boys taking more responsibility for their depression, whereas for girls government intervention was more likely seen as necessary. A similar contrast was seen for physical fitness, with girls seen as needing to take more responsibility, but boys needing more health promotion. Participants agreed more strongly (d = .22) that outreach programmes are needed for boys who had few friends, but there were no sex differences regarding the two vignettes regarding academic achievement.

Vignettes with adults as characters

In the case of some vignettes (internet usage, homelessness, burglary, emphysema in a smoker), there was little difference in the attribution of responsibility. A previous study had found that a hypothetical male patient with bone cancer was seen as more responsible than a female patient for their long-term cancer status (Ruthig & Holfeld, 2016), but the present study found little difference between the genders in attributions about emphysema in a smoker. In fact, in the present study participants agreed more strongly that outreach should be provided to prevent alcoholism in men with liver cancer (d = .22, a small effect size) though this effect weakened after adjusting for demographic characteristics of participants (p = .078).

Some vignettes elicited interesting differences, in some cases related to the demographic characteristics of the participants. Age made a difference to opinions about sex differences in responsibility in three vignettes. For example, participants younger than 50 years old agreed more strongly that men were responsible for getting themselves sales jobs, whereas participants aged 50 or more agreed more strongly that women were responsible for getting themselves sales jobs.

Reynolds et al. (2019) found men are less likely than women to be typecast as victims. This finds support in the present study where participants agreed more strongly than male victims of mugging should have taken more care of their belongings. This effect became stronger after adjusting for demographic characteristics of the participants (p = .020).

Participants – especially female participants – agreed more strongly that it is men's responsibility to avoid workplace accidents. By contrast, participants agreed more strongly that mothers had more responsibility for their child's playground accident.

Male and female traditional gender scripts

The pattern of the findings of 'total internal attribution scores' (Table 2) fits with the notion that responsibility for situations is attributed according to traditional gender role expectations. An example of traditional gender role expectations (or social scripts) is described by Seager et al. (2014). These 'traditional gender scripts' drive men to (1) be a fighter and a winner in life e.g., earn a top salary; (2) be a provider and protector to one's family; (3) have mastery and control over one's emotions. Correspondingly, the traditional female gender script drives women to (1) be glamorous/attractive; (2) bear children; (3) nurture children and family life. In the present study, we can see how the finding regarding men's greater responsibility for workplace accidents relates to the provider role, men's greater responsibility for getting a job relates to being a fighter and winner, and boys' men's greater responsibility for overcoming depression relates to the drive for mastery and control of one's feelings. Similarly, the findings that girls' greater responsibility for being physically fit might relate to being attractive, and women's' greater responsibility for making sure their children don't have a playground accident might relate to the drive to nurturance.

The traditional gender scripts are suggested to be archetypes rather than stereotypes, having come about through evolutionary forces and complementing sex differences in reproductive function (Seager, 2019). Whether these scripts are biologically driven (by nature) socially defined (by nurture) is a moot point, though there is evidence that sex differences that are seen internationally map onto our notions of masculinity and femininity (Liddon & Barry, in press).

It is notable in the present study that when the age of the protagonist was salient, the sex difference in responsibility was applied more significantly to adults. This echoes the 'women and children first' phenomenon, and suggests evolutionary roots in terms of protection of the future population growth of a community. This gender-related pattern of these findings was not hypothesised, and this interpretation is presented here as descriptive rather than prescriptive.

We might speculate how the view of women as being responsible for issues related to the traditional female role might impact how much responsibility women are seen as having when they are in male-

traditional roles. It could be that, for example, being seen as being less responsible in such roles might be associated with them being seen as less suited to such roles.

Impact of context vs person

Jones & Harris (1967) suggested that when someone is having problems, we tend to blame the person rather than their context, and this is possibly related to the culture of the observer (Miller, 1984). This 'fundamental attribution error' finds some support in this study, though only partial. Table 2 shows that the context was held responsible slightly more than the individual was, which is in contrast to the fundamental attribution error.

The results could indicate that men are perceived as having more personal agency than women have. Because the sample is from the UK in 2017, a relative individualist culture which values agency and autonomy, the finding of greater attribution of responsibility could be interpreted as something positive about men and women.

Strengths and limitations

Previous research has not highlighted the relevance of traditional gender roles across a spectrum of everyday situations, so the strength of this study is that it presents the issue of sex differences in responsibility in a new way. Another strength is that the large sample was stratified by UK region, meaning that the findings cannot be attributed to regional differences in the UK. A limitation of this study is that it does not address the issue of whether the findings are a result of archetypes or stereotypes.

Future research

The present study was exploratory, and the findings suggest many paths for future research. The present study presented participants with a wide variety of everyday situations, and apart from future research testing whether the present findings are replicable, it would be interesting to explore other types of attributions in other situations, especially about how responsible men compared to women are in situations related to the female gender role e.g. a man who tries to make himself look glamorous but fails, or a stay-at-home-dad who knocks over and breaks a lamp while vacuum cleaning.

The findings could also be tested about gamma bias. The vignettes used in the present study correspond with the 'victimhood' cell of the gender distortion matrix, and future research could explore the other three cells of the matrix. For example, a vignette about a person achieving success in the workplace would test the 'celebration' cell, and it might further be interesting to see whether a hypothetical man or woman is differently celebrated depending on whether the workplace is male-typical (e.g., construction site) or female-typical (e.g. nursing). It could be that in the absence of other information about a protagonist, people fall back on archetypes, but other information (e.g., information about the protagonist's social class) (Baron et al., 1995), or level of education, might impact attributions of responsibility independently of gender.

Future research might examine the degree to which responsibility and suitability are linked concerning women experiencing problems in traditionally male roles (see above). Future research might also test the degree of correlation between the constructs of responsibility and gamma bias, and the contexts in which each might vary. Future research might also examine the degree to which responsibility and suitability are linked (see also *agency*, above in the section on *Impact of context vs person*).

Features of the participants (age, ethnicity and gender) might be further investigated, as should features of the vignette character. For example, future research could test the effect of systematically varying information about the protagonist (e.g. whether they had often previously found themselves in a similar predicament), so see how much this moderates the effect of the protagonist's gender on their responsibility score.

In the present study, the age of the boys and girls was not clear, apart from the vignette about not having friends, which specified the characters as teenage boys or girls. It would be interesting to vary the age more specifically to see at what age males begin to be attributed with more responsibility than females.

The present study looked at the opinions of the general public. It would be valuable for future studies to look at the opinions of people working within various relevant fields e.g. the opinions of teachers regarding sex differences in responsibility for grades.

It would be useful to address in future research the issue of whether the findings are a result of archetypes (which are related to the traditional gender scripts) or of stereotypes (widely held views of men and women which are not related to gender scripts), perhaps by comparing similarities and differences in various gender-related attitudes in cross-cultural samples.

CONCLUSION

The findings have implications in many fields, such as healthcare, education, and the legal system. For example, if boys tend to be seen as more responsible for how depressed they feel, this might impact strategies for encouraging help-seeking by boys. Although taking responsibility is no doubt a good thing if we have blind spots to how we attribute responsibility to others, this might lead to unequal treatment of others, and how we are treated by others.

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Table S1
Description of Vignettes

Title of vignette	Gender of character in example	Situation	How much do you agree with the following statements	
			Attribution to individual concerned	**Attribution to context**
Depressed children	Female	A health spokesperson recently stated that the depression rate had increased for girls aged 10-12, and that it was time that we started taking depression in girls more seriously.	Girls should take more responsibility for how depressed they feel.	The Government should do more to reduce depression in girls
Unfit children	Male	A social commentator complained that results of physical fitness tests show that boys are less healthy than at any time previously recorded. The recommendation was to increase health promotion in schools aimed at boys.	Boys should take more responsibility for improving their own physical fitness.	More health promotion in schools should be aimed at improving the physical fitness of boys.
Children with no close friends	Male	A YouGov survey suggests that around 28% of teenage boys have no close friends they can turn to in a crisis.	If boys want friends, it is up to them to go out and make some friends.	The Government should create community outreach programs to get boys together so that they have friends.
Low confidence in science and maths	Female	An international report found that girls self-confidence in their ability to solve mathematical and science-based problems is lower today than 10 years ago.	Girls should spend more time practicing mathematics if they wish to improve their confidence.	Teachers and families should spend more time helping girls with their confidence in science and maths.
Poor academic grades	Male	An academic recently highlighted how boys are getting worse grades than girls in a particular subject for the 11th year in a row. The recommendation was that more funding was needed to reduce this disparity.	Boys should take responsibility for improving their school grades.	More funding should be aimed at improving the school grades of boys.

Getting into sales jobs	Female	A government-funded charity produced a report showing that there are too few women in sales jobs. They advised that the government should spend more money on training female salespersons.	Women should work harder to get into sales jobs.	More sales jobs should be created in order to help more women into them.
Workplace accidents	Male	Data from the Office for National Statistics shows that men are significantly more likely to suffer workplace accidents than women.	If men were more careful at work, there would be fewer accidents.	More work should be done for Health & Safety to make the workplace safer for men.
Adverse effects of internet usage	Female	Women's usage of the internet has been cited as a cause for the increase in the number of women suffering from common types of mental disorder e.g., depression and anxiety.	Women should take responsibility for the amount of time they spend on the internet.	More work is needed to research the effects of the internet on women's lives.
Being mugged	Female	A woman was walking home from a social event when she decided to take a short-cut down an alley. Someone approached her from behind, grabbed the laptop bag that was half-hanging off her shoulder, and ran off with it.	She should have taken more care for her personal belongings.	The police should do more work to prevent such crimes occurring.
Being burgled	Male	A man was rushing late for work one early morning and, as he ran out of the door, he forgot to lock it. In fact, when he tried slamming the door behind him when running out, it bounced slightly ajar. When he returned from work, he found he had been robbed.	He is at least in part to blame for the robbery.	More needs to be done for Community Watch programs.
Emphysema in smoker	Female	A woman started coughing blood and was admitted to the emergency room. She was suffering from emphysema after 40 years of smoking cigarettes. She was ordered to stop smoking and was prescribed a medical inhaler.	If smoking caused her condition, then she should pay for the treatment.	More health promotion work is needed to help women stop smoking.
Liver cancer in drinker	Male	A man went to the doctor complaining of abdominal pains. Upon admittance to hospital it was found he was suffering from cancer of the liver after years drinking too much. Because of his financial circumstances, he might have to pay for his medical treatment.	He should pay for his medical bills.	More outreach work is necessary to prevent alcoholism in men.

Where homeless people can sleep	Male	A homeless man almost froze to death outside a major department store and only recovered after a hospital treatment. The department store claimed that it did not allow rough sleeping outside their premises, and therefore denied responsibility for his suffering.	Homeless men should take more responsibility for where they sleep.	Department stores should allow homeless men to the outside of their premises if needed.
Playground accident	Male	A father took his four-year-old child to the playground where the child was playing on an age appropriate climbing frame. While the father was chatting with a friend the child fell and bumped their head and needed to be checked out at A&E.	The father should have been focusing more on their child rather than chatting with a friend.	Playgrounds should be made safer e.g., by using grass areas instead of concrete.

NB: The vignettes were created for this study by JB and JH, with some suggestions from other members of the Male Psychology Network.

Table S2
Gender of Character in Vignettes Shown to Participants

Vignette title	Pattern 1	Pattern 2
Depressed children	Female	Male
Unfit children	Male	Female
Children with no close friends	Male	Female
Low confidence in sicence/maths	Female	Male
Poor academic performance	Male	Female
Getting into sales jobs	Female	Male
Workplace accident	Male	Female
Adverse effects of social media	Female	Male
Being mugged	Female	Male
Being burgled	Male	Female
Emphysema among smokers	Female	Male
Liver cancer among drinkers	Male	Female
Where homeless can sleep	Male	Female
Playground accident	Male	Female

NB: Each participant was shown male or female vignette characters according to the two patterns shown in the table but the order in which the vignettes were shown to each participant was random.

Table S3

The Difference in Attribution Scores Between Male and Female Vignette Characters for Each Vignette, Adjusted for Gender, Age, Ethnicity and Education Level of Participant

	Individual(s) responsible male minus female scores [a]				**Context needs to change** male minus female scores [b]				**Total internal attribution** males minus female scores [c]			
	M	*SE*	$F_{(1,399)}$	*p*	*M*	*SE*	$F_{(1,399)}$	*p*	*M*	*SE*	$F_{(1,399)}$	*p*
Depressed children	.21	.131	2.49	.116	−.19	.121	2.58	.109	.40	.168	5.71	.017
Unfit children	−.13	.103	1.58	.209	.09	.101	.79	.375	−.22	.115	3.63	.058
Children with no close friends	.10	.240	.59	.443	.27	.129	4.38	.037	−.17	.198	.75	.387
Low confidence science/maths	.08	.102	.65	.422	−.04	.090	.218	.641	.12	.106	1.38	.242
Poor academic grades	−.06	.107	.34	.561	.06	.128	.194	.659	−.12	.156	.58	.447
Getting into sales jobs	.03	.129	.04	.845	−.47	.134	12.31	.001	.50	.157	9.93	.002
Workplace accident	.75	.138	29.47	<.001	.12	.126	.98	.323	.63	.190	10.81	.001
Adverse effects social media	.01	.106	.01	.929	−.16	.129	1.51	.220	.17	.163	1.07	.303
Being mugged	.36	.152	5.58	.019	−.11	.115	.85	.356	.46	.199	5.45	.020
Home robbed	.09	.142	.40	.528	.16	.126	1.55	.214	−.07	.206	.11	.744
Emphysema in smoker	−.03	.157	.04	.843	−.12	.121	1.04	.309	.16	.207	.56	.455
Liver cancer in drinker	−.04	.156	.06	.803	.20	.116	3.11	.078	−.24	.205	1.41	.235
Where homeless can sleep	−.06	.150	.15	.703	.09	.151	.32	.571	−.14	.244	.34	.558
Playground accident	−.19	.134	2.02	.156	.12	.111	1.21	.273	−.31	.160	3.82	.051

N = 406; 8 individuals did not answer the question on academic qualifications

[a] Positive sign indicates stronger attribution to the individual(s) concerned when the character(s) of the vignette were male

[b] Positive sign indicates stronger attribution to the context when the character(s) of the vignette were male

[c] Positive sign indicates stronger total internal attribution when the character(s) of the vignette were male

[d] 206 participants saw male vignette character(s); 200 saw female vignette character(s)

[e] 200 participants saw male vignette character(s); 206 saw female vignette character(s)

Bias against men's issues within the United Nations and the World Health Organization: A content analysis

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Males fare worse than females on many health outcomes, but more attention, particularly at a national level, is given to women's issues. This apparent paradox might be explained by gamma bias or a similar gender bias construct. Such potential biases require exploration. The purpose of the current paper is to present six streams of evidence that illustrate a bias against men's issues within the United Nations (UN) and World Health Organization (WHO). First, the UN's sustainable development goal on 'gender equality' is exclusive to females. Second, the UN observes nine International Days for women's issues/achievements and one day for men's issues/achievements. Third, the UN operates 69 Twitter accounts dedicated to women's issues, culminating in 328,251 tweets since 2008. The UN does not operate a Twitter account for men's issues. Fourth, female words (e.g., 'women') appear more frequently than male words (e.g., 'men') in documents archived in the UN and WHO databases, indicating more attention to women's issues. Fifth, in WHO reports where similar use of male and female words might be expected (e.g., gender and health reports), female words appear more frequently. Sixth, more female than male words appear in the *Bulletin of the World Health Organization*, with articles on women's health more frequently non-original research (e.g., editorials). Overall, because the UN and WHO are the causal agents directly responsible for the outcomes assessed, the findings reveal a bias against men's issues within these organisations. The findings support the construct of gamma bias. Ways to reduce this bias are discussed.

Keywords: bias; gender; men's health; public health; women's health

Life expectancy for males is lower than for females in every country in the world (Wang et al., 2012). This sex difference is due to numerous factors. In the US, for example, males are more likely than females to die in motor vehicle accidents, bicycle crashes, occupational incidents, drownings, and murders (Nuzzo, 2020). Males are also more likely than females to commit suicide and die from most types of cancers (Nuzzo, 2020). Males are also more likely than females to use alcohol, tobacco, and illicit drugs (Nuzzo, 2020). Finally, males are also more likely than females to be homeless or incarcerated (Nuzzo, 2020).

In the US, a 'national health paradox' appears to exist regarding men's health issues (Nuzzo, 2020). On several important physical and mental health outcomes, males fair worse than females; yet, national offices, such as the Office for Research on Women's Health, exist for the discovery and dissemination of knowledge about women's health but not men's health (Nuzzo, 2020). The notion of a 'national health paradox' has also been supported by an analysis of biomedical research articles indexed in the PubMed database. The analysis revealed the term 'women's health' appeared in the titles or abstracts of 14,501 articles, whereas the term 'men's health' appeared in the titles or abstracts of 1,555 articles (Nuzzo, 2020). PubMed also indexes more journals on women's health than men's health (Nuzzo, 2020). Thus, unlike women's health, men's health is not being conceptualised as a distinct field of medicine or research, and it might not be receiving adequate attention relative to the epidemiological data (Nuzzo, 2020).

A similar lack of recognition of men's issues might also occur at an international level within the United Nations (UN) and the UN's health branch – the World Health Organization (WHO). Seager and Barry (2019) revealed the UN celebrates International Women's Day but not International Men's Day (Teelucksingh, 2019). Moreover, Bates et al., (2009) noted that a 2008 report on health equity by the WHO included a chapter on gender that did not mention men's health (Commission on Social Determinants of Health, 2008).

