Engaging Men in Therapy:
A Polyvagal Approach

by

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Abstract

This capstone focusses on the issue of male disengagement in psychotherapy. It explores evidence for this claim and why it may matter to attempt to mitigate this disengagement. It then considers why this disengagement persists and what barriers men and boys experience in the process of seeking and continuing to receive help from therapeutic spaces and professionals. I consider three categories of barrier including culture, biology, and systems, with a special focus on masculinity and how it interfaces with modern psychotherapy. Finally, I explore current recommendations in the literature on how to increase male engagement and attendance in therapy. This includes a look at my recommendation and consideration of using the polyvagal lens in therapy to more efficiently and effectively engage men through safe and socially engaging therapeutic alliances.

Keywords: disengagement, masculinity, polyvagal theory, safety

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And to Mason, may there be peace where you rest

Thank you!

Table of Contents

Chapter One: Introduction 6
Research Questions 7
Purpose Statement 8
Theoretical/Conceptual Framework 9
Contributions to the Field 11
Reflectivity and Positionality Statement 12
Definition of Terms 15
Chapter Outlines 17
Chapter Two: Literature Review 19
Engagement 19
Help-Seeking 19
Disengagement 21
Drop-Out 21
Importance 22
Suicide 23
Violence 23
Incarceration 24
Addiction, Substance Use, and Overdose 24
Loneliness 25
Conclusions 25
Barriers 27
Culture 27
Biology 32

Systems ... 35
Recommendations ... 36
Challenge Masculine Norms ... 37
Working With and Respecting Masculine Norms ... 38
Diversity Considerations ... 41
Systems and Bias ... 42
Initial Engagment ... 44
Safety and Trust ... 45
Polyvagal Theory ... 46
Polyvagal Theory Overview ... 47
Applying Polyvagal Theory to Men ... 48
Summary and Synthesis ... 51
Chapter Three: Discussion and Applied Practices ... 53
Logistics ... 53
Framework ... 54
Introduction ... 54
How Men are Struggling ... 55
Why is it Difficult for Men to Access Help? ... 56
What Works? ... 58
Polyvagal Theory ... 60
Closing ... 62
Conclusions ... 63
References ... 65

Chapter One: Introduction

This capstone seeks to investigate male disengagement with psychotherapy. It will explore how much disengagement we see, why it is important to mitigate it, and what sorts of recommendations are found in the literature on how to engage men more effectively in a therapeutic context. Furthermore, I recommend polyvagal theory as an additional approach to mitigating this disengagement by quickly and intentionally building the strong therapeutic relationships that men need through safety, trust, and rapport.

Men are found to be less likely than women to seek help (Mackenzie et al., 2019) and are more likely to disengage and drop out prematurely (Seidler et al., 2021a). Men are also more likely to be incarcerated (Malakieh, 2020), experience substance use disorders (Vasilenko et al., 2017), die from overdose (Eeckhaut et al., 2020; McHugh et al., 2018), engage in violent behaviour (Australian Bureau of Statistics [ABS], 2021 ; Sinha, 2013), experience loneliness and isolation (Cigna, 2020 ; Ernst et al., 2021; Umberson et al., 2022), and die by suicide (Centers for Disease Control and Prevention [CDC], 2024; World Health Organization [WHO], 2019). It is apparent that there are important male-specific issues that men would benefit from addressing in a safe and effective therapeutic environment.

If we can begin to mitigate male resistance to, and disengagement with, psychotherapy, this could be an effective way to also mitigate, even to a small degree, some of the statistics on suicide, violence, incarceration, substance use, and other issues that have male overrepresentation. This could also go some distance in reducing the cycle of violence and trauma that leads to further violence, trauma, death, and disease (Felitti et al., 1998; Renner, 2021). Of course, this would have to be one of several approaches in our society, as these issues

are multifaceted and find origins in culture, biology, policy, and much more. Psychotherapy is simply one route to beginning the mitigation of some of the devastating results of these issues.

I will explore what male-specific attributes might be contributing to drop-out, disengagement, and reduced help-seeking behaviour. The concept of masculinity and its contributions to the issue at hand will be discussed, as well as biological and systemic barriers that must also be acknowledged. This exploration opens the doors for current recommendations for working with men effectively to combat some of the barriers they experience due to masculinity, male biology, and the mental health systems they are attempting to use.

After exploring what the current literature recommends for working with men, I will make a suggestion for further exploration and research. My recommendation is to use polyvagal theory as a means of quickly and initially forming strong and safe therapeutic bonds with men to combat some of the factors at play in high rates of drop-out and disengagement. I will discuss what polyvagal theory is and how it fits into the current literature. For example, how it could be used to work with the sometimes-small window of opportunity we have to engage men. The final section of my paper will outline a framework for a workshop on working with and engaging men in therapy, with a special focus on using polyvagal theory.

Research Questions

The purpose of this capstone is to situate polyvagal theory within the current research and recommendations on engaging men in psychotherapy to mitigate male disengagement with therapy. To do this, I explore four main research questions in the chapter 2 literature review. First, is there male-specific resistance to psychotherapy? Second, why is this a problem? Third, what attributes of men and masculinity contribute to male-specific disengagement with psychotherapy? And finally, what approaches or recommendations exist to mitigate male-

specific resistance? This is where I will situate polyvagal theory as another avenue for mitigation based in the answers to the previous research questions. The final chapter will offer a workshop design for psychotherapists on the topic of engaging men with special attention towards using polyvagal theory as a launching point to develop strong, attuned, and safe therapeutic alliances.

Purpose Statement

This topic was chosen as I noticed a lack of male engagement in psychotherapy. This comes from personal experience in myself and my male friends. I also noticed it as a trend in our culture more generally. Furthermore, I notice a lot of men increasingly struggling with identity, purpose, addiction, and more. I was curious to determine whether my observations were founded in research, and if they were, why this might be the case and how might it be mitigated. Moreover, I wanted to consider what impact this mitigation could have if men found therapy more accessible and engaging. When I was introduced to polyvagal theory, it made a lot of sense to me and it felt like it may have a useful application specifically with engaging men, to encourage strong bonds, safety, and vulnerability in a space that is perhaps unnatural or uncomfortable for them (i.e., sitting across from another person and expressing emotions and deep thoughts and feelings). Although this may not be what all or most therapy looks like, it may be what therapy is commonly assumed to be or is portrayed as.

The intended audience for this research paper is primarily counsellors and other mental health care practitioners. It is intended to provide some guidance on how to engage men more effectively in therapy, preventing disengagement and premature drop-out. It is also for mental health care educators and advocates as it offers an understanding of the barriers men face to therapy, specific recommendations on working with men, and provides an outline for a workshop focused on this. Although my primary focus is on the therapy itself, advocacy and education are

required to encourage help-seeking in men and provide more accurate information around mental health concerns and the available mental health services to help men get to therapy in the first place. Therefore, it could also be helpful to educators and advocates.

I also hope that it will be more generally relevant to the population, clients, and specifically men or the loved ones of men who are suffering from mental health issues as it may provide some insight into the reasons for resistance and how to mitigate it, thereby increasing a sense of hope and accessibility. Family and partners are often the most important factors in encouraging men to seek help (Stiawa et al., 2020) and this could be a useful resource. For example, with my research, it may be helpful for individuals in their efforts to screen potential counsellors for men based on current recommendations and psychotherapist sensitivities to increase the engagement of men in psychotherapy and prevent poor fits. This may help men and family to reach out to counsellors and mental health practitioners to gain specific information about their practice and approach.

Finally, it could be used by researchers in this area. My research highlights a need for further research surrounding the engagement of men as well as polyvagal theory and its applicability to engaging men and the specific mechanisms of male neuroception and sense of safety and how it may be attenuated by masculinity.

Theoretical/Conceptual Framework

Stephen Porges's (1995) polyvagal theory is a foundational framework for this research paper, offering a lens through which to understand engaging men and fostering effective therapeutic relationships with them. This theory examines the hierarchy of the nervous system and how it shifts between states based on perceived safety. Through the process of neuroception,

we subconsciously assess our environment for safety by attuning to subtle social cues in others and our environment (Porges, 2004).

When we perceive safety, our capacity for social engagement and connection increases, allowing us to effectively connect and reflect (Porges, 2003). Conversely, when we feel unsafe, our nervous system activates survival responses, mobilizing us to fight or flee. In cases of extreme unsafety or trauma, this can escalate to complete shutdown and dissociation (Porges, 2022).

The psychotherapeutic environment may not feel safe for men due to norms and expectations around seeking help, being vulnerable, and expressing emotions. These factors could inhibit their ability to connect with themselves and their therapist. It could also be due to systems that are unattuned to male needs and modes of expression. With a polyvagal lens, we may work at fostering environments where men can move out of fight, flight, or dissociated states and into the safe, connected, and reflective states where therapeutic and transformative work can be done.

Masculinity is a central conceptual aspect of this capstone. This is an expansive and dynamic concept, ever evolving how it is perceived politically and individually. Due to limited space for exploration of current perspectives and critical analysis of masculinity, I will be using ‘traditional masculinity’ to refer to traditional western ideals and expectations of men. It is important to acknowledge current language around ‘toxic’ and ‘hegemonic’ masculinity. Although I believe these can be important and useful qualifiers to the concept of masculinity, they are also politically loaded and negatively valanced. That discussion is valuable, but it is beyond the scope of my paper and purpose. My intention is to use neutral language that does not presuppose the positivity or negativity of different masculinities. This allows room for an

analysis that is ideally more neutral and less judgmental, allowing me to challenge the negative and supporting the positive without providing a firm opinion or position on any masculine identity itself.

Furthermore, I acknowledge the history and continuing evolution of the men's movement. A movement dedicated to addressing issues affecting men and boys such as mental health, fatherhood, legal rights, socialization, pursuing gender equity, and more. My paper is situated within this broad context of social and political thought, but this context is beyond the bounds of my exploration in this paper. Suffice it to acknowledge an ongoing and historical movement towards acknowledging injustice, suffering, and inequality towards men that is not at odds with acknowledging oppression and inequality among underprivileged and marginalized groups. My goal is to provide evidence for the suffering and need for help that men have while situating it within a broader societal context, not in opposition to other groups and identities, but actually in service of all.

Contributions to the Field

There are a number of contributions this paper will make to the field. Firstly, it offers the framework for a workshop focused on workable recommendations for engaging men in therapy. More training, education, awareness, and attention given to this gender-sensitive approach could have an impact on stigma and rates of attendance and engagement in therapy for men. It would encourage attuned and effective psychotherapy for men and open up awareness of the need for consideration of sex and gender in psychotherapy, and awareness of our assumptions and biases that contribute to the disengagement of men and the perpetuation of male resistance. It would consider the male, the masculine, and how they interface with our mental health systems. I hope to explore, coalesce, and expand current recommendations for engaging men.

Furthermore, