ARTICLE

Are mental health services inherently feminised?

Linda Morison, Christina Trigeorgis and Mary John investigate

A man entering mainstream NHS psychological services will correctly perceive this world to be predominantly populated by women. He might wonder if such services are meant for him – will he be misunderstood or judged, will he be forced to talk about his feelings?

So are mental health services indeed 'feminised' and therefore off-putting to men? This can be considered from a number of different angles – the gender of those who provide psychological services; how policies and services potentially influence men's ability to access help; and whether men might experience the psychological interventions provided as feminised and therefore not appropriate or helpful for them.

questions

In what ways might mental health services be particularly off-putting for men who need help?

Why do we need to recruit more male applied psychologists?

resources

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Take a look at the graph on the right, which we have compiled from various data sources (available on request). It shows the sex of the staff who provide psychological help in England. The vast majority (around 70 per cent to 85 per cent) are women, and there is no reason to expect that it might be different in other parts of the UK or the West generally. Women also predominate in the immediate management of psychological services, with around 65 per cent of managers being women.

The Equality Act 2010 requires organisations – including the NHS – to ensure that services do not discriminate between men and women, and it also actively promotes equality of opportunity for both sexes. Given the disproportionately low number of men working in frontline mental health service provision in the UK, some parts of the NHS are trying to redress this. For example, the British Psychological Society has raised concerns about diversity in the applied psychology workforce and, alongside efforts to recruit from minority groups, is making efforts to recruit men. As an example, the clearing house for postgraduate clinical psychology training courses website (https://chpccp.leeds.ac.uk/Default.aspx) has as its second sentence:

> We welcome applications from people from ethnic minority backgrounds, people with disabilities and men as these groups are currently under-represented in the profession.

It is not clear what impact this message has on applications, but our experience on the clinical psychology programme at Surrey remains of vastly more applications from women than men.

This gender imbalance is echoed in all branches of the psychological therapies (e.g. see Bradley, 2013, expressing concern at the lack of males in counselling training). One reason put forward for this is that applied psychology is associated with the more feminine 'caring' aspects of human nature and, as with nursing, this makes men reluctant to pursue it as a profession. In addition, some argue that being seen as a 'female' profession also bestows lower prestige and levels of pay (Willyard, 2011), therefore deterring men. In our experience as trainers in clinical psychology, male trainees often comment on the difficulty of being a very small minority, amongst predominantly female trainees, female course staff and female supervisors. They say that as well as questioning the appropriateness of clinical psychology as a career for them they also question the extent to which the complexity of masculinity and identity is addressed in the training.

However, the 'lack of men' does not become apparent only at the level of postgraduate training. The number of men applying for and graduating with a psychology degree is disproportionately low. In 2004 only 22 per cent of applications to psychology undergraduate programmes were from men (British Psychological Society, 2004), and more recent data from the Universities and Colleges Admissions Service (UCAS) shows little change. In a previous article in *The Psychologist*, psychology teacher Marc Smith (2011) argues that by the time students choose A-levels, psychology is already seen as a 'female' subject, with boys making up only around a quarter of those who take it. Smith considers as possible explanations for this: the predominance of women among teachers of psychology; the choice of topics within psychology that teachers tend to focus on; psychology's image as less scientific than chemistry, physics and biology; methods of

references

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assessment that favour girls; and the fact that a boy who chooses to study psychology will be in the minority. It is clear that if the proportions of men providing psychological services are to be more representative of the general population, these factors need to be addressed at this early stage.

Who shapes mental health services?

NHS mental health services are shaped by politicians, senior civil servants and commissioners. Unlike the provision of services, women are underrepresented at this level, and in this case barriers to women taking senior leadership roles need to be understood (Kings Fund, 2013).

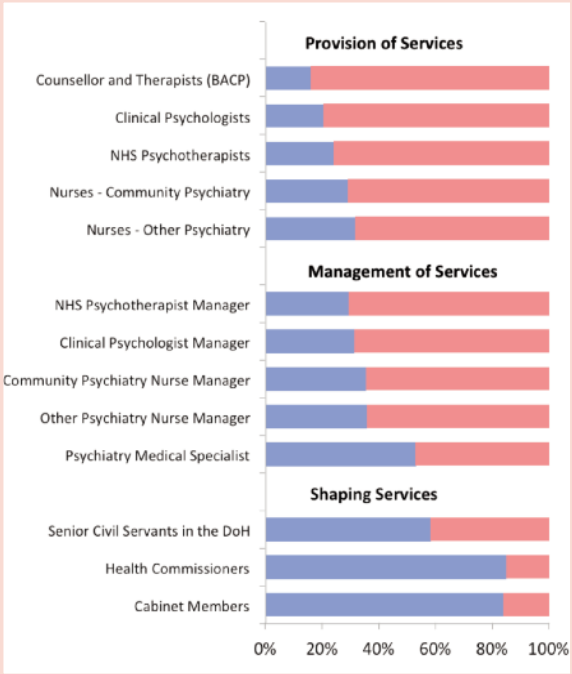
So has the high proportion of men making decisions about services resulted in 'male friendly' services? A decade ago the Department of Health produced a document called 'Into the Mainstream' with the expressed intention to facilitate service providers and commissioners in paying attention to the needs of women (Department of Health 2002). It seems, however, that gender-specific has become synonymous with addressing women's issues, largely because historically it has been women who were disenfranchised. This policy has proved powerful in ensuring services are reorganised to meet the needs of women, but there has been no parallel strategy for men.

This approach is in contrast to that taken by the governments of Australia and Ireland. These two countries have produced policies explicitly articulating the needs of men and paying attention to individual, societal and community contextual factors (Department of Health and Aging [Australia], 2010; Department of Health and Children [Ireland], 2008). However, Richardson and Smith (2011) argue that while these policies identify men's health as a priority there are substantial challenges to implementing such policies, especially when they are not associated with additional funding. The NHS has adopted the phrase 'protected characteristic,' to highlight characteristics such as age, sex and disability that might lead to discrimination. This does provide a potential framework for men's specific needs to be recognised, but there is at the moment no clear policy directive or funding mechanism. As yet, we would argue that the predominantly male decision makers have not conceptualised men's distress in ways that require help through mental health services.

Less accessible to men?

At a practical level one issue that might create an obstacle for men who have some motivation to seek help is opening hours. While employment rates are similar among men and women (77 per cent and 70 per cent respectively) (Office for National Statistics, 2013) the proportion working full-time is larger for men (87 per cent) than women (56 per cent) (Equality and Human Rights Commission, 2013). To this end accessing GPs and specialised mental health help poses a challenge owing to the hours of access, which for the most part fall within the nine-to-five timeframe. Services under the Improving Access to Psychological Therapies (IAPT) programme are available from 8am to 8pm and Saturday mornings, and may thus be helpful to men in this regard. The Department of Health and local primary care trusts require GPs and other services to provide access to health care out of hours. NHS Direct, the 111 service and out-of-hours clinics have begun to provide a means to access such support. However, individuals working within NHS Direct or 111 operate using checklists of symptoms with an associated timeframe of distress. If a person does not fit neatly within the set framework there is an automatic redirection to alternative services unless there is an emergency. The subtlety of men's distress is unlikely to be captured in this process.

Since April 2012 adult mental health services in the NHS have been organised around Care Pathways and Payment by Results. These two processes are meant to promote evidence-based practice that responds to the needs of individuals rather



Where are all the men?

These graphs show the proportions of men (blue) and women (pink) in the provision, immediate management and shaping of psychological services in the NHS (sources available from authors). They show that around 80 per cent of those who provide psychological services are women. The proportion of men increases when we consider the management of services, but the majority are managed by women (around 65 per cent). Psychiatrists, who manage at a more senior level but who also treat patients, was the most evenly balanced category, with 47 per cent being women. When considering who shapes mental health services within the NHS, a different pattern is seen: men make up around 85 per cent of commissioners and cabinet members.

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than just being reliant upon a formal diagnosis. However, diagnosis is still used as a primary method for making decisions about access to services, which leads to a variety of challenges. The way that men and women articulate and express mental and emotional distress is different; in particular, men are more likely to externalise their feelings. Whereas women are more likely to present with anxiety or depression, data show that men are more likely to turn to substance abuse, aggressive behaviour, violence and suicide (Wilkins, 2010). Such men are thus more likely to be directed towards punitive interventions where their behavioural needs may take precedent over their emotional distress. A recent paper describes how differences in the ways men express depression lead to a substantial proportion of cases being missed by traditional diagnostic criteria (Martin et al., 2013). Fear that their distress might be misunderstood and lead to punitive interventions might also therefore make men reluctant to seek help.


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Are the therapies appropriate?

Men might also question how applicable to them the psychological therapies practised within services are. We considered the four main psychotherapeutic approaches adopted within the NHS: psychodynamic, humanistic, cognitive/behavioural and systemic. In all cases the approaches were originated by (white, Judeo-Christian) men. However, many of the ideas underlying these approaches could be seen as counter to traditional masculine norms, particularly the masculine norms of self-reliance and control over emotions. For example, psychodynamic approaches place great emphasis on emotional disclosure and emotional dependence. The humanistic approaches emphasise the provision of an intimate therapeutic environment based on empathy and unconditional positive regard, which might feel counter to traditional masculine norms.

On the other hand, cognitive approaches which emphasise 'rational' thinking and systems approaches (with their grounding in cybernetics) could be seen as being more compatible with traditional masculine norms. However, even the cognitive-behavioural and systems approaches incorporate an empathetic approach and acknowledge the importance of direct emotional disclosure that could be perceived or experienced as un-masculine. This raises the question of whether there is some fundamental contradiction between how psychological therapy is traditionally practised and traditional masculinity, and whether or how psychological interventions can be adapted to reach out to those who conform strongly to traditional masculine norms. Some important preliminary answers to this question are provided by Roger Kingerlee and colleagues in the following article in this collection.

Training and professional development of NHS staff

Training should ensure that practitioners are enabled to adapt their interventions to the diverse needs of the population. This is particularly pertinent for working with men, given the high proportion of female service providers and what is known about male help-seeking behaviour. As far as we are aware there seems to be little included in training curricula to date on the extent to which men and women might have differing mental health needs, the challenges this could raise and potential ways of addressing such challenges. We suggest that closing this training gap is an urgent goal that would be relatively quick and simple to attain.

Once qualified, professionals are required to undertake continuing professional development (CPD). In our experience, CPD seminars relating to men and mental health seem rare, although there are indications of an increase recently. Many psychological services providers work as part of multidisciplinary teams, and it is still possible that an individual practitioner who has a good awareness of men's issues may find themselves in a team that does not share that awareness. The need for team discussion as well as individualised CPD is therefore critical. Given the significant number of women in mental health work, providing space for reflection and consideration of male gender issues is likely to be of benefit, just as considering female gender issues has been beneficial for male practitioners.

Conclusion

We have argued that the lack of men in service provision, combined with arguably feminised psychotherapeutic approaches, is likely to be off putting for men who are known to be less likely to seek help in the first place. There is an urgent need therefore to increase gender awareness in the NHS and to highlight the ways in which services might not be serving men well. This information could be incorporated into training, and could go some way towards meeting the aim of a more gender-sensitive provision of mainstream services for everyone.

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