Evidence of a lack of international recognition of men's issues should be considered closely. First, not acknowledging men's issues might be detrimental to the flourishing of boys and men. Second, the agendas of the UN and WHO influence numerous organisations. Third, the UN and WHO are funded, in part, by taxpayers of members states. Thus, if the UN and WHO do not operate in an objective way, taxpayers and legislators of member states should be made aware of this. Fourth, the exploration of a potential difference in international recognition of men's and women's issues might also relate to the study of human psychology. For example, studies in experimental psychology have revealed both sexes are more protective of women and more likely to consider women as victims (Reynolds et al., 2020; Stewart-Williams et al., 2020). These experimental results appear to support the construct of 'gamma bias's – a proposed cognitive bias in which male issues/achievements are minimised while female issues/achievements are magnified as demonstrated by Seager and Barry (2019), who also provided other examples to support gamma bias. One example was the frequent portrayal of men as the perpetrators of intimate partner violence against women; when in fact, males and females are sometimes equally likely to be perpetrators (Archer, 2000; Fiebert, 2014; Seager & Barry, 2019).

Therefore, given the importance of men's health issues and the potential implications that their lack of recognition might have, the current paper presents and discusses six new streams of evidence that confirm the existence of bias against men's issues within the UN and WHO. The six evidence streams have arisen from the examination of the following outcomes: (a) the number of UN sustainable development goals aimed at males and females; (b) the number of UN International Days of Observance for men's and women's issues or achievements; (c) the number of UN Twitter accounts used to disseminate knowledge about men's and women's issues; (d) the number of times sex-/gender-specific terms have appeared in documents archived in the UN and WHO databases, and the number of times UN and WHO documents have been categorised under 'women's health' and 'men's health'; (e) the number of times sex-/gender-specific terms have appeared in WHO reports on topics in which similar use of male and female words might be expected (i.e., health equity, gender and health); and (f) the number of times sex-/gender-specific terms have appeared in articles published in the *Bulletin of the World Health Organization*.

Normally, descriptive comparisons of the above type are not ideal for determining causation. However, except for outcome 'f', all the above outcomes are directly controlled by the UN and WHO. For example, the UN chooses what goals to declare as sustainable development goals, what days to observe as

International Days, and how many Twitter accounts to create and operate. Thus, the UN and WHO are the causal agents directly responsible for any potential differences observed.

Evidence stream 1: United Nations' Sustainable Development Goals

BACKGROUND AND METHODS

One outcome that can be examined to look for evidence of potential bias within the UN is the organisation's 'sustainable development goals' (UN, 2015, 2020b). In September 2015, the UN announced these goals in *Transforming Our World: The 2030 Agenda for Sustainable Development* (UN, 2015). In their report, the UN declared 17 sustainable development goals and 169 associated target goals (UN, 2015). The intent of this 'new Agenda' has been to inform policy and 'address the global challenges we face' and 'achieve a better and more sustainable future for all' (UN, 2020a). According to the UN, the 'new Agenda' is meant to 'stimulate action over the next 15 years in areas of critical importance for humanity and the planet' (UN, 2015). In January of 2016, the sustainable development goals went into effect (UN, 2015). In 2020, the UN published its *Sustainable Development Goals Report 2020* (UN, 2020b), which provided an update on progress made toward these goals.

RESULTS AND BRIEF DISCUSSION

Analysis of the UN's sustainable development goals reveals a lack of recognition of boys' and men's issues. Of the 17 sustainable development goals, one goal (Goal 5) is dedicated to the topic of gender. Goal 5 reads: 'Achieve gender equality and empower all women and girls.' Goal 5 has nine associated target goals (Table 1). The nine associated targets are all directed toward girls and women (e.g., violence against girls and women, women in leadership roles in government). In the *Sustainable Development Goals Report, 2020* (UN, 2020b), the only time the word 'men' appears in the section 'Goal 5: Gender Equality' is to emphasise greater needs of women. The 2015 report briefly mentions engaging with boys and men as a way to reduce domestic violence against girls and women (UN, 2015). However, the report does not mention (a) engaging with boys and men about violence against other boys and men, nor does it mention (b) engaging girls and women about violence against boys and men. The reason 'a' and 'b' should be considered is that violence against boys and men from other boys and men, and violence against boys and men from adult women, are both known problems (Archer, 2000; Breiding et al., 2014; Costa et al., 2015; Fiebert, 2014; Seager & Barry, 2019; Stemple & Meyer, 2014; Stemple et al., 2017). Lack of recognition of 'a' and 'b' suggests an institutional-level bias that males are almost always the perpetrators of violence and females are almost always the victims, which would be consistent with the experimental findings that women are often viewed as victims (Reynolds et al., 2020). Recommendations for moving forward with sustainable development goals are provided in the discussion of the current paper.

Table 1
The United Nations' Sustainable Development Goal for 'Gender Equality'

Item	Goal (direct quotation) [a]	Target gender
5.1	End all forms of discrimination against all women and girls everywhere.	Female
5.2	Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.	Female
5.3	Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.	Female
5.4	Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.	Female [b]
5.5	Ensure women's full and effective participation and equal opportunities for leadership at all levels of decision making in political, economic and public life.	Female
5.6	Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.	Female [b]
5.a	Undertake reforms to give women equal rights to economic resources, as well as access to ownership and control over land and other forms of property, financial services, inheritance and natural resources, in accordance with national laws.	Female
5.b	Enhance the use of enabling technology, in particular information and communications technology, to promote the empowerment of women.	Female
5.c	Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels.	Female

[a] *Quoted from the UN's report, Transforming Our world: the 2030 Agenda for Sustainable Development (United Nations).*
[b] *Females are not mentioned explicitly in the goal, but the UN's accompanying report, Sustainable Development Goals Report, 2020 (United Nations, 2020b), indicates females are the targets of these goals.*

Evidence stream 2: United Nations' International Day of Observance

BACKGROUND AND METHODS

Another outcome that can be examined to look for evidence of bias within the UN is the organisation's International Days of Observance, which were given initial consideration by Seager and Barry (2019). The UN designates specific days within a calendar year as International Days. Member states propose International Days, then a consensus is reached by the UN General Assembly on whether to establish a particular day as an International Day. According to the UN, International Days are: 'occasions to educate the general public on issues of concern, to mobilise political will and resources to address global problems and to celebrate and reinforce achievements of humanity. The existence of international days predates the establishment of the United Nations, but the UN has embraced them as a powerful advocacy tool. Each international day offers many actors the opportunity to organise activities related to the theme of the day. Organisations and offices of the United Nations system, and most importantly, governments, civil society, the public and private sectors, schools, universities and, more generally, citizens, make an international day a springboard for awareness-raising actions (UN, 2020c).

Moreover, the UN states themes of international days are:

> *'always linked to the main fields of action of the United Nations, namely the maintenance of international peace and security, the promotion of sustainable development, the protection of human rights, and the guarantee of international law and humanitarian action.'* (UN, 2020c).

For the current paper, a list of the UN's International Days was acquired from the UN's website. The title of each day was categorised as being either sex-/gender-neutral or sex-/gender-specific. A sex-/gender-neutral day was one whose name/theme was not specific to one sex. A sex-/gender-specific day was one whose name/theme was specific to either a men's issue or a women's issue. Days named after prominent male or female figures were also considered sex-/gender-specific days.

RESULTS AND BRIEF DISCUSSION

The UN observes a total of 172 international days (Table 2). Ten days (5.8%) are sex-/gender-specific. Nine of the 10 sex-/gender-specific days (90%) are dedicated to women's issues. The UN does not observe any days for boys' or men's issues, although one of the 10 sex-/gender-specific days (10%) is the observance of the life/achievements of one man (Nelson Mandela International Day, 18th July).

The specific themes of International Days and the context surrounding the days also warrant consideration. First, the UN does not hold days of observance on all calendar days. Thus, there are calendar days available to celebrate men or bring awareness to men's issues. Moreover, if a calendar day is already used to observe a topic, a precedent already exists within the UN that a given calendar day can be used to observe multiple topics. For example, the UN observes five different topics on 21st March. Thus, a day that is already used to observe one topic could also be used to observe a men's issue. This is relevant regarding International Men's Day (November 19), which is not observed by the UN. Instead, the UN observes World Toilet Day on 19th November (Seager & Barry, 2019; Teelucksingh, 2019). Thus, the UN could choose to observe both World Toilet Day and International Men's Day on 19th November.

Second, even if all calendar days were used for other topics, and a policy was adopted that only one topic could be recognized per day, this would still not justify ignoring men's issues. Bringing attention to men's issues is arguably more important than bringing attention to many topics on the UN's list of International Days. For example, the UN observe numerous days for language – French (20th March), Chinese (20th April), English (23rd April), Spanish (23rd April), Russian (6th June), and Arabic (18th December). The UN also observes days for radio (13th February), poetry (21st March), jazz music (30th April), tuna (2nd May), bees (20th May), tea (21st May), bicycles (3rd June), yoga (21st June), asteroids (30th June), chess (21st July), tourism (27th September), toilets (19th November), television (21st November), banks (4th December), and mountains (11th December). Migratory birds receive *two* days of observation (9th May and 10th October). Finally, the UN observes two days to recognise *itself* (29th May and 24th October).

Third, some themes associated with women's days are also applicable to men, but the male equivalent is not recognised. For example, the UN observes a day for widows (23rd June) but not for widowers. The UN also observes International Day of Women and Girls in Science (11th February), but it does not recognize a day for men and boys in academic fields for which they have historically not been a substantial part of (e.g., nursing, elementary education). The UN also observes the International Day for the Elimination of Violence against Women (25th November). However, violence against men is also an issue. For example, assumptions that males rarely experience intimate partner violence (Archer, 2000; Fiebert, 2014; Seager & Barry, 2019) and sexual abuse/victimisation (Breiding et al., 2014; Stemple et al., 2017; Stemple & Meyer, 2014) are false.

Fourth, the UN sometimes names international days in a sex-/gender-specific way when an issue is believed to affect females more than males, but the organisation does not name a day in a sex-/gender-specific way when the issue affects males more than females. For example, 2nd April is World Autism Awareness Day. Males are four times as likely as females to be identified with autism spectrum disorder (Nuzzo, 2020). However, the UN does not name or frame World Autism Awareness Day in a sex-/gender-specific way. Moreover, on 31st May, the UN observes No Tobacco Day. Tobacco abuse is primarily a men's health issue (Nuzzo, 2020). However, the UN does not name or frame No Tobacco Day in a sex-/gender-specific way. The same lack of male recognition also applies to days observed for achievements. For example, males have arguably made more contributions to human space flight (12th April), jazz music

(20th April), and philosophy (19th November) than females. However, these days are not named or framed in a sex-/gender-specific way.

Fifth, for some international days that are specific to women, the root cause of the issue is arguably a men's issue. For example, the UN observes International Widows Day on 8th March. But why are many women widows in the first place? Perhaps their husbands died in war or from suicide, a motor vehicle accident, or an occupational incident. Thus, it would be appropriate to also recognise the underlying causes of widowing. Recommendations for moving forward with International Days of Observance are provided in the discussion of the current paper.

Table 2
United Nations' Days of Observance for Women's Issues, Men's Issues, and Other Topics

Date	Women's day name	Date	Men's day name
06 February	International Day of Zero Tolerance to Female Genital Mutilation	18 July	Nelson Mandela Day
11 February	International Day of Women and Girls in Science		
08 March	International Women's Day		
23 April	International Girls in Information and Communication Technologies Day		
23 June	International Widows Day		
18 September	International Equal Pay Day		
11 October	International Day of the Girl Child		
15 October	International Day of Rural Women		
25 November	International Day for the Elimination of Violence against Women		

Date	All other day names	Date	All other day names (cont.)
04 January	World Braille Day	27 June	Micro-, Small, and Medium-Sized Enterprises Day
24 January	International Day of Education	29 June	International Day of the Tropics
27 January	International Day of Commemoration in Memory of the Victims of the Holocaust	30 June	International Asteroid Day
04 February	World Cancer Day	30 June	International Day of Parliamentarism
10 February	World Pulses Days	04 July	International Day of Cooperatives
13 February	World Radio Day	11 July	World Population Day
20 February	World Day of Social Justice	15 July	World Youth Skills Day
21 February	International Mother Language Day	18 July	Nelson Mandela Day
01 March	Zero Discrimination Day	20 July	World Chess Day
03 March	World Wildlife Day	28 July	World Hepatitis Day
20 March	International Day of Happiness	30 July	International Day of Friendship

20 March	French Language Day	30 July	World Day against Trafficking in Persons
21 March	International Day for the Elimination of Racial Discrimination	09 August	International Day of the World's Indigenous People
21 March	World Poetry Day	12 August	International Youth Day
21 March	International Day of Nowruz	19 August	World Humanitarian Day
21 March	World Down Syndrome Day	21 August	International Day of Remembrance and Tribute to the Victims of Terrorism
21 March	International Day of Forests	22 August	International Day of Commemorating the Victims of Acts of Violence Based on Religion
22 March	World Water Day	23 August	International Day for the Remembrance of the Slave Trade and its Abolition
23 March	World Meteorological Day	29 August	International Day against Nuclear Tests
24 March	World Tuberculosis Day	30 August	International Day of the Victims of Enforced Disappearances
24 March	International Day for the Right to the Truth concerning Gross Human Rights Violations and for the Dignity of Victims	05 September	International Day of Charity
25 March	International Day of Remembrance of Slavery Victims and the Transatlantic Slave Trade	07 September	International Day of Clean Air for Blue Skies
25 March	International Day of Solidarity with Detained and Missing Staff Members	08 September	International Literacy Day
02 April	World Autism Awareness Day	09 September	International Day to Protect Education from Attack
04 April	International Day for Mine Awareness and Assistance in Mine Action	12 September	International Day for South-South Cooperation
05 April	International Day of Conscience	15 September	International Day of Democracy
06 April	International Day of Sport for Development and Peace	16 September	International Day for the Preservation of the Ozone Layer
07 April	World Health Day	17 September	World Patient Safety Day
07 April	International Day of Reflection on the 1994 Genocide against the Tutsi in Rwanda	21 September	International Day of Peace
12 April	International Day of Human Space Flight	23 September	International Day of Sign Languages
20 April	Chinese Language Day	24 September	World Maritime Day
21 April	World Creativity and Innovation Day	26 September	International Day for the Total Elimination of Nuclear Weapons
22 April	Earth Day	27 September	World Tourism Day
23 April	World Book and Copyright Day	28 September	World Rabies Day
23 April	English Language Day	29 September	International Day of Awareness of Food Loss and Waste

23 April	Spanish Language Day	30 September	International Translation Day
24 April	International Day of Multilateralism and Diplomacy for Peace	01 October	International Day of Older Persons
25 April	International Delegate's Day	02 October	International Day of Non-Violence
25 April	World Malaria Day	05 October	World Teachers' Day
26 April	World Intellectual Property Day	05 October	World Habitat Day
26 April	International Chernobyl Disaster Remembrance Day	09 October	World Post Day
28 April	World Day for Safety and Health at Work	10 October	World Mental Health Day
29 April	Day of Remembrance for all Victims of Chemical Warfare	10 October	World Migratory Bird Day
20 April	International Jazz Day	13 October	International Day for Disaster Risk Reduction
02 May	World Tuna Day	16 October	World Food Day
03 May	World Press Freedom Day	17 October	International Day for the Eradication of Poverty
07 May	'Vesak', the Day of the Full Moon	20 October	World Statistics Day
08 May	Time of Remembrance and Reconciliation for Those Who Lost Their Lives during the Second World War	24 October	United Nations Day
09 May	World Migratory Bird Day	24 October	World Development Information Day
15 May	International Day of Families	27 October	World Day for Audiovisual Heritage
16 May	International Day of Living Together in Peace	31 October	World Cities Day
16 May	International Day of Light	02 November	International Day to End Impunity for Crimes against Journalists
17 May	World Telecommunication and Information Society Day	05 November	World Tsunami Awareness Day
20 May	World Bee Day	06 November	International Day for Preventing the Exploitation of the Environment in War and Armed Conflict
21 May	International Tea Day	10 November	World Science Day for Peace and Development
21 May	World Day for Cultural Diversity for Dialogue and Development	14 November	World Diabetes Day
22 May	International Day for Biological Diversity	15 November	World Day of Remembrance for Road Traffic Victims
23 May	International Day to End Obstetric Fistula	16 November	International Day for Tolerance
29 May	International Day of United Nations Peacekeepers	19 November	World Philosophy Day
31 May	World No Tobacco Day	19 November	World Toilet Day
01 June	Global Day of Parents	20 November	Universal Children's Day
03 June	World Bicycle Day	20 November	Africa Industrialization Day

04 June	International Day of Innocent Children Victims of Aggression	21 November	World Television Day
05 June	World Environment Day	29 November	International Day of Solidarity with the Palestinian People
05 June	International Day for the Fight against Illegal, Unreported and Unregulated Fishing	30 November	Day of Remembrance for all Victims of Chemical Warfare
06 June	Russian Language Day	01 December	World AIDS Day
07 June	World Food Safety Day	02 December	International Day for the Abolition of Slavery
08 June	World Oceans Day	03 December	International Day of Persons with Disabilities
12 June	World Day Against Child Labour	04 December	International Day of Banks
13 June	International Albinism Awareness Day	05 December	International Volunteer Day for Economic and Social Development
14 June	World Blood Donor Day	05 December	World Soil Day
15 June	World Elder Abuse Awareness Day	07 December	International Civil Aviation Day
16 June	International Day of Family Remittances	09 December	International Anti-Corruption Day
17 June	World Day to Combat Desertification and Drought	09 December	International Day of Commemorations and Dignity of the Victims of the Crime of Genocide
18 June	Sustainable Gastronomy Day	10 December	Human Rights Day
19 June	International Day for the Elimination of Sexual Violence in Conflict	11 December	International Mountain Day
20 June	World Refugee Day	12 December	International Day of Neutrality
21 June	International Day of Yoga	12 December	International Universal Health Coverage Day
23 June	Public Service Day	18 December	International Migrants Day
25 June	Day of the Seafarer	18 December	Arabic Language Day
26 June	International Day Against Drug Abuse and Illicit Trafficking	20 December	International Human Solidarity Day
26 June	International Day in Support of Victims of Torture		

[a] *List of days were acquired from https://www.un.org/en/sections/observances/international-days*

Evidence stream 3: United Nations' Twitter accounts

BACKGROUND AND METHODS

Another outcome that can be examined to look for evidence of bias within the UN is the organisation's Twitter accounts. Twitter is a social media platform. Created in 2006, the platform now has 134 million daily active users and 330 million monthly active users (Twitter, 2019). In the United States, 22% of the population say they have used Twitter (Perrin & Anderson, 2019), and 63% of users say they get their news from Twitter (Pew Research Center, 2015). Moreover, about 60% of journalists in the US say they are on Twitter several times a day or are connected all day to Twitter (McGregor & Molyneux, 2020). Thus, tweets from a prominent organisation's Twitter account might influence the opinions of the

account's followers directly but might also lead to coverage of the tweet (and its related content) by the journalist who reports on the topic across various platforms. Moreover, every Twitter user who reads a tweet has the potential to serve as a multiplier for spreading information.

Before undertaking this part of the study, I was aware that the UN had a general Twitter account for women's issues (@UN_women) but not an account for men's issues. Thus, the aim was to determine if the UN had other Twitter accounts for women's issues, and if so, how many followers do the accounts have, and how many tweets have been sent out. The data on numbers of followers and tweets is publicly available and reveals the scope and breadth of this knowledge dissemination pathway. To identify accounts, relevant keyword searches were performed in the Twitter search bar. Twitter algorithms aided in the identification of accounts because once a given UN account is identified, Twitter populates a list of potentially related accounts. The search was performed on 29th August 2020.

RESULT AND BRIEF DISCUSSION

Table 3 presents data on UN Twitter accounts dedicated to men's and women's issues. The UN has 69 Twitter accounts dedicated to women's issues and zero dedicated to men's issues. The 69 accounts are typically associated with individual countries. The general UN Women Twitter account, which was created in 2008, has approximately 1.8 million followers. It has posted approximately 60,700 tweets. For the other 68 accounts dedicated to women's issues, the average number of followers was 23,967 (minimum: 45; maximum: 578,600). The average number of tweets was 3,935 (minimum: 31; maximum: 22,000). As of 29th August 2020, the 69 UN women's accounts had sent out a total of 328,251 tweets. Recommendations for moving forward with UN Twitter accounts are provided in the discussion of the current paper.

Table 3
Numbers and Names of Un Twitter Feeds Dedicated to Men's and Women's Issues

Tally	Twitter profile name	Twitter handle	Followers [a]	Number of tweets [a]	Year joined
UN Twitter profiles for men					
0	N/A	N/A	N/A	N/A	N/A
UN Twitter profiles for women					
1	UN Women	@UN_Women	1.8 million	60,700	2008
2	UN Women Afghanistan	@unwomenafghan	5,443	2,439	2018
3	UN Women Africa	@unwomenafrica	52,600	11,000	2013
4	UN Women Albania	@unwomenalbania	3,523	2,241	2015
5	UN Women Arabic	@unwomenarabic	28,900	7,916	2015
6	UN Women Asia Pacific	@unwomenasia	41,000	12,800	2012
7	UN Women Australia	@UNWomenAust	26,700	18,300	2009
8	UN Women Austria	@unwomenaustria	371	790	2014
9	UN Women BiH	@unwomenbih	1,821	1,777	2010
10	UN Women in Brussels	@unwomenEU	14,200	6,538	2015
11	UN Women Burundi	@UNWomenBurundi	500	177	2019
12	UN Women Canada	@CCUNIFEM	907	111	2009
13	UN Women Central Asia	@unwomenctrlasia	1,757	1,914	2015
14	UN Women Deutschland	@UNWomen_Germany	4,639	4,658	2011
15	UN Women Egypt	@unwomenegypt	3,570	970	2019
16	UN Women Ethiopia	@unwomenethiopia	431	159	2020
17	UN Women Europe & CIS	@unwomeneca	20,500	7,396	2014
18	UN Women IES	@unwomenEval	5,191	5,194	2015
19	UN Women India	@unwomenindia	578,600	14,100	2012
20	UN Women Indonesia	@unwomenid	1,628	941	2019
21	UN Women Iraq	@unwomeniraq	1,548	321	2018
22	UN Women 日本事務所	@unwomenjapan	4,505	2,183	2015
23	UN Women Jordan	@unwomenjordan	13,900	4,551	2016
24	UN Women Kenya	@unwomenkenya	1,200	327	2019
25	UN Women Kosovo	@unwomenkosovo	767	747	2019
26	UN Women Lebanon	@unwomenlebanon	947	764	2020
27	UN Women Liberia	@unwomenliberia	335	131	2020
28	UN Women Malawi	@unwomenmalawi	1,538	721	2019
29	UN Women Moldova	@unwomenmoldova	1,570	2,511	2014
30	UN Women Myanmar	@unwomenmyanmar	534	161	2020
31	UN Women Nepal	@unwomennepal	5,827	1,554	2017
32	UN Women_NL	@UNWomen_NL	1,375	1,378	2016
33	UN Women Nordic	@unwomennordic	2,405	1,669	2018
34	UN Women Pacific	@unwomenpacific	10,900	4,211	2015
35	UN Women Pakistan	@unwomen_pak	24,300	2,911	2016
36	UN Women Rwanda	@unwomenrwanda	1,146	150	2019
37	UN Women South Africa	@unwomenSA	2,897	1,278	2018
38	UN Women Suomi	@UNWomenSuomi	5,770	6,748	2009
39	UN Women Sweden	@UNWOMENSweden	2,369	8,029	2012
40	UN Women Turkey	@unwomenturkey	1,069	299	2020
41	UN Women in UAE	@unwomenuae	4,373	1,552	2018
42	UN Women Uganda	@unwomenuganda	6,501	2,755	2016
43	UN Women Ukraine	@unwomenukraine	1,319	538	2017
44	UN Women USA	@UNWomenUSA	5,143	10,200	2010

45	UN Women USA Chicago Chapter	@UNWomenChicago	406	630	2014
46	UN Women USA Los Angeles	@UNWomenLA	2,475	9,243	2012
47	UN Women USA NY	@UNWomenNY	3,677	7,013	2008
48	UN Women USA - GCC	@UNWOMEN_GCC	45	755	2017
49	UN Women USA Miami	@UNWomenMiami	129	256	2013
50	UN Women USA SFBA Chapter	@UN_Women_SF	708	1,810	2009
51	UN Women Viet Nam	@unwomenvietnam	1,276	1,191	2018
52	UN Women Watch	@UNWomenWatch	159,000	9,271	2010
53	UN Women Zimbabwe	@unwomenzw	2,188	230	2019
54	ONU Femmes	@ONUFemmes	38,600	8,053	2010
55	ONU Femmes Cote d'Ivoire	@onufemmesCIV	319	128	2020
56	ONU Femmes Frances	@ONUFemmesFR	12,600	4,633	2013
57	ONU Femmes Haiti	@ONUFemmesHaiti	1,182	255	2018
58	ONU Femmes Maroc	@ONUFemmesMaroc	5,209	4,387	2016
59	ONU Femmes Niger	@NigerOnu	48	31	2019
60	ONU Mujeres	@ONUMujeres	328,000	14,600	2009
61	ONU Mujeres Bolivia	@onumujeresbol	355	121	2020
62	ONU Mujeres Chile	@ONUMujeresChile	21,700	4,227	2015
63	ONU Mujeres Col	@ONUMujeresCol	28,200	7,802	2014
64	ONU Mujeres El Salvador	@onumujeressv	3,582	3,713	2017
65	ONU Mujeres Guatamala	@onumujeresgt	3,016	3,141	2018
66	ONU Mujeres Mexico	@ONUMujeresMX	91,200	22,000	2013
67	ONU Mujeres Rep. Dom	@onumujeresRD	2,229	2,416	2011
68	ONU Mulheres Brasil	@ONUMulheresBR	28,700	6,328	2015
69	ONU Mulheres Mocambique	@onumulheresmz	381	207	2019

Evidence stream 4: Sex-/gender-specific words in the United Nations and World Health Organization databases

BACKGROUND AND METHODS

Both the UN (https://search.un.org) and WHO (https://apps.who.int/iris) archive reports and other documents they have created and published. The WHO database, for example, archives over 220,000 documents. Thus, other ways to explore potential gender bias within the UN and WHO is to quantify the use of sex-/gender-specific words in documents archived in their databases and to quantify the number of documents that have been indexed in their databases within sex-/gender-specific categories.

For this analysis, sex-/gender-specific keyword searches were performed within the databases. The female words searched were 'girl', 'female', 'women', and 'women's health'. The male words searched were 'boy', 'male', 'men', and 'men's health.' For the UN database, searches were performed to identify sex-/gender-specific words in both the titles of documents and 'anywhere on the page' of the document. For the WHO database, searches were performed to identify sex-/gender-specific words only in the titles of documents. Within the WHO database, searches were also performed to identify sex-/gender-specific categories that have been created and used by the WHO to index documents by subject/topic (e.g., 'men's health', 'women's health').

RESULTS AND BRIEF DISCUSSION

The number of times sex-/gender-specific words appeared in the titles or text of documents archived in the UN's database is displayed in Table 4. Female words appeared in the titles of 12,117 documents. Male words appeared in the titles of 769 documents. The term 'women's health' has appeared in the titles of 51 documents archived in the UN's database. The term 'men's health' has never appeared in a document title in the UN's database. Female terms appeared anywhere in the page for 445,943 documents in the UN database. Male terms appeared anywhere in the page for 168,576 documents.

The number of times sex-/gender-specific words have appeared in the titles of documents archived in the WHO's database is displayed in Table 5. Female terms appeared in the titles of 1,184 documents, whereas male terms appeared in the titles of 209 documents.

The number of documents archived in the WHO's database under sex-/gender-specific subject categories is displayed in Table 6. A total of 1,716 documents were categorised under 'Women's Health' and related subject categories. A total of 19 documents were categorised under 'men's health' and related subject categories. Overall, the findings are consistent with the study by Nuzzo (Nuzzo, 2020), which reported a substantial difference in the number of times the terms 'women's health' and 'men's health' appeared in the titles or abstracts of papers indexed in PubMed. Recommendations for moving forward with increasing the number of UN and WHO reports on men's issues are provided in the discussion of the current paper.

Table 4
Number of Times Sex-/Gender-Specific Terms Have Been Used in the Titles or Text of Documents Archived in the United Nations' Database

Male keywords	Count	Female keywords	Count
In document titles		*In document titles*	
'men's health'	0	'women's health'	51
'men'	398	'women'	10,270
'male'	46	'female'	428
'boy'	325	'girl'	1,368
Total	769	*Total*	12,117
Anywhere in page		*Anywhere in page*	
'men's health'	152	'women's health'	7,257
'men'	104,294	'women'	319,702
'male'	21,214	'female'	37,505
'boy'	42,916	'girl'	81,479
Total	168,576	*Total*	445,943

NB: Searches performed at https://search.un.org on 27 August 2020.

Table 5
Number of Times Sex-/Gender-Specific Terms Have Been Used in the Titles of Documents Archived in the World Health Organization's (WHO) Database

Male keywords	Count	Female keywords	Count
'men'	93	'women'	979
'male'	158	'female'	156
'boy'	32	'girl'	49
Total	209	*Total*	1,184

NB: Searches performed at https://apps.who.int/iris on 27 August 2020.

Table 6
Number of Documents Archived in the World Health Organization's (WHO) Database Under Sex-/Gender-Specific Subject Categories

Male subject category	Count	Female subject category	Count
'Men's Health'	19	'Women's Health'	1,104
		'Women's health'	171
		'Women's Health and Development'	2
		'Women's Health Services'	119
		'Women's Rights'	320
Total	19	*Total*	1,716

NB: Searches performed at https://apps.who.int/iris on 27 August 2020

Evidence stream 5: Sex-/gender-specific words in the United Nations and World Health Organization reports on health equity and gender and health

BACKGROUND AND METHODS

According to Evidence Stream 4, women's issues receive considerably more attention in documents archived in the WHO database. However, Evidence Stream 4 does not reveal if potential bias exists within reports where one might think men's and women's issues would be given more equal attention – that is, in general reports on health equity and gender and health. Thus, a further way to explore potential bias within the WHO is to quantify the use of sex-/gender-specific words in documents on health equity and gender and health.

To identify reports on health equity, a keyword search for 'health equity' in the titles of reports was performed in the WHO database (https://apps.who.int/iris). Similarly, to identify reports on gender and health, a keyword search for 'gender and health' in the titles of reports was performed in the WHO database. Only reports published in English and after 1999 were included in the analysis. Reports on only men's health or women's health were not included in the analysis. After eligible reports were identified, they were downloaded to a computer and opened in Adobe Acrobat Reader. The 'advanced search' option in Adobe Acrobat Reader was used to identify the number of times the words 'male', 'men', 'men's health', 'female', 'women', and 'women's health' were used in each report.

RESULTS AND BRIEF DISCUSSION

A total of 25 reports on health equity were eligible for analysis. The number of times sex-/gender-specific words appeared in the text of these reports is displayed in Table 7. When summed across all reports, female words were used 2,714 times. Male words were used 1,190 times. A total of 38 reports on gender and health were eligible for analysis. The number of times sex-/gender-specific words appeared in the text of these reports is displayed in Table 8. When summed across all reports, female words were used 11,638 times. Male words were used 5,757 times.

One observation that I made while performing the sex-/gender-specific words searches was the WHO's use of 'although statements' or 'however statements' to emphasise women's issues. These statements are a potential form of bias because the men's issue, which is typically larger in magnitude, is usually only given one or two sentences of attention and is quickly followed by a more in-depth discussion on the women's issue, which is smaller in magnitude. 'Although statements' and 'however statements' were observed, for example, in reports on smoking/tobacco:

Example 1. Worldwide, daily tobacco smoking is approximately five times more common in males than females (GBD 2015 Tobacco Collaborators, 2017; Ng, M. et al., 2014). However, in WHO reports on

health equity and gender and health, 'although statements' or 'however statements' were sometimes used to draw attention to tobacco use in females, which naturally draws attention away from tobacco use in males. The below example is from section 3.6 of *Gender and health in the Eastern Mediterranean Region: conceptual and operational advocacy* (WHO Regional Office for the Eastern Mediterranean, 2006). Italics have been added below to reveal the start of the 'however statement.'

'There is a higher prevalence of male smokers in all countries of the Region. *However*, increasingly aggressive tobacco campaigns targeting women and the easing of societal restrictions regarding women's behaviour and autonomy have resulted in a rise in tobacco use among women. Recent reports from Somalia show greater use of tobacco among female youth than male youth' (WHO Regional Office for the Eastern Mediterranean, 2006).

Example 2. Below is an example of a 'however statement' from the chapter on 'gender equity in health' in *Improving Equity in Health by Addressing Social Determinants* (WHO, 2011).

'Smoking is an area where men have traditionally borne the bulk of the health effects. Globally, women comprise about 20% of the world's more than one billion smokers (Haglund, 2010). *However*, with considerable gendered marketing by the cigarette companies, smoking is seen as both an emancipating and coping strategy for women and this gender shift is most notable among the young. Data from 151 countries show that about 7% of adolescent girls smoke cigarettes as opposed to 12% of adolescent boys. In some countries, almost as many girls smoke as boys (WHO, 2009). Future projections of tobacco-related deaths must consider these changing gender trends in smoking (Snow, 2008; WHO, 2003; WHO, 2011).

However, the two examples above should be interpreted with caution. No attempt was made to quantify this information. Moreover, no attempt was made to identify opposing examples, in which 'although statements' or 'however statements' were used to draw attention to men's issues. Nevertheless, few opposing examples are likely to exist because many health outcomes are already worse in males than females, so there is no need to use 'although statements' or 'however statements' to draw attention to men.

Table 7

Number of Times Sex-/Gender-Specific Words Appeared in Reports Published by the World Health Organization on Health Equity

	Report name	Year	'Male'	'Female'	'Men'	'Women'	'Men's health'	'Women's health'
1	*Equity-oriented national strategy for public health in Sweden: a case study*	2001	0	0	4	9	0	0
2	*Tenth futures forum on steering towards equity in health*	2006	0	0	4	5	0	0
3	*Achieving health equity: from root causes to fair outcomes*	2007	1	2	13	51	0	2
4	*Actions towards health equity*	2007	1	0	1	4	0	0
5	*High-level meeting on promoting health equity: evidence, policy and action*	2007	0	0	3	10	0	0
6	*Closing the gap in a generation: health equity through action on the social determinants of health (Final report)*	2008	9	29	67	259	0	10
7	*Closing the gap in a generation: health equity through action on the social determinants of health (executive summary)*	2008	0	1	8	21	0	0
8	*How can gender equity be addressed through health systems?*	2009	6	5	114	123	2	4
9	*Promoting health and equity: evidence, policy and action – cases from the Western Pacific Region*	2009	3	2	6	19	0	0
10	*Equity, social determinants and public health programmes*	2010	32	29	74	306	0	13
11	*Urban HEART: urban health equity assessment and response tool - user manual*	2010	1	0	2	25	0	5
12	*Urbanization and health: health equity and vulnerable populations, case studies from the Eastern Mediterranean Region*	2010	2	10	5	28	0	1
13	*Improving equity in health by addressing social determinants*	2011	30	43	100	257	6	19
14	*Regional meeting on social determinants of health and health equity*	2011	0	0	2	11	0	1

15	*Closing the health equity gap: policy options and opportunities for action*	2013	0	5	9	44	0	2
16	*Intersectoral factors influencing equity-oriented progress towards Universal Coverage: results from a scoping review of literature*	2017	0	4	4	35	17	10
17	*Advancing health through attention to gender, equity and human rights: stories from the Western Pacific Region*	2017	6	11	47	195	0	10
18	*Advancing health through attention to gender, equity and human rights: summary of stories*	2017	0	0	4	16	0	2
19	*Delivered by women, led by men: a gender and equity analysis of the global health and social workforce*	2019	58	108	189	497	0	3
20	*Accountability as a driver of health equity*	2019	0	1	8	14	0	0
21	*Healthy, prosperous lives for all: the European Health Equity Status Report*	2019	5	6	160	184	0	3
22	*Strategic mapping of institutional frameworks and their approach to equity: mapping exercise conducted to inform the implementation of the Health Equity Status Report initiative (HESRi) of the WHO Regional Office for Europe*	2019	0	0	0	11	0	0
23	*Strategic mapping of public perceptions of health equity: what the public think is important to live a healthy prosperous life*	2019	1	0	16	22	0	0
24	*Workshop on strengthening governance for health equity to advance the sustainable development goals*	2019	0	0	6	7	1	0
25	*Health equity and its determinants in the Western Pacific Region*	2020	80	78	83	142	0	0
	Total	N/A	252	334	929	2,295	26	85

NB: All reports are publicly-available in the WHO database (https://apps.who.int/iris). Data on use of words 'boy' and 'girl' are not reported because both were used infrequently.

Table 8
Number of Times Sex-/Gender-Specific Words Appeared in Reports Published by the World Health Organization on Gender and Health

	Report name	Year	'Male'	'Female'	'Men'	'Women'	'Men's health'	'Women's health'
1	*A training curriculum for health programme managers - Transforming health systems: gender and rights in reproductive health*	2001	75	64	312	818	4	87
2	*A training manual for health managers - Transforming health systems: gender and rights in reproductive health*	2001	75	64	312	818	4	87
3	*Gender analysis in health: a review of selected tools*	2002	11	8	192	293	10	44
4	*Gender and health: gender and health in disasters*	2002	5	2	29	39	0	1
5	*Gender and health: gender and mental health*	2002	3	1	37	37	0	1
6	*'En-gendering' the Millennium Development Goals (MDGs) on Health*	2003	5	3	24	62	0	6
7	*Gender and health: gender, health and ageing*	2003	4	2	46	62	0	2
8	*Gender in mental health research*	2004	32	37	82	121	1	1
9	*Gender issues in health in the sociocultural context of the Eastern Mediterranean Region*	2004	12	10	64	149	0	21
10	*Integrating poverty and gender into health programmes: a source for health professionals – module on nutrition*	2004	9	9	89	214	0	1
11	*Health and gender: gender and mental health in the Eastern Mediterranean Region*	2005	2	2	22	42	0	0
12	*Integrating poverty and gender into health programmes: a report on surveys of health ministries and educational institutions*	2005	7	8	15	51	0	10
13	*Integrating poverty and gender into health programmes: a source for health professionals – module on gender-based violence*	2005	18	15	40	378	0	23
14	*Integrating poverty and gender into health programmes: a source for health professionals – module on HIV/AIDS*	2005	37	37	223	410	3	6

15	*Integrating poverty and gender into health programmes: a source for health professionals – module on malaria*	2005	12	14	66	160	0	4
16	*Integrating poverty and gender into health programmes: a source for health professionals – module on mental health*	2005	2	1	48	128	0	9
17	*Integrating poverty and gender into health programmes: a source for health professionals – module on sexual and reproductive health*	2005	54	46	282	559	1	14
18	*Integrating poverty and gender into health programmes: a source for health professionals – module on curricular integration*	2005	0	0	5	10	0	2
19	*Gender equality, work and health: a review of evidence*	2006	22	22	96	223	2	13
20	*Gender analysis of health care access and utilization in Pakistan*	2006	23	31	59	91	1	3
21	*Integrating poverty and gender into health programmes: a source for health professionals – module on ageing*	2006	13	9	121	202	2	4
22	*Integrating poverty and gender into health programmes: a source for health professionals – module on poverty*	2006	4	7	32	108	0	2
23	*Women, ageing and health: a framework for action: focus on gender*	2007	11	12	103	452	1	21
24	*Integrating poverty and gender into health programmes: a source for health professionals – foundation module on gender*	2007	88	77	707	999	3	42
25	*Integrating poverty and gender into health programmes: a source for health professionals – module on noncommunicable diseases*	2007	18	14	168	266	0	22

26	*Integrating poverty and gender into health programmes: a source for health professionals – module on water, sanitation and food*	2007	4	10	84	196	0	4
27	*Integrating gender into HIV/AIDS programmes in the health sector: tool to improve responsiveness to women's needs*	2009	81	36	192	766	0	4
28	*Sex, gender and influenza*	2010	54	61	68	199	0	2
29	*Gender, women and primary health care renewal: a discussion paper*	2010	14	19	195	487	10	57
30	*Gender mainstreaming for health managers: a practical approach*	2011	77	46	480	786	4	30
31	*Gender, work and health*	2011	8	5	38	103	0	1
32	*Human rights and gender equality in health sector strategies: how to assess policy coherence*	2011	21	22	108	196	1	22
33	*Report on the first international symposium on self-testing for HIV: legal, ethical, gender, human rights and public health implications of HIV self-testing scale-up*	2013	5	2	25	11	0	0
34	*Increasing access to health care services in Afghanistan with gender-sensitive health service delivery*	2013	7	16	47	79	1	5
35	*Gender, climate change and health*	2014	6	6	119	232	2	3
36	*Gender and health in the Western Pacific Region*	2014	4	6	65	105	1	3
37	*A tool for strengthening gender-sensitive national HIV and Sexual and Reproductive Health (SRH) monitoring and evaluation systems*	2016	47	43	228	447	2	5
38	*Growing up unequal: gender and socioeconomic differences in young people's health and well-being*	2016	2	4	9	5	0	1
	Total	N/A	872	771	4,832	10,304	53	563

NB: All reports are publicly-available in the WHO database (https://apps.who.int/iris). Data on use of words 'boy' and 'girl' are not reported because both were used infrequently.

Evidence stream 6: Sex-/gender-specific words in Bulletin of the World Health Organization

BACKGROUND AND METHODS

Another way to explore the potential lack of recognition of men's issues within the WHO is to quantify the use of sex-/gender-specific words in the *Bulletin of the World Health Organization*. The *Bulletin of the World Health Organization* is the WHO's flagship periodical for scholarly articles. According to the WHO' website, the *Bulletin of the World Health Organization* is 'an international journal of public health with a special focus on developing countries.' The journal was first published in 1948. The *Bulletin* has published 12 issues per year since 1999. In 2018, the journal's impact factor was 6.818, and it was ranked 7th out of 185 journals in the area of public, occupational, and environmental health.

Use of sex-/gender-specific words in the *Bulletin* can potentially reveal differing levels of attention given to men's and women's issues among scholars (Nuzzo, 2020). Also, analysis of article type might reveal under what circumstances sex-/gender-specific terms are used in the *Bulletin*.

Thus, the archives of the *Bulletin* were searched via PubMed, as PubMed is a database where researchers might perform broad searches for articles on men's and women's health. The search was performed using a combination of the search term for the journal (Bull World Health Org [jour]) and the exact phrase within the title or abstract (men's health [TIAB]). PubMed facilitates the process of identifying article type because each article is categorised by its design/methodology. I recorded the number of articles indexed by PubMed as 'clinical study', 'clinical trial', 'comparative study', 'controlled clinical trial', 'observational

study', and 'randomised controlled trial.' I then collated the results from these types of articles into one broad category called 'original research.' I also recorded the number of articles indexed by PubMed as 'comment', 'editorial', 'letter', 'meta-analysis', 'news', 'review', and 'systematic review.' I collated the results from these types of articles into one broad category called 'non-original research.' I also created a third, broad category called 'other/non-categorised.' The number of articles placed into this broad category was equal to the total number of articles revealed by the keyword search minus the number of articles classified as original and non-original research.

RESULTS AND BRIEF DISCUSSION

A total of 10,571 articles were published between 1948 and 2019 in the *Bulletin* and indexed in PubMed. Table 9 displays the number of times sex-/gender-specific terms appeared in the titles or abstracts of articles published between 1948 and 2019. The words 'male' and 'female' were used in the same number of times. However, the word 'women' was used three times more than the word 'men.' Moreover, the term 'women's health' was used in the title or abstract of 21 papers, whereas the term 'men's health' was used in the title or abstract of two papers. These findings are consistent with results from a previous study (Nuzzo, 2020). Also, the examination of article type revealed the word 'women' was used in a large proportion (23.5%) of non-original articles (e.g., comments, editorials), whereas the word 'men' was not (8.7%). This result suggests there is more commentary about women's health than men's health. Recommendations for moving forward with increasing the number of articles in the *Bulletin of the World Health Organization* that discuss men's issues are provided in the discussion of the current paper.

Table 9

Number of Times Sex-/Gender-specific Terms Appeared in the Titles or Abstracts of Articles Published in the Bulletin of the World Health Organization Between 1948 and 2019

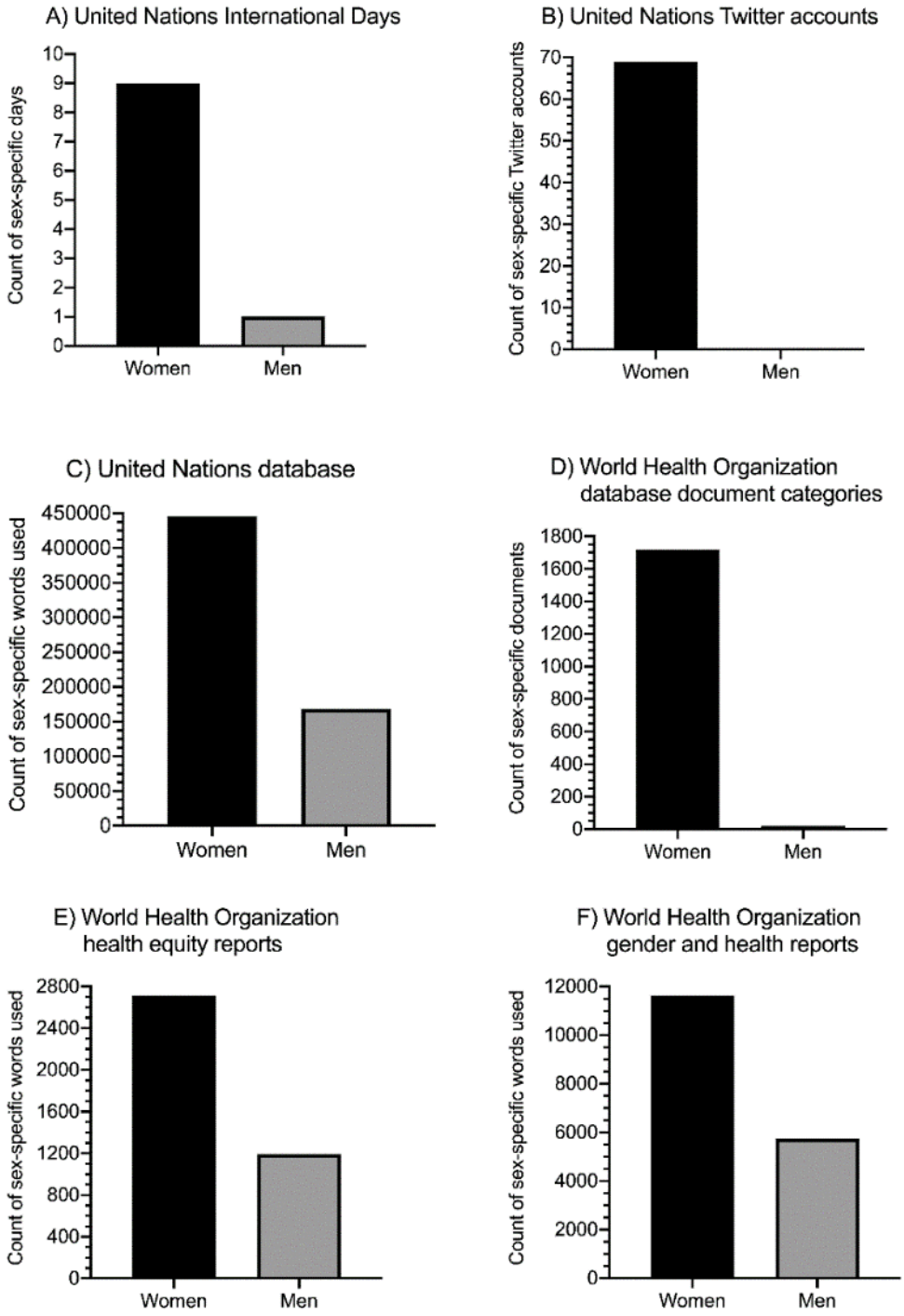
Male terms	Count	%[a]	Female terms	Count	%[a]
'Men'	183		'Women'	592	
Original research	34	18.6	*Original research*	117	19.8
Clinical study	5	2.7	Clinical study	16	2.7
Clinical trial	5	2.7	Clinical trial	16	2.7
Comparative study	16	8.7	Comparative study	58	9.8
Controlled clinical trial	4	2.2	Controlled clinical trial	14	2.4
Observational study	0	0	Observational study	0	0
RCT	4	2.2	RCT	13	2.2
Non-original research	16	8.7	*Non-original research*	139	23.5
Comment	0	0	Comment	5	0.8
Editorial	0	0	Editorial	10	1.7
Letter	0	0	Letter	3	0.5
Meta-analysis	1	0.5	Meta-analysis	11	1.9
News	2	1.1	News	21	3.5
Review	12	6.6	Review	69	11.7
Systematic review	1	0.5	Systematic review	20	3.4
'Male'	164		'Female'	164	
Original research	110	67.1	*Original research*	46	28.0
Clinical study	22	13.4	Clinical study	6	3.7
Clinical trial	22	13.4	Clinical trial	6	3.7
Comparative study	27	16.5	Comparative study	26	15.9
Controlled clinical trial	20	12.2	Controlled clinical trial	5	3.0
Observational study	0	0	Observational study	0	0
RCT	19	11.6	RCT	3	1.8
Non-original research	9	5.5	*Non-original research*	9	5.5
Comment	0	0	Comment	0	0
Editorial	0	0	Editorial	0	0
Letter	0	0	Letter	0	0
Meta-analysis	0	0	Meta-analysis	1	0.6
News	2	1.2	News	2	1.2
Review	5	3.0	Review	5	3.0
Systematic review	2	1.2	Systematic review	1	0.6
'Men's health'	2	N/A	*'Women's health'*	21	N/A
'Boy'	1	N/A	*'Girl'*	2	N/A

RCT = randomised controlled trial. a Rows do not total 100% because some articles were indexed in PubMed as an article type that is not listed. Also, some articles were indexed as more than one article type. The most common article type not listed is 'Research Support, Non-US. Gov't' Data from this article type are not presented because articles indexed under the 'Research Support, Non-US Gov't' article type were sometimes also indexed as an original research article type, and in other instances, they were also indexed as a non-original research article type. Thus, it was not possible to make this article type a third broad category, and it was also not possible to categorise it under 'original research' or 'non-original research'.

DISCUSSION

Six streams of evidence illustrate bias against boys' and men's issues within the UN and WHO. First, boys and men are not mentioned in the UN's sustainable development goals for 'gender equality.' Second, the UN observes nine International Days for women's issues/achievements and one day for men's issues/achievements. Third, the UN has 69 Twitter accounts dedicated to women's issues and zero dedicated to men's issues. Fourth, more female than male words appear in documents archived in the UN and WHO databases, and substantially more documents are archived under women's health categories than men's health categories, indicating more attention to women's issues. Fifth, in WHO reports where more equal use of male and female words might be expected (e.g., reports on gender and health), more female than male words appear, again indicating more attention to women's issues. Sixth, more female than male words appear in the *Bulletin of the World Health Organization*, with articles on women's health more likely to be non-original research (e.g., editorials). As the UN and WHO are the causal agents directly responsible for most of these outcomes, the results confirm international bias against men's issues and in favour of women's issues. Figure 1 provides a visual summary of the key findings.

Figure 1
Summary of Key Findings



A: Number of United Nations (UN) International Days of Observance for men and women
B: Number of UN Twitter accounts used to disseminate information about men's and women's issues.
C: Number of times male and female words appeared in the UN database.
D: Number of documents in the World Health Organization's (WHO) database indexed under female- or male-specific categories (e.g., 'women's health', 'men's health').
E: Number of times male and female words appeared in WHO reports on health equity.
F: Number of times male and female words appeared in WHO reports on gender and health.

Bias and causes of the observed results

The results show men's issues are given less attention than women's issues by the UN and WHO. However, this difference should not be automatically assumed to be caused by bias. Differences in observational, cross-sectional studies can be impacted by unmeasured confounders. However, in the current study, confounding was not an issue. Confounding was controlled naturally by the experimental model, as the UN and WHO are the causal agents responsible for the outcomes assessed. Therefore, the observed differences could have two possible explanations: (a) lack of awareness of men's issues by UN and WHO staff, or (b) bias (conscious or unconscious) against men's or in favour of women's issues by UN and WHO staff.

Lack of awareness of men's issues by the UN and WHO staff might play a role but it is unlikely to fully explain the UN's and WHO's lack of recognition of men's issues. For one, men's issues are mentioned in passing, as part of 'however statements' in some WHO reports. Also, a small number of men's health reports have been generated by the WHO (WHO, 2010; WHO, Barker, Ricardo, & Nascimento, 2007; WHO Regional Office for Europe, 2000, 2007, 2018a, 2018b; WHO Regional Office for Europe, Gough, & Novikova, 2020). Thus, some staff at the UN and WHO are aware that men's issues exist.

Another possible explanation for the results is a large-scale manifestation of individual-level cognitive bias against men and in favour of women. Recent experimental work in psychology has documented that bias against males and in favour of females exists when study participants are presented with certain scenarios. For example, Stewart-Williams et al. (2020) found men and women from different cultures reacted more positively to research that revealed female-favouring sex differences than research that revealed male-favouring sex differences. When considered in light of other findings, Stewart-Williams et al. (2020) concluded the results are 'consistent with the idea that both sexes are more protective of women than men, but that people tend not to be aware of this.' Similarly, in six experiments, Reynolds et al. (2020) discovered females were more likely to be considered the victims (and males the perpetrators) in scenarios in which the sex of the victim was unknown to the study participants. Finally, the findings from the current study appear to support the construct of gamma bias – that is, magnification or minimisation of a gender issue depending on whether the issue relates to males or females (Seager & Barry, 2019).

Bias beyond the UN and WHO

The current results illustrate bias against boys' and men's issues occurs at an international level. However, the UN and WHO are not the only institutions to exhibit this bias. Nuzzo (2020) documented it within the US government and perhaps within biomedical research more broadly. Moreover, in some instances, individual researchers do not frame certain issues as primarily men's issues. For example, in a *Lancet* commentary about homelessness in the United Kingdom (Aldridge, 2020), the author did not mention the majority of homeless individuals in the United Kingdom are male (Office for National Statistics, 2019). Similarly, in a *BMJ* commentary on global suicide rates (Matthay, 2019), the author never mentioned rates of suicide are higher in males than females in every geographic region of the world (Naghavi & Global Burden of Disease Self-Harm Collaborators, 2019). This lack of framing health outcomes in a sex-/gender-specific when the outcomes are more prevalent in males than females is like how the UN does not name or frame international days in a sex-/gender-specific way when the topic is one that is more relevant to males than females.

Moreover, as mentioned earlier, one reason bias against men's issues by the UN and WHO is worthy of investigation is because the agendas of these organisations influence other organisations, thus multiplying the effects of bias. For example, the International Society for Physical Activity and Health aligned their goals for increased physical activity participation (ISPAH, International Society for Physical Activity and Health, 2017) with the UN's sustainable development goals (UN, 2015, 2020b). The Society called for increased physical activity and sports participation in girls and women (ISPAH, 2017). They did not announce any goals about increasing physical activity and sports participation in boys and men (ISPAH, 2017).

A future focus on both sexes

The UN and WHO appear to have adopted an approach where only one sex can be the focus of their efforts and resources. This approach should be revised. For example, there is no conceptual limitation to the number of sustainable development goals that can be created. Thus, there are no reason boys' and men's issues cannot also be addressed by these goals. A focus on men's issues is likely to be indirectly beneficial to the lives of many women.

Outside of the UN and WHO, researchers and organisations have started to recognise the need for more attention to boys' and men's issues (Baker et al., 2014; Ng, Teo, Ho, & Tan, 2017; Nuzzo, 2020; Richardson & Smith, 2011; Seager & Barry, 2019; Seager, Farrell, & Barry, 2016; Smith, Adams, & Bonson, 2018). Encouragingly, in 2014, the *Bulletin of the World Health Organization* published a commentary by Baker et al. (2014) that concluded men's issue was generally not recognised within the 'global health equity agenda.' Evidence presented in the current analysis supports the conclusion by Baker et al. (2014). Moreover, Seager et al. (2016) have published on the 'gender empathy gap', Nuzzo (2020) has published on the 'national health paradox', and Barry et al. (2019) have edited *The Palgrave Handbook of Male Psychology and Mental Health*.

Potential criticisms of the current paper

One potential criticism of the current paper is that the UN and WHO are primarily concerned with 'developing countries', where women's issues might be more pressing concerns than men's issues (Stoet & Geary, 2019). For a few reasons, this argument is not entirely sound. First, boys and men in developing countries also have health issues that require attention. Second, the UN and WHO do not limit their scope of influence on developing countries. Both organisations create global-wide agendas. They attempt to influence policies in most countries, including developed countries where males appear to be falling behind females on key outcomes, as reflected in scores on the Basic Index of Gender Inequality (Stoet & Geary, 2019). Third, many women's issues are also men's issues, even in developing countries. For example, framing violence against women by men as a women's issue is somewhat misguided because the *causal agent* of the violent act is the male perpetrator. Addressing mental health issues in men might be a solution to preventing such behaviour.

Another possible criticism of the current paper is that inferential statistics were not applied to the data. Inferential statistics were not used because the intent of the study was not necessary to infer or generalize from the data (i.e., inferential statistics) to other international organisations. Instead, the aim was to use descriptive statistics to describe the degree to which the UN and WHO have given different degrees of attention to men's and women's issues. This difference is obvious based on the number of evidence streams assessed (i.e., six streams), the magnitude of difference within each stream (e.g., 69 UN women's Twitter accounts versus zero UN men's Twitter accounts), and the context surrounding the streams (i.e., the UN and WHO are the causal agents directly responsible for the streams/outcomes).

What I am not saying

In recent years, the topic of sex/gender has become contentious in academia and the media. Thus, a few points of clarification about the current paper are warranted. First, I am not saying women's health does not need attention nor am I saying men's and women's issues should necessarily be given equal levels of attention. I am saying boys' and men's issues deserve acknowledgement by the UN and WHO, and they warrant more attention than what they are currently given. Other researchers have also reached similar conclusions (Baker et al., 2014; Ng et al., 2017; Richardson & Smith, 2011; Seager et al., 2016; Smith et al., 2018). Second, I am not saying men's issues are never given attention from national or international organizations. The WHO has generated some reports on boys' and men's issues (Barket et al., 2007; Gough & Novikova, 2020; WHO, 2010; WHO Regional Office for Europe, 2000, 2007, 2018a, 2018b). Instead, I am saying the degree of attention given to boys' and men's issues is less than one might expect based on the epidemiological data (Nuzzo, 2020). Third, I am not saying there are never any biases that work in favour of men. Fourth, I am not saying male and female issues are the same in all geographic regions. Each country and region should be examined separately. Nevertheless, some issues will be similar across regions (e.g., shorter life expectancy, higher suicide rates, and higher substance abuse rates in

males than females) (GBD 2015 Tobacco Collaborators, 2017; Naghavi & Global Burden of Disease Self-Harm Collaborators, 2019; Ng, Freeman, et al., 2014; Wang et al., 2012).

Recommendations for moving forward

UN Sustainable Development Goals

The UN is encouraged to include boys' and men's issues within their sustainable development goals. Several sources, including a small number of reports from the WHO, are available on men's health issues to guide the creation of these goals (Australian Government Department of Health Ageing, 2010; Baker et al., 2014; Barker et al., 2007 Barry et al., 2019; Gough & Novikova, 2020; Ng, C.J., 2014; Ng et al., 2017; Nuzzo, 2020; Richardson & Smith, 2011; Seager et al., 2016; Smith et al., 2018; Teo et al., 2015; WHO, 2010; WHO Regional Office for Europe, 2000, 2007, 2018a, 2018b; Wilkins, 2009).

UN International Days of Observance

The UN is encouraged to adopt a sex-neutral approach to International Days or a fairer and more precise sex-/gender-specific approach. The sex-neutral approach would mean no days would be named after one sex or have a focus on one sex. Instead, the focus would be on the outcome, irrespective of what group is most impacted. Alternatively, the sex-/gender-specific approach would associate an issue or topic with the sex most at risk or in need of attention. If this approach is taken, the UN is encouraged to be fairer and more accurate with their representation of men's and women's issues. The sex-/gender-specific approach is probably not ideal because, unless biologically constrained, most issues (e.g., violence) impact both men and women. A few specific recommendations for the sex-/gender-specific approach are as follows: if International Women's Day is observed than International Men's Day should also be observed; if International Day for the Elimination of Violence against Women is observed than a day for the elimination of violence against men should also be observed; if World Autism Awareness Day is observed then it should be renamed in a sex-/gender-specific way that reflects the epidemiological data (e.g., Boys with Autism Day).

UN Twitter accounts

The UN is encouraged to create a 'UN Men' Twitter account. The purpose of this account should be to disseminate knowledge about boys' and men's issues. Alternatively, the UN could create a sex-neutral account that tweets about *both* men's and women's issues. The UN is also encouraged to create Twitter accounts for men's issues for each of the countries and geographic regions for which there already existing accounts for women's issues.

WHO reports and database

Relatively few reports from the WHO have focused on boys' and men's issues (Barker et al., 2007; Gough & Novikova, 2020; WHO, 2010; WHO Regional Office for Europe, 2000, 2007, 2018a, 2018b; WHO, 2010). Thus, the WHO is encouraged to generate up-to-date reports that summarise boys' and men's issues. Moreover, in reports on the broader topics of health equity and gender and health, the WHO is encouraged to give attention to both men's and women's issues. Finally, the WHO is discouraged from using 'although statements' or 'however statements' in their reports when attempting to bring attention to women's issues. Instead, facts about health issues in both men and women should be stated plainly and given the appropriate coverage based on the epidemiological data.

Bulletin of the World Health Organization

The editors at the *Bulletin of the World Health Organization* are encouraged to put out a call for papers on boys' and men's issues.

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A male perspective of psychology from the Rainbow Nation

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This perspective piece aims to provide a current snapshot of the psychology curriculum as experienced by a male middle adulthood student in South Africa. A short declaration of my lived experience is followed by a review of literature relevant to the topics of feminism, masculinities, individual identity, community development and gender diversity. I discuss the questionable ethics of adopting various ideas coming from Western sociology and social justice activism, used to train Generation Z adolescents in counselling techniques. From my audience perspective, I reflect on the impact of including catastrophising theoretical material on young females, males, and people of colour who enter psychology with the best intentions; to learn how to help others. There is a bias in psychology today towards feminine traits which may ostracise the young male student at a time we when need more male counsellors. Concurrently, the inappropriate use of foreign theories may be driving away people of colour who are seeking emic solutions to their environment. There is a danger that we are fuelling the radical 'decolonise' advocates, which will further devalue psychology in developing communities. I advocate for material in the curriculum to allow for a balance within male psychology, science-based theories, and humanist values rather than identity politics and victimology. This discussion happens in the context of lower resilience in Generation Z, evidence of social contagion through social media, evolving masculinities, identity confusion, rising mental health challenges, and calls for decolonisation of education.

Keywords: adolescents; counselling; decolonisation; gender diversity; male psychology

There is a conflict of visions playing out in politics, society, and education, marked by Brexit and the election of Donald Trump, currently being exacerbated by COVID-19. Many are left questioning what is going on in our developed communities. This question has led to an abundance of theory and literature on the topic, offering us an array of explanations, excuses, and dire warnings. Many liberation movements have splintered into sub-groups of grievances using hybrids of moral philosophy from feminism, race equality, and human rights ideals. As a male adult, with my own business and no prior formal education, concerned about the future, the question gripped me in my early 40s.

I veered into the world of social media to find answers. I quickly realised that in 2016, social media provided weak, polarising answers to the big questions. I delved into sociology, hoping for the study of human behaviour to provide solutions. Here again, I would be disappointed; I found progressive ideology and technocratic elitism that left me feeling manipulated (Henning, 2012). It was after reading Stephen Pinker's book *The Blank Slate* that I finally sensed an intuitive truth behind human group behaviour. I finished the book in January 2019, put it down and picked up my phone to find a way to study psychology further. I was 46 years old, owned my restaurant and married with no children. I wanted to help others who may face what I have overcome, but I also wanted to delve deeper into human behaviour to enrich the second half of my life.

I registered with a private college for a full-time undergraduate psychology degree. The programme aims to qualify us as honours graduates in counselling with practical counselling experience in a condensed course of four years. This programme is a result of the Health Professions Council of South Africa (HPCSA) realising we urgently need more psychologists, especially counsellors in a nation ravaged by chronic, generational trauma.

This perspective paper will investigate some of the answers I found to the question: what is happening to our Western, developed societies? I also propose an idea that the tacit vilification of men in sectors of psychology represents a drift toward progressive ideology at the expense of mental health best practice, further neglecting males who need help and ostracising males who would enter psychology. With that in mind, I will unpack a few hot button topics we cover in our curriculum, how they are presented and how the adolescent students interpret them. I will discuss if we, as the adults in the room, are doing more harm than good by moulding these young students to a world view based on victimology and fear.

I give some detail on my life to be transparent about my possible bias. I write this paper with the utmost respect to my College and its dedicated educators and administrators who have presented these issues with professionalism and passion, always allowing other opinions and creating an open atmosphere of learning, engagement, respect and growth. It is the atmosphere at this College which allows me to engage with these ideas.

Development, meaning, and experience

This paper is my perspective on themes in psychology being taught in South Africa in 2020, although they are common globally, in most Western higher education institutions. First, I present my heritage and give relevant lived experiences before I attempt to reflect on the material I have encountered in my studies. My goal is to advance the discussion on the utility of various theories in training counselling psychologists, the impact they have on Generation Z adolescent students, especially males who are a minority in counselling. I aim to highlight the discrepancy between the lack of male student psychologists and the apparent need for more males in counselling psychology (for more detail see Bedi et al., 2016; Westwood & Black, 2012). This deficiency seems to be gaining attention lately as male psychology modules are now being proposed in universities, male mental health groups are popular, and we finally have a formidable resource in the *Palgrave Handbook of Male Psychology* (Barry et al., 2019). These developments come as I began questioning my decision to study psychology after encountering some of the political ideology while being a male student at the age of 46 in a young, multicultural, sensitive atmosphere.

It may not surprise the reader that integrating into first-year higher education, as a business owner, a capitalist, cisgender, heterosexual male was not easy. My cohort is mostly female between 19 and 23 years old who eyed me suspiciously for the first few weeks. There is a ratio of one male to three females

in the students and educators, not unlike most aspects of psychology today (Bedi et al., 2016; Westwood & Black, 2012). I am old enough to be my classmates' father and the educator's sibling. However, I proceed with enthusiasm because I am aware of the privilege of having access to higher education. I respect them for choosing psychology when other, less personally challenging options exist. When I was my classmates' age, I had already been thrown out of school at 15 and left alone to fend for myself after my abusive, emotionally detached father moved out. I had to grow up overnight and get a job or face humiliation by going for help to the misandrist female matriarchs in my Italian family.

Development on being South African

After decades of race-based oppression under apartheid, we emerged as a free democracy in 1994. However, not all Whites benefited from Apartheid to the degree that Dutch or British immigrants did. Many immigrants to South Africa after World War II barely spoke English, or the Dutch-derivative language Afrikaans. Italians and other post-war immigrants were enemies of South Africa during World War II, seen as ignorant, although skilled, cheap labour by the ruling Afrikaners and upon arriving in South Africa 'faced the hostility of former settlers' (OECD, 2018) who came before the wars.

Consequently, many second-generation Italian immigrants of post-World War II Europe grew up ostracised by most white Afrikaners. The apartheid system stoked classism within the White community, albeit far less aggressively, than it did between Blacks and Whites. A careful reading of the records reveals many European immigrants' escaped the tyranny and race-based politics rising in Europe, culminating in the spectre of Hitler (Zukowski, 1996). I believe this would later contribute to the liberal wave of White resistance to apartheid I witnessed, that would challenge apartheid from within the borders (Henkes, 2016). For a detailed history, you can read the respected writer Marriane Thamm's article *The Conscience of White South Africa* (Thamm, 2015) where she summarises the contribution of White activists, many of them children of those post-World War II immigrants, in the anti-apartheid movement during apartheid.

Due to mental health problems running through my family and an abusive dysfunctional father, I grew up in various degrees of relative poverty, at times, even starvation. My parents divorced when I was 8 years old; my mother had been coping with my father's beatings for 13 years by then. Ultimately, she would have a complete schizophrenic break and leave us for good when I was 13 years old. She had spent her whole life trying to find a safe place for us but could not continue as; even her own family blamed and ostracised divorced women with no education or skills. She would spend the next 34 years in poorly managed mental institutions and later, old-age care homes. Medication only stabilised her behaviour; she was never socially functional again. At 8 years old, I had to be rescued from absolute poverty; we were living in a tin shack shooting pigeon for food. I attempted suicide at 13 because I had no support; I was abandoned to a boarding school, and usually left there over weekends, even on holidays a teacher had to find someone in the family to come and get me. At that boarding school, I later realised, I was being groomed for sexual abuse by a male teacher. Luckily, I avoided the abuse by being removed from the school, only to be put into a worse school. At 15, I was brutally attacked by my father in front of my matriarchal, detached grandmother. After escaping across town covered in blood, I was attacked again by my older, remorseless brother in front of my girlfriend. In this incident, I believe I narrowly escaped fratricide because he only stopped when my girlfriend intervened; he had no empathy for me. I became an adolescent alcoholic at 15 and was dismissed from high school before I could finish the final year, even though I was a higher-grade student. I would later discover I endured attention deficit disorder (ADD), exacerbated by poor diet, my whole childhood.

Nevertheless, I survived adolescence; I welcomed the end of apartheid after decades of horrific violence which threatened me personally; I was near to an explosion in Johannesburg which devastated a five-block radius when I was 14 years old. After Mandela's election in 1994, I felt that the nation and I were being reborn into an era of hope and peace. I persisted with the only talent I had – creating fantasy art paintings, which got me accepted into a prestigious advertising agency at 19. This would take me away from the crime and drugs in my environment. Later, I would leave advertising on moral grounds; the illegal drugs and immorality in deceptive marketing were eating away at my soul. At 29 years old, utilising a private loan from a wealthy client, I purchased the restaurant business I managed at the time. I have owned it for 20 years now and I have been happily married for nine years.

To clarify why I am telling you this unfortunate story; I am painfully aware of the harsh realities of poverty, gender and class injustice, and I fully supported the transition to constitutional democracy in 1994. I would have called myself a feminist metrosexual when I was younger. However, circumstances forced me to change. Owning a business made me deal with people on two levels: as the service provider host, and as the employer. Somehow, during my 20 years of owning a restaurant I became a confidante to everyone; from the CEO client to the newly arrived undocumented migrant from another African state who faces xenophobia in South Africa (Schierup, 2016). My transition to middle adulthood in this environment took place as I was developing the stages mentioned in psychology. *Post-formal thought*; that life is ambiguous and contradictions are common, and *reflective judgement*; reasoning through the dilemmas of current affairs, religion and relationships (King & Kitchener, 2004). I read *Finding Meaning in the Second Half of Life* (Hollis, 2006) and began to embrace the potential in later life stages. Finally, reading *The Blank Slate* (Pinker, 2016) pushed me to grasp psychology with both hands and make the *midlife correction*; changing my goals after reviewing my values to find meaning later in life (Newton & Stewart, 2012).

Discovering psychology

After overcoming some awkwardness as a middle-adulthood student, I bonded with my adolescent cohort and embraced the curriculum material. Discovering my life-stage traits within the developmental models defined in psychology is empowering, while also helping me relate to the adolescent students with patience and empathy, skills I had neglected. Learning the successful approaches and theories in counselling is exciting and deeply rewarding, we really can help people. The requirement to read academic literature forces me to engage with the material, to which I would not typically expose myself. As a result, I modified some ideas I had before I began this process.

However, I noticed the themes of the progressive ideology embedded in various theories presented as empirical fact. Specific material has stood out for me: feminism, masculinities, individual identity, community development.

Gender diversity

I find the curriculum to be mostly psychology with a dash of sociology, a feeling shared by a few of my classmates. South Africa is a nation birthed by colonialism, brutal wars and group identities struggling to survive against the challenges of a developing country. I accept the curriculum in psychology is established by a national body which has broader social justice concerns, optimistically in line with the Department of Basic Education (DBE) and the progressive constitution of South Africa (Motshekga, 2011). The debate around psychology in South Africa is mired in its history as the enabler of racist policies through IQ testing and race theory, as detailed in *Decolonising Psychology in South Africa* (Clay, 2017). It is an unfortunate legacy of psychology in South Africa that a psychologist, Hendrik Verwoerd, was the chief architect of apartheid (Clay, 2017). In contrast, Jan Christiaan Smuts (1870–1950) was Prime Minister of South Africa on two separate occasions and was a contributor to the League of Nations which later became the United Nations (South African History Online, 2019). Smuts coined the term *holism* and collaborated with Alfred Adler, who, ironically, is the founder of individual psychology, which aims to address feelings of inferiority (Nicholas, 2014). I highlight these contrasting figures as it seems to be what is happening in psychology today. The focus has moved away from any positive themes, shifting from 'do no harm' to psychology's potential as the activist role in social justice. The activists aim is to 'translate useful theoretical resources into meaningful psycho-political practices' (Pillay, 2016). Psycho-political? Nowhere in my admission forms did it say I was registering for 'psycho-political' training.

Pillay goes on to lay claim to the humanist ideal while turning psychology into a political force to end capitalism and the perceived exclusion in academia, in post-apartheid South Africa (Pillay, 2016). With sincere respect for other people's moral beliefs, I counter this perspective on our society's ills, in the age of rising inequality, with economist Thomas Sowell who eloquently analyses these issues in his book Wealth, Poverty and Politics: 'People, who have acquired academic degrees, without acquiring many economically meaningful skills, not only face personal disappointment and disaffection with society but also have often become negative factors in the economy and even sources of danger, especially when

they lash out at economically successful minorities and ethnically polarise the whole society they live in,' (Sowell 2015, p. 85).

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With this quote, I hope to bring us back to the realm of positive, politically neutral psychology. I want to reset the activist direction taken by Pillay, and papers I have encountered. The agenda of activist academics directing adolescent students into political activism is unethical. Adolescent students enter the system naive and malleable, trusting the adults in the room. The activist is fuelled by notions of creating a utopia of equality by discarding decades of the intellectual capital and experience which are embedded in most areas of modern psychology. I do not deny that older forms of psychology had a role in oppression and injustice. By a review of the literature, let me attempt a justified perspective of topics which concern me in the context of South Africa today.

Feminism

Stephen Pinker wrote an assessment of feminism today in *The Blank Slate* (2016), he paraphrased Christina Hoff Sommers; *equity feminism* is the classical liberal idea rooted in individual human agency and humanism, which calls for gender role equality (Pinker, 2016, p. 341). I support this position, and I live it daily in my marriage and my business. I believe men need to be educated in this idea and its potential for equality which empowers men and women. *Gender feminism* is in opposition to classical liberalism, choosing a social constructionist, postmodern, radical view instead; declaring that infants are socially conditioned to gender roles of power, dominance, and submission. It rejects the individual and proposes we can only act as groups (Pinker, 2016). Pinker goes into detail about the biological realities of gender development, which I will come back to later.

However, in my readings and lectures, the critical differences are not clarified. They are obscured by the opaque language, not so much in textbooks, but in journal articles. We are presented with general feminism; the liberation of women and some suggestion is made that it allows for progressive changes in gender roles. The gender feminists would have us reject the science of biology and assume the patriarchy is a vast underground network of male sociopaths hell-bent on raping and enslaving women; we are simultaneously told to manage 'catastrophising' in counselling, yet we allow it in the educational material. The distinction between these two opposing feminist movements is not made clear or even mentioned, neglecting an opportunity for moral psychology education. The student is left with current hashtags like *men-are-trash* and readings bemoaning oppressive patriarchy used to prop up capitalism. I have seen their reactions; they are mostly confused, defensive and filled with fear.

This is what we offer young students? Especially young females learn this upon entering the real world, at least as it exists in higher education. This victimology is presented as an empirical fact during the fragile *identity versus identity confusion* stage proposed by Erikson (Kail & Cavanaugh, 2017). Are we not duty-bound, as the adults in the room, to equip children and adolescents with the tools to navigate an already torrid world of social media and pornography which depicts them as objects subject to abuse and violation? Could we not educate them on the humanist ideals in equity feminism, thereby providing them with a resource of pride and individual power to face the world as adult psychologists? Meanwhile, the young boys are left feeling guilt, like unwitting members of an oppressive male cult.

Masculinities

The modern boy has a morass to navigate before he achieves adulthood; he is a pariah in the contemporary world of feminine ideals and gender role confusion. Boys are flooded with testosterone in utero. As they mature, they are more likely than girls to be hobbled by ADHD (attention deficit hyperactivity disorder) and dyslexia. Less well known, they are also more like that girls to endure colour blindness which distorts their academic progress, anorexia nervosa from identity conflict, autism and high

energy levels with no outlet (Arnett et al., 2017; Barry & Owens, 2019; Gurian, 2011; Stoet, 2019; Supplee et al., 2011; Sweeting et al., 2015; van Wijngaarden-Cremers, 2019; Whitmire, 2010).

Boys must choose an expression of masculinity once they reach puberty, best suited to their environment. The discussion of masculinities is limited at college. As a representative example, the writings of sociologist Raewyn Connell are often cited in our curriculum. Connell is a sociologist specialising in 'large scale class dynamics'; she transitioned from a man to a woman late in life and as a teacher; 'emphasised student control of learning processes'. She is cited up to 98,000 times regarding her work on gender and was the author of *Masculinities* (1995; 2005), by all accounts a detailed dive into the topic, albeit from someone with her gender identity conflict and a declared political agenda. I have struggled to understand the rationale used by Connell and other gender theorists, not for lack of trying. As described by Ridge (2019, p. 209), some avenues of theory eventually 'collapsed for want of evidence'. I defer to social and cognitive scientist Dan Sperber. Sperber (2010) proposes the *guru effect* which states; by using deliberately opaque language and broad terms 'authors come to be overestimated, often ridiculously so, not in spite but because of their very obscurity [in their language]' (Sperber, 2010, p. 592). As an expert on cognitive anthropology and linguistic pragmatics, Sperber (2010) explains that many intellectuals benefit from an 'epidemiological mechanism' (p. 592) which leads them to levels of authority unsupported by rational arguments. I suggest that this 'obscurity' is particularly dangerous if taught to a cohort of adolescent counselling psychology students.

However, I must concede to the 'hegemonic production of knowledge'; Connell's 1985 paper, using her previous gender-neutral name; Connell (1985) is a pivotal piece on gender roles for the time. The idea that men, like women, can choose new roles in a society free from predetermined gender-based categories is the best thing to happen to men since the cessation of global wars which cost so many disposable men's lives (Farrel, 2019). However, Connell's paper also affirms the Marxist ideology of class and power relations in gender identity and descends into denial of biological roots of gender behaviour (see Connell, 1985). The use of this type of material in a psychology degree should be presented as sociology theory and balanced by readings on the scientific, evolutionary basis of gender expression. For example, statements like 'gender are the socially-constructed role' (Graaff & Heinecken, 2017, p. 622) are used a lot in South African papers aiming to explain the epidemic rates of gender-based violence (GBV). To be fair, in one South African study, they found 'violence was present in 50% to 60% of marital relationships' (Peacock & Levack, 2004, p. 174). However, In an education setting, we must evaluate a theory 'because it asks us to filter our answers through a structural theory' (Ridge, 2019, p. 210). We must ask: what is the goal of the theory?

I believe this distraction to progressive theory devalues the tangible issues involved and implies a level of power, control and choice by the male perpetrators which they lack in South Africa, otherwise, we would not have the highest suicide rate (Demissie & Clayton, 2018; Seager, 2019; van der Merwe, 2019). In his introduction to *gamma bias* in the *Palgrave Handbook of Male Psychology* (Barry et al., 2019), John Barry recounts how, during a seminar on clinical psychology in the 1990s, the topic of high male suicide rates was 'glossed over' (p. 87). I am sorry to report that this scenario repeats itself in 2020. Gamma bias represents the gendered cognitive distortion matrix (Acharya & Relojo, 2017)which minimises the suffering of males in society. I stress the injustice of male suicide being glossed over, while all four of the males in my class have attempted or seriously considered suicide already, all of us before our 21st birthdays.

We already know South African men face a 'complex interaction of social, cultural and family dynamics' (Enderstein & Boonzaier, 2015, p. 253). Ramphele (1990), long before she attempted national politics, presciently wrote how men in South Africa are already dehumanised and 'feel threatened by loss of control over the only people [women] who cushion them against their perception of total powerlessness' (p. 13). Perhaps men's presentation of masculinity is related to their survival strategy.

Graaf and Heinecken (2017) provide other possible causes of GBV in South Africa that are worth mentioning in this discussion: the legacy of apartheid, income inequality, militarised hypermasculinities, and gender inequality. Nevertheless, they too, ignore the biological factors. Crucial to this discussion, Pinker (2016) notes: 'the usual suspects for understanding violence are completely unproven and sometimes patently false' (p. 310). To be clear, research is abundant in proven, measurable biological and

neurological differences between male and female which are glossed over in the discussion around gender expression (Barry & Owens, 2019; Pinker, 2016; Studholme et al., 2020). I suggest we connect GBV and other antisocial behaviour by men, with the suicide rate by men, if we are to address many of our chronic social ills permanently. Currently, in South Africa, rape, GBV, suicide, gangs, murder, joblessness and human trafficking of men are entirely out of control (Allais, 2013). Simultaneously, women and children are at the mercy of men with nothing to lose, creating a crippling environment of traditional patriarchy where any well-meaning development programmes fail, leading to children being stunted in their development, and sustaining the deprivation trap (Food and Agriculture Organization, 2010; Hemson, 2006; Mbambo, 2012; Onwutuebe, 2019; Tariquzzaman & Hossain, 2009).

Being a man

On a personal note, in my 47 years of being male, I have also struggled with masculine identities. I would agree with Ridge (2019) that there 'is not… multiple masculinities, but multiple interpretations of masculinity' (p. 219) which, I believe can be transient in men with developed emotional intelligence. Having had no good male role models in childhood, I used male teachers or movie heroes to construct an idea of the 'masculine hero prepared to use violence in a just cause' (Pinker, 2016, p. 310). When I was younger, I relished the opportunity to express anger through violence in the name of a just cause. The lack of positive male role models is a known factor in multiple developmental problems in boys, even causing them to reject fatherhood themselves (Farrel & Gray, 2018; Kail & Cavanaugh, 2017; Spjeldnaes et al., 2011; Stoet, 2019). Many years spent failing to meet these unrealistic standards; of provider, role model, emotional but tough man, possible father and business owner caused me, like many other men, to question myself and slip into periods of depression and resignation. I questioned my sexual gender preference for about two weeks after my first intimate heterosexual experience, but I soon discovered the pleasure of heterosexual sex, although I rejected the overt sexuality expressed by many men. Following that, I struggled with traditional macho masculinity, equating it with my violent, detached father.

Consequently, I embraced the metrosexual identity for many years, developing orthorexia (a form of obsessive-compulsive eating, usually resulting in anorexia) through vegetarianism, which I believe I used to avoid seeing my father in the mirror. I became a business owner at 29 years old and began to express domineering masculinity fuelled by my newfound power as an employer. By age 32, I realised that it was not a successful strategy in my personal life or my business. I was attracting all the wrong people. I began a change to humanist ideals, eating better and approaching each person with unconditional positive regard, which I later learned is successful in counselling psychology (Corey et al., 2017). This new awareness allowed me to re-engage with my father, and I managed to build a relationship with him in his last ten years which almost made up for the previous 32 years of detachment. I cannot stress enough what I learned from this: the importance of adult men engaging with their fathers no matter what the past sins of the father were. We cannot be complete, wholesome, wiser men if we have not faced the man who brought us into this world.

It is beyond the scope of this paper to debate toxic masculinity. Instead, I will highlight the excellent work being done by male-run programmes which seek to assist men around the world to develop *positive masculinity* (Enderstein & Boonzaier, 2015; Graaff & Heinecken, 2017; Hoang et al., 2013). There is *Respect UK*, which provides support for people who use violence in their relationships*; Men's Shed Worldwide*; working to provide a supportive space for older men; *The Lions Barber Collective*; who use hair grooming as an opportunity to 'recognise, ask, listen and help men' in a mental health crisis.

The popularity and success of these groups represent a new age of men awakening to the potential of a life lived with a self-defined, socially responsive 'readings of masculinity' (Ridge, 2019, p. 207). 'My two decades of research has convinced me that the male brain and the masculine approach to life are vastly under nurtured in our culture' (Gurian, 2011).

Individual identity

In counselling psychology, we allow for the unique identity of the client, even a child at school-going age, to emerge, and we are encouraged to affirm their chosen identities (Corey et al., 2017; Meyer, 2010a). Within the therapeutic environment, this is ethical and allows us to create a bond with the client, respecting their individual path. However, there are contradictions in the curriculum. For example, the theory of *intersectionality*, benevolently presented as an approach to understanding a person's identity as a result of converging identities, roles and circumstances (Beattie et al., 2018). Further inspection reveals the grievance-based political goals of this idea unifying 'power and privilege [and] oppression' (Beattie et al., 2018, p. 239), while simultaneous advocating counsellors use their power to direct individuals through social justice counselling (Crethar, 2008). This theory suggests we are merely members of our allocated, politically convenient groups and cannot have individual agency without creating a victim to the individual agency (Shefer, 2016). As an adolescent in the late 1980s and the early 1990s, I was witness to the change in South Africa, which aimed to have individuals judged by the content of their character not the colour of their skin, as equals. We wanted to free our countrymen from politically convenient categories. Now at 47 years old, I hear how we can imagine new sub-categories which can be useful for political goals (Ramphele, 1990). The change in South Africa required the abandoning of race categories, and optimistically, the class categories which fuel prejudice. Intersectionality would have us sub-divide into new groups of victims all with a new claim on some new common enemy, undoing the efforts of previous generations. Anyone with knowledge of South Africa's long, bloody struggle to democracy will find this obscene and woefully ignorant of the achievements already made by the previous generation.

Nevertheless, utilising an individual agency is advocated in counselling and community psychology (Butchart & Seedat, 1990). There seems to be a political-activist agenda at play alongside, but not complementary to the best-practice tools essential to successful counselling psychology. Intersectionality appears to be a political tool to unify the victim against the oppressor. This oppressor is allocated by the latest trend, which would only be useful in what has been called the global industry of victimology (Ramphele, 1990).

Community development

Community development is a fundamental goal in a nation like South Africa. Rural areas were held back by apartheid for five decades. Community psychology practises within this area of community work. Initially, the module Community Development appears to be a practical approach based on a learning curve from the efforts of nations and NGOs working to improve the developing world, and people living in poverty (Ansari et al., 2012; Bradshaw, 2007; Bruursema, 2015; Nesamvuni et al., 2016; Swanepoel et al., 2016). Here again, ideologies infiltrate to conflict with nationalist and political goals which are usually a cover for corruption (Ake, 1996; Hope & Chikulo, 2000). Gender-based programmes which use Western feminist, moral ideals have already created havoc where people are living in poverty, depending on the culture of the community, sometimes causing the deaths of those it professes to help (Balasubramanian, 2013; Posso & Zhang, 2017). In Africa, we do have a conflagration of culture and gender roles which act to perpetuate the cycle of GBV, HIV, and poverty (Dunkle & Decker, 2013). While we have a progressive constitution on paper, we have a disconnect with the rural community (Wlokas et al., 2017). Governments' goals seem to conflict with best practice in community development approaches. Further investigation, concerning South Africa, gives us a picture of corruption and traditional patriarchy. This combines to hobble development and keeps rural areas locked in the deprivation trap (Ake, 1996; Hope & Chikulo, 2000; Thwala, 2010); 'with few exceptions their rule has been notable for oppression, corruption, social disorganisation, the demise of the development project, and growing poverty' (Ake, 1996, p. 153).

Rather than applying Western elite progressive ideals on deprived rural communities, the determined community development work would be well advised and more effective by increasing the social capital. The literature assures us that communities building social capital can 'facilitate the actions of individuals in them' (Villalonga-Olives & Kawachi, 2015, p. 62). I discern social capital here as distinctly opposed to the victimology of identity-based theories. Social capital can be refined into *cognitive*; trust, sharing and reciprocity between members of the community, and *structural* social networks and patterns of civic engagement (2015, p. 63). This approach values individual agency and the circumstances of the

community while holding those with power accountable for violations of trust. As long as orphans are being used as child slaves in deep rural areas to fetch water from dry river beds (Mbambo, 2012), we cannot afford to be distracted by imported lofty ideological goals. We should be sceptical of theorists who never have to face the real-world consequences of their theories, applied inappropriately on cultures which have not had the privilege of economic development (Ake, 1996).

Gender diversity

The gender debate has polarised our society. On one side, we have well-meaning gender diversity advocates who would have LGBT (lesbian, gay, bisexual, and transgender. On the other side, we have those who feel it is a degradation of the traditional norms in society and rally against its acceptance. Studies are showing broader acceptance of LGBT rights in developed liberal societies (Kosciw & Gay, 2014; Meyer, 2010b; Twocock, 2019). However, this sexual liberalisation is not happening in South Africa (Butler et al., 2003; DeBarros, 2018; Mitchell & Nel, 2017; Müller, 2017; Reygan, 2016). The resistance to sexual and gender diversity is well known in South Africa and exists at all levels, from minors to national political leaders (Mitchell & Nel, 2017). Studies in South Africa suggest that acceptance of radical Western gender diversity ideologies is unlikely. There is open defiance of the liberal laws in our constitution which has allowed same-sex marriage since 2006 (Anderson, 2018). Legally, the rights of LGBT protect individuals in South African law, but practically they are victimised, raped and even murdered daily.

Aggravating this conflict of goals are the new ideas coming from the West, which enter higher education first. As described by Reygan (2019), in South Africa 'poverty, inequality and exclusion are often rightly understood in terms of race, class and gender' (p. 90); this is well-meaning but highbrow theory while we have LGBT adults abused because of their HIV status in hospitals (Müller, 2017). I cannot help being sceptical; we have critical leadership, cultural and economic challenges before we can start turning children into gender diversity advocates at school. Their parents are struggling to survive in absolute, generational poverty. We may be increasing their risk. As formidably discussed in *From psychology in Africa to African psychology: Going nowhere slowly*, Makhubela (2016), I too worry we will be participating as 'accessory to domination' (p.1) by adopting lofty Western, or colonial ideals while ignoring emic, locally respected solutions. This respectful approach would have the added benefits of increasing the cognitive and structural social capital for South Africans, thereby disarming the blanket rejection of science by the 'decolonise' radicals, which aims to remove Western influence. An increase in social capital appears to be the key to arresting corruption and allowing people living in poverty to lay claim to their heritage which is being squandered by politicians (for more detail see Hope & Chikulo, 2000). We, as South Africans, should be adopting science-based developments free of Western cultural and ideological influences on progress in a society as fragile and diverse as South Africa.

There are new brave voices in this debate. Research is improving our knowledge of gender de-transitioning and the effects of social media on social contagion as described in *Irreversible Damage* (Shrier, 2020). This book details how young girls are lured by the trans trend on social media to transition permanently to boys, often undergoing detrimental chemical and surgical intervention to their development (Shrier, 2020). Another controversial book *The End of Gender* (Soh, 2020) by sexologist and neuroscientist Debra Soh, clarifies the science behind gender and warns of the pressures to comply with the narrative of gender being socially constructed. We should consider that 'research continues to accumulate, showing that gendered power flows in different directions, mediated by other factors, like ethnicity' (Ridge, 2019, p. 210).

Further, although I accept that gender-roles are locked in problematic traditional practices, thereby keeping communities locked in poverty, the community development literature does not support irresponsible disruption to traditional cultural norms (Ake, 1996). As described in a short paper discussing the difficulties a Namibian male faced when trying to study psychology, Plattner (1999) reminds us that intellectuals living in developed areas tend to romanticise rural customs and traditions. 'Individualism is often declared to be selfish and egocentric, while the restrictions of collective norms are overlooked' (Plattner, 1999, p.475). Collective norms are called *Ubuntu* in South Africa, which denotes unique, almost mythical traits to African society. However, Makhubela (2016) alerts us to the contradiction; Africans cannot exclusively claim this worldview. After all, this can only prove that African experiences are

universal experiences, shared by other human beings and not as unique as some in the current African psychology discourse would want us to believe (p. 9).

A re-evaluation of ideology would mean we would review attempts to use Western theories to sexual and gender diversity in education and instead develop emic approaches. These methods can be based on science, which can still be sensitive and respectful of the culture and circumstances and allow them to find their path.

A duty to do no harm

As students, we adopt the ethics of 'do no harm, which implies that we should put the needs of the client first and work to put aside our personal biases and moral values. The aim is to remove coercion and judgement from the therapeutic environment, thereby allowing the client to feel safe, accepted, supported and free to grow at their own pace (McLeod, John & McLeod, Julia, 2011). While, as a student, I accept that the learning experience must be challenging and have moments of discomfort, I wonder if theories like intersectionality and diversity have strayed into harming Generation Z adolescent students rather than preparing them for the therapeutic relationship. They did not sign up for social justice activism; arguably, this generation is ill-prepared to rationalise the complexities of society's ills. Are we prioritising the ideology of a few adults over the healthy development of these adolescents into useful counsellors?

As it is, we have a fiery debate about the utility of Western psychology in Africa (Makhubela, 2016). In a later paper, Makhubela (2018) rails against 'liberal ideology' (p.1) enforced by Western knowledge systems. Potentially, his piece successfully dismantles the value of diversity in favour of decolonisation in South African Universities. He begins by declaring the 'farcicality and impossibility of strategies, attendant ideologies' (p. 1), referring to the ideals of diversity, multiculturalism and the *Rainbow Nation*, which was introduced by Nelson Mandela at his inauguration as first democratic president in 1994.

> We enter into a covenant that we shall build the society in which all South Africans, both Black and White, will be able to walk tall, without any fear in their hearts, assured of their inalienable right to human dignity - a rainbow nation at peace with itself and the world (Mandela, 1994).

I mention Makhubela's 2018 paper not because I agree with his argument for decolonisation; I do not, but instead to show that weak western theories have their antithesis in reactions like what Makhubela (2018) calls radical 'decolonisation… a refusal to participate in the structures of our subjugation' (p. 17). This assumes perceived power and oppression structures, theorised by various activists, are deliberate and work to sustain this 'subjugation'. Fortunately, there is resistance to these radical 'theoretical and practical dead-ends' (Long, 2016). I am advocating for caution when importing ideas hatched in safe, prosperous societies that do not merge productively with the conditions in countries like South Africa. As a secondary effect, I am concerned that adolescent students are confused and conflicted by the mixed messages in the contradictory theories presented. Further, we may be driving away potential counsellors by alienating well-meaning, but not 'activist' males and students of colour.

In particular, I notice the males in my cohort, myself included, struggle to motivate ourselves against the tide of feminine and feminist characteristics embedded in psychology. As proposed by Westwood and Black (2012), counsellors should develop feminine and masculine nurturance in their counselling skills (p. 287). The issue of transference and countertransference, in particular regard to males counselling females, does not get enough attention. I want to engage with the risk of eroticised transference to pre-empt problems I may face in practice, as many other male counsellors already have. The issue is briefly noted in the curriculum, but the risk to male counsellors is 'glossed over' (for more see Alvarez, 2010; Blum, 1973; Guttman, 1984; Jackson, 2017). There is a bias towards feminine traits in society and for counselling. I would have masculine nurturance skills and the male perspective addressed in one module. This approach would welcome males into psychology and provide a resource to men seeking male-friendly therapy.

CONCLUSION

I have attempted to build a picture of psychology as perceived by an adult male student in South Africa. In this process, I have pointed out the contradictions and incoherence of clashing ideals in the material we are exposed to. Along the way, I have mentioned the male experience in psychology. This opinion is generated from my observations but also from discussions with other adolescent male students and a few of the female students who have cause to defend equality. The bias toward feminine material is not unique to my college (see Boonzaier & Shefer, 2006; Westwood & Black, 2012), although thankfully, the atmosphere here is respectful and interactive. However, it cannot be disguised from the material and leaves the males feeling powerless to challenge theories. I have suggested to my colleagues that they add male psychology literature to their onsite library to mitigate this effect. Finally, I am concerned about incoherent ideology, which threatens to devalue the field of psychology in developing societies, with its conflicting and incompatible theories. I suggest this is what is 'going wrong' in developed societies, as evidenced by the COVID-19 lockdown riots, but also by the rejection of all Western ideas by radical decolonises, and the failure of psychology to attract men to counselling. As the adults in the room, we may be alienating people of colour and males, yet advocating for more inclusive practices at the same time. This is causing erosion of trust and is a tragedy leading to the abandonment of the most vulnerable in developing societies to untried, untested, and unscientific methods. Rather than distract those with good intentions, we are duty-bound to nurture them to face up to mental health, gender-based violence, gender equality and ultimately the poverty which fuels it all.

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Delta bias in how we celebrate gender-typical traits and behaviours

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Cognitive biases and distortions are a common feature of the human condition. In gender research, two biases are well established: *alpha bias* which is the tendency to highlight sex differences and *beta bias* which is the tendency to minimise or play down sex differences (Hare-Mustin & Marecek, 1988). Last year we introduced the theory of *gamma bias*, which is the simultaneous shrinking and magnifying of gender differences (*alpha* and *beta bias* combined) resulting in the distortion of public perceptions of masculinity towards the negative and femininity towards the positive (Martin Seager & Barry, 2019). We now build on this theory by introducing a further concept: *delta bias*. Delta bias may be defined as the simultaneous denigration or celebration – depending on the gender of the performer – of an archetypal masculine gender behaviour or characteristic. This is similar to the 'celebration' aspect of gamma bias, except that delta bias emphasises how celebration tends to occur where the behaviour is gender atypical.

Keywords: cognitive biases; distortions; gender differences; masculinity; sex differences

Delta bias may be defined as the simultaneous denigration or celebration – depending on the gender of the performer – of an archetypal masculine gender behaviour or characteristic. This is similar to the 'celebration' aspect of gamma bias, except that delta bias emphasises how celebration tends to occur where the behaviour is gender atypical. Delta bias can be illustrated in terms of the three male archetypes as defined by (M. Seager et al., 2014). Each of these archetypes can be shown in contemporary public media and political discourse to be simultaneously celebrated if exhibited by females but denigrated if exhibited by men.

Fight-win

Competitiveness combined with an aggressive ambition to win or succeed is currently valued publicly as an attribute in women and girls (as positive ambition and achievement) but simultaneously devalued in men and boys (as dominating, macho or 'traditional' behaviour). Delta bias could partly, therefore, offer one explanation for society's obliviousness to the significant underperformance of young men and boys in schools and university entrance since the 1980s (Liddon & Barry, in press). However, in everyday life, it is not clear that women are ceasing to find men competitive and successful men attractive.

Provide-protect

In the same way, traditional masculine attributes of hard work, career aspiration, supporting families, promotion, leadership and earning power are currently celebrated and encouraged in women as highly positive qualities but simultaneously are viewed with great suspicion in men as likely signs of a dominant, selfish or 'patriarchal' attitude. Again, however, while such a distorted narrative may be operating in public discourse and policy, it is not at all clear that this has changed the dynamics and preferences of women in their everyday lives relating to attraction, mate selection, and the acceptance of male protection.

Mastery-control

Similarly, the archetypal masculine attribute of keeping emotions under control and focusing on task performance (especially under pressure) is increasingly valued and celebrated in women, for example in sport and business circles. However, what is now valued in women as strength is increasingly denigrated in men as 'macho' and a character flaw. At the same time, men are consistently criticised in contemporary Western societies for not 'opening up' and showing their emotions.

The same level of delta bias does *not* generally apply to the three female archetypes (Seager et al., 2014) which retain respect and value. These archetypes are now still celebrated in women more than men. Men are not highly valued if they encroach in these domains, but they are also criticised for not aspiring to them.

Beauty-glamour

The beauty ideal continues to be valued primarily as a feminine attribute. Beauty is usually revered, though the aspiration to beauty as a sole aim in women has been increasingly questioned. However, the female beauty or glamour archetype is still celebrated, as most obviously evidenced by supermodels. Even males who copy the extreme feminine ideal ('drag queens') are celebrated and not denigrated.

Child-rearing/caring/nurturance

Childcare is still valued as a primarily female attribute, as enshrined in terms of legal rights and social policy relating to child access. While motherhood as a sufficient aspiration in itself has been increasingly questioned, motherhood *per se* has not typically been denigrated. While women are increasingly expected to seek paid employment outside the home, many women gravitate to careers in childcare and the caring professions. Though men are increasingly criticised for not entering the domain of childcare, they are often not highly valued if they do so, and may also attract suspicion.

Family harmony/home-making

This archetypal behaviour is valued less in women than in previous generations. Men are increasingly criticised for not aspiring to this archetype, but also are not highly valued if they do exhibit such behaviour

CONCLUSION

Male archetypes (often misrepresented as stereotypes) are still accepted in today's Western culture but are celebrated most noticeably when these traditional male behaviours are exhibited by women and girls. In effect, this means we, as a culture, are reversing our attitudes and expectations of the genders rather than changing anything fundamental or 'progressing'. Even if this were a successful enterprise it would result in nothing more than a mirror image of traditional gender patterns. Male archetypes are now socially and politically devalued or questioned if pursued by males but celebrated if pursued by women. Female archetypal behaviour is still largely valued. The role of 'housewife' may now be said to be devalued for women but men who perform this role are not highly valued either.

The impact of all this could at first glance be seen as simply the equivalent of making guitars sounding more like pianos and vice versa, as according to *The Beatles'* drummer Ringo Starr, was attempted in the making of their iconic album *Sergeant Pepper's Lonely Hearts Club Band* (Cable News Network, 2014). This probably seemed like a great idea at the time and was at great cost to studio time but arguably added little to an otherwise inspired record. In gender terms, then, the archetypes are still there in the mix, as is inevitable if they truly are evolved archetypes. Socially and politically, we have simply reversed how we attach value to these archetypes. However, musically we do not devalue guitars or pianos by swapping them, however wasteful the enterprise. In the domain of gender, however, we no longer see masculinity and femininity as equal and essential elements in a harmonious musical palate (Yin and Yang) but have valued some (feminine) sounds above others (masculine), thus creating potential and actual disharmony. We are valuing a guitar *only* if it sounds like a piano.

The net impact is a constant pressure to split men from their evolved archetypes while largely allowing women to aspire to male archetypes and at the same time largely preserving their female archetypes. Women can therefore remain *archetype-congruent* and at the same time be celebrated for venturing into characteristically male behaviours. Men on the other hand are under pressure to move away from male archetypes while being offered no equivalent honourable admission to female archetypes. This is damaging for us all, men, women and children but especially men and boys. There is a crisis but not of masculinity itself, but rather in terms of society's stigmatisation of masculinity as 'traditional', 'rigid', and 'dominant'. Men can no longer fit comfortably even within their gender archetypes while women can enjoy increasing freedom and comfort within both sets of archetypes. In musical terms, the guitar is in effect being lowered in the mix and the piano made louder; the guitar is still there to be heard, but only celebrated and turned up if played by a pianist. We might speculate on the implications for the well-being of men and boys of experiencing restrictions on the expression of their masculinity. For example, if a boy grows up sensing that his competitiveness is frowned upon, how does he cope with this? What happens to his competitive energy if he tries to reign it in to comply with the wishes of others?

Perhaps the real question is how far these attitude changes penetrate through all layers of society. Are they mainly beliefs that affect those who have influence and power, in other words, journalists, politicians, lawmakers, teachers, and academics? And are these attitudes as evident in the private actions of these influencers as they are in their public speeches? Are people who attend university more vulnerable to these views? Do older people share these views, and do people retain these views to the same extent as they grow older?

If the delta bias hypothesis is correct in its reference to gender archetypes – as opposed to stereotypes – there will be a large body of men and women who find their archetypal gender instincts and gender differences far less problematic – and perhaps much more life-enhancing – than suggested by the prevailing narrative encouraging gender-atypical behaviour. To the degree that the currently prevailing narrative is promoting a social construct of gender, it might be expected that evolutionary imperatives

will cause the pendulum of gender role erasure to sway back to something more inclusive and accepting of archetypal masculinity.

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How much are therapists' views on patriarchy related to their approach to therapy for men? Preliminary findings from a survey

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In the past few years, guidelines have been published which encourage therapists to see masculinity in relation to power, privilege, and other constructs from 'patriarchy theory'. The brief notes presented here are based on findings from the first responses to a survey of therapists (psychotherapists, clinical psychologists etc) on how they view masculinity in their work. Based on the first 25 respondents who described their practice in detail, it was found that those who made efforts to practice in a male-friendly way (e.g., accommodating male-typical communications styles) compared to those who took a gender neutral approach to male clients, endorsed significantly less the view that patriarchy prevents women from having equal rights (t = −3.334, df = 23, p < .003, two-tailed). This finding is discussed in relation to the potential impact of therapists' views on gender and how they work with male clients.

Keywords: feminism; masculinity; patriarchy; therapy for men; training for therapists

Recent guidelines for psychologists who practice as therapists with male clients make assumptions about gender, such as the notion that masculinity is just a social construct without any influence of biology, and that masculinity is problematic due to the influence of patriarchy (American Psychological Association, Boys and Men Guidelines Group, 2018; Johnstone et al., 2018), These guidelines raise a number of questions, for example: (1) To what extent is this view of masculinity supported by evidence in comparison to other theories? (2) To what extent do psychological therapists working with male clients subscribe to such views of masculinity? (3) To what extent is therapy that is influenced by these views safe and beneficial for male clients?

The first question has been extensively researched, though many of the findings are conspicuously absent from much of the discourse on masculinity (Liddon & Barry, 2021). The second and third questions have received much less attention. The third question is vital, yet remains largely overlooked. The aim of the present paper is to address the second question.

During October 2020, attitudes towards masculinity were surveyed in a snowball sample of therapists (clinical psychologists, psychotherapists, etc). The setting was online, and the questionnaire was designed for the present study. The survey followed ethical guidelines e.g., informed consent was sought. The preliminary results were interesting, so the decision was made to share these findings with readers of this special issue of the *Psychreg Journal of Psychology* (PJP), who will have a particular interest in male psychology.

Forty-four therapists have responded to the survey so far, 25 of whom met the inclusion criteria and had completed a sufficient amount of the survey for analysis of their approach to therapy with men. Of these 25, the characteristics of the therapists were: mean + *SD* age 56.4 + 11.6; 96% (24) Caucasian; 68% (17) male; 60% (15) in stable relationship; 88% (22) heterosexual; and 56% (14) based in the UK. The types of therapies were: psychotherapy 44% (11); clinical or counselling psychology 24% (6); counselling 24% (6); other psychological therapy 8% (2). They had an average of 13.9 years in practice (post-qualification), and the ratio of male to female clients was approximately 49:51.

Participants were asked, as per (Barry et al., 2020), how much therapists agreed with the following three statements: I am a feminist; Women should have equal opportunities to men; and Patriarchy prevents women from having equal rights to men; 28% (7) of participants moderately agreed or more than they were feminists; 100% moderately agreed or more than women should have equal opportunities to men; 32% (8) moderately agreed or more that patriarchy prevents women from having equal rights to men.

Like Mahalik et al. (2012) the therapists in the present study were asked to describe what, in their experience, good practice with men and bad practice with men. Twenty five therapists answered, and their suggestions grouped by content analysis as either consciously male-oriented (e.g., being aware of male-typical preferences for therapy such as being more solution-focused than feelings-focused; $n = 12$), or gender neutral (e.g., treating male and female clients in the same way; $n = 12$). The therapists who did gender neutral rather than overtly male practice significantly agreed more than the male-oriented therapists that patriarchy prevents women from having equal rights to men ($t = -3.334$, $df = 23$, $p < .003$, two-tailed). There were no significant differences based on therapy style in the answers to the questions on feminism or equal opportunities. This suggests that the therapists who think patriarchy holds women back are significantly less likely to use male-oriented approaches with male clients.

Our survey, which is one of the first of its kind, shows that in the vacuum of research and clear guidance on what therapeutic approaches actually work for men, the personal attitudes of therapists towards masculinity are likely to influence the style of intervention that men are currently being offered.

Although there is evidence from therapists (Liddon et al., 2019) and the general population (Liddon et al., 2017) than men have slightly different preferences for therapy than women do, the key questions are: (1) do the findings of the present study replicate in a larger sample, and (2) is a gender-neutral approach any different in terms of safety and efficacy than a male-orientated approach. Also, given than men seek help from psychological therapists less often than women do, will a male-orientated therapy appeal more to men and make them more inclined to seek help?

Future directions for research might include comparing the appeal of different styles of therapy to men and women, and the outcomes of these therapies. This will help ensure that future teaching and training of psychologists, counsellors and therapists can be based on a scientific foundation.

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An open message to the APA on ethics and ideology

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This letter is a transcript of Dr Shawn Smith's YouTube video on this topic, available online: *https://youtu.be/33y6fXECg9Q*

Greetings American Psychological Association! My name is Shawn Smith. I'm a clinical psychologist in Denver, Colorado. I've spoken to you before. You might remember my critique of your guidelines for working with boys and men.

Incidentally, you never responded to my invitation to discuss those guidelines. I'm not going to lie, that hurt. But I can't stay mad at you, APA. You're so darned cute when you play hard-to-get. So today, I'm going to take a different approach. I'm not going to yell at you about methodology or challenge you to a debate. I'm going to be nice, for the most part, and see if we can find some common ground about better serving our clients. *I'm going to make you love me.*

So, let's get down to business. Our profession has been consumed by a dogmatic ideology, and it's creating serious ethical problems out here on the front lines. You, the leadership of the APA, are in a unique position to get our profession back on track, and today I'm hoping to persuade at least some of you to try.

This problem of ideology in our profession is not new. I was speaking up about it a decade ago when I saw social psychologists producing passive-aggressive, low-rent studies claiming that conservatives are mentally inferior to liberals.

Those papers were really just editorials masquerading as research, and they were a symptom of a much larger problem that plenty of people were already aware of.

For example, this 2012 study uncovered open hostility against conservatives within our own ranks. Back then, conservative psychologists – both of them – were afraid to reveal their political leanings because doing so might harm their careers, and they were right to be anxious. Their liberal colleagues openly admitted that they would discriminate against them because of their political beliefs. In fact, the more liberal the respondents were, the more enthusiastically they said they would mistreat their conservative colleagues.

That was a simpler time. Open hostility was something psychologists merely inflicted on each other. Just good, clean fun in the halls of academia. Well, that was then, and this is now.

This political ideology, with all its malevolence toward those who don't toe the line, has leaked into the clinical world like the contents of a busted sewer line. The ideology has grown, it has mutated into a more aggressive strain, and it's harming people.

We all know which set of ideas I'm referring to: I'm talking about progressivism, social justice theory. Those beliefs that are based on intersectionalism and critical theory, and that view the world through the lens of power structures and identity politics.

Some of the APA's recent publications make it clear that at least some of you enthusiastically endorse this ideology and its political aims. And for my part, I've made it clear that I view this ideology as intolerant and destructive. So, we disagree, but I'd like to set that aside. My hope is simply to convince you that our profession shouldn't be dominated by any political ideology because when we allow that, we create winners and losers among the people we serve.

Now, because I'm outspoken about this problem, I hear from a lot of people who feel unwelcome in our profession. Again, it's not my intent to beat up on you here, but it so happens that a lot of the complaints I hear are a direct result of the APA's guidelines for working with boys and men. That's just my little self-selected group of people who feel comfortable approaching me, so take it for what it's worth. And it's not to say that the APA has singlehandedly created this problem. You haven't. The problem is less with any particular player, and more with an ideological monoculture that dominates our field.

Let me give you a small sample of what I'm talking about. This year alone I've been approached by roughly 100 people like these men seeking my advice on how to find a psychologist whose judgement isn't biased by a progressive political agenda. Many of them have been fathers seeking help for their sons. They're concerned that finding the wrong clinician would mean their sons receive judgement and indoctrination rather than treatment.

Others are men seeking help for the first time and they're concerned about being misunderstood and pathologised. Many of them specifically mention their concerns about the influence of radical feminism, and some are concerned about antipathy toward conservatives and Christians. These guys just want to know that they'll get a fair shake in our offices.

There are also students and trainees who feel ostracised or silenced. So far this year, I've heard from about a dozen students seeking my advice on how to find graduate programmes that focus on clinical skills rather than ideological indoctrination – like this student who is nervous about navigating what he calls an 'overly woke culture' as he tries to move up in his studies, or this undergraduate who has already experienced what he describes as 'hostile groupthink' in his classes. And then there are clinicians. I've heard from several this year who are exasperated with the expectation that they replace clinical judgement with ideological conformity.

For example, one psychologist who wrote me, works in a large institution that treats an underserved population. They told me they're resigning because of the militant ideological turn the agency has taken over the last few years.

I can't share the details because this person fears reprisal if they're identified, but I want to be clear: this is a seasoned, doctoral-level clinician who is self-censoring on clinical matters in order to avoid retribution from an ideologically possessed administration. It's hard for me to imagine that the clients of this agency will be well-served by this person's absence.

Paul Meehl pointed out way back in 1973 that our patients pay a heavy price when we throw out critical thinking and replace it with intellectual uniformity. He was writing about a less pathological form of the problem, but the principle still holds.

These are just a few examples of what's going on out here on the front lines, and in each case, the alienation these people experience is the direct result of a progressive ideology that is flat-out hostile to people who hold alternate opinions. Again, I'm not trying to beat upon you, but the APA is part of the problem by sending the kind of divisive messages that seem pervasive in our profession.

Aside from openly advocating for political activism in the clinic – as you did in your guidelines for working with boys and men – there is a steady drumbeat of political messaging from the APA. For example, a few

weeks ago, the APA wrote a letter to Mark Zuckerberg recommending that he ban hate speech on Facebook. The letter didn't define hate speech, which is a very sticky problem, but you made the argument that banning it, whatever it is, is good for mental health.

For some of you at the APA, restricting people's speech may seem like a perfectly reasonable and uncontroversial thing to do. Maybe you don't realise that most Americans disagree with you. Maybe you're all stricken with that special academic illness of never having encountered anyone who disagrees with you.

So, you may not realise that you've taken a rather radical position on one of the fundamental points of contention between the American left and right, which is whether to prioritise safety over freedom, or freedom over safety. I'm not mad at you for being on the progressive left, as long as you campaign on your own private time.

But when you speak on a topic like freedom of expression, and you're doing so in the official capacity of our profession's highest authority, it gives the impression that collectively we either don't know or don't care about those who are reasonably suspicious of people who want to regulate speech. *The strongest weapon against hateful speech is not repression. It is more speech.*

Here's another example of the kind of idea that pervades our profession and alienates people: It's the APA's recent showcasing of the idea that, quote, 'Every institution in America is born from the blood of White supremacist ideology and capitalism – and that's the disease.'

Now I happen to be familiar with postmodern philosophy and critical race theory, and so I realise that to some of you at the APA this sounds like reasonable discourse. This is probably your version of pillow talk; I understand that. But I hope you can understand that that level of rhetoric is unsettling to those of us who happen to not be wild-eyed Marxist revolutionaries.

You might try some deep-breathing exercises because, frankly, this stuff makes it sound as if your hearts are filled with rage, and that's not what anyone is looking for when they hire a psychologist.

The divisiveness doesn't stop at philosophy. The APA, again reflecting the culture of our profession, also has a habit of taking specific policy stances for which a group of shrinks has no formal expertise – things like climate policy, immigration policy, economic policy – always presented with the not-so-subtle insinuation that the progressive opinion is the opinion that correlates with sanity and virtue.

So, you're all psychologists. If you employ some theory of mind, do you imagine that people who disagree with your progressive ideology are more or less likely to seek us out if they believe we already think they're crazy? Here's another question to chew on: what message is the APA sending to frontline clinicians about using professional influence to push an agenda?

You don't mind if we push a progressive agenda, but what if there are psychologists who want to use the therapeutic relationship to persuade their patients to vote for Republicans because research says conservatives are happier than liberals? They could justify it, just as the APA does, by saying it would improve mental health. Would you be OK with those psychologists following your example? Let me take a guess. *How about no?*

Look. You're a private organisation. You can take any stance you want. And again, I don't mean to pin the problem on the APA because the problem is much bigger than the APA. But you are the leaders of our profession. You set the tone. You set the expectations. And if we are in fact a healing profession, then I simply don't see the morality in alienating entire groups of people.

So how do we fix it? Well, smarter people than me have written at length about the importance of cultivating ideological diversity on the academic side of our field. I agree; I think that would improve every corner of our profession.

I also think it would take a very long time to implement – if it's even possible – and it would take even longer for those changes to flow into the clinic and reverse the damage that's already being done. Luckily for you, I'm a simple man, and I see a simple solution to this problem.

The APA could usher in a new era of tolerance and inclusivity, and it wouldn't involve any new rules, or initiatives, or funding. It would simply involve enforcing the very first principle of APA's code of ethics. I'm sure you're all familiar with Principle A. It's the one that says psychologists shouldn't misuse their influence by advancing their personal agendas while they're on the clock.

Now, I look around, and I see clear violations of that principle flowing straight into the clinic from academic and administrative leaders. When people who need our services avoid us because they feel ostracised, it's because someone has been misusing their influence. When psychology students can't explore ideas without being shouted down by the righteous mob, it's because somebody has been misusing their influence. And when clinicians are forced to stifle themselves to protect their pay checks, it's because someone has been misusing their influence.

Now, since the APA holds so much power in our profession, particularly through the tremendous power of accreditation, you're in the unique position to set a new tone for tolerance. You can remind psychologists that it's our job to serve our clients, not our politics. At the very least, you could require psychologists to disclose their agenda if they view the clinic as the place to advance feminism or to dismantle Western power structures, or to do whatever it is therapists do when they don't know how to do therapy.

If therapists abided by the rules of informed consent, then clients and insurance companies could decide for themselves if they want to pay to be preached at, or if they'd prefer to work with someone who takes their job a little more seriously.

But hey, I don't need to tell the APA about informed consent. You all practically invented the concept. In your own code of ethics, you clearly state that psychologists must inform clients as early as feasible about the nature of the therapy, so if the nature of the therapy includes any form of political persuasion or any ideological framework that shapes the therapy in any way, then certainly that needs to be disclosed at the outset, am I right? I mean, I don't see another way to interpret that phrase. However, I am aware that there are a couple of roadblocks.

The first problem is that some of you are shameless ideologues who see no problem here. I know from experience that some of you think progressive ideology is simply the correct point of view. To you, something like critical theory is no more controversial than the Golden Rule, so nothing needs to change. And you're absolutely certain that you're right because all the smart people you hang out with agree with you, or at least they let you believe that. If that's you, I wish you would get out more. There is no intellectual monoculture among our clients. It may appal you to hear this, but some of them do unsavoury things like pump iron and vote for Donald Trump. Some of them even shop at Walmart.

And some of them would rather write off our profession entirely than hear one more word of your precious worldview that in no way resembles the reality of their daily lives. So that's the first problem. Some of you are heartless ideologues who don't give a damn about the collateral damage as long as your side wins the war of ideas. There's a second problem. It's equally troubling in my view, but it's more insidious. It's that some of you know I'm right. I'm not telling you anything new. You already know there's a serious problem here. You already know people are getting hurt. And ff you're not speaking up, then let's call it what it is: expediency.

I'm not unsympathetic. You've all worked hard to earn nice positions of influence within the hierarchy of our profession. But let's be honest: you probably didn't get there by challenging the culture in any meaningful way. It's not easy to go against the grain in positions like yours, especially in the current climate. This ideology that has gripped our profession… it has a vicious streak, and anyone of you who advocates for tolerance runs a very real risk of being labelled and treated like an apostate.

So, the smart thing to do is to write me off as some crackpot out in the sticks who's just waving around a few anecdotes. That's what a rational person might do because there's no downside to ignoring this problem. Just avert your gaze.

You'll never know how many potential patients don't seek our services, and how much they and the people around them will suffer for it. You'll never know how many brilliant young minds avoid taking up our profession because they don't want to deal with an abusive mob of social justice warriors. You'll never know what innovations we might have developed if clinicians and researchers had the ability explore ideas without risking their careers.

None of you will ever personally experience those costs. So, you're better off ignoring the situation. Take the path of least resistance. Your colleagues will admire your agreeable nature, and you'll get promoted right on schedule. All you have to do is toe the line. And that's the tricky thing about ethics. Sometimes there are powerful incentives to turn a blind eye while a situation deteriorates, but it's precisely times like this when a strong ethical compass is most necessary.

So, I hope you'll think it over. Take care.

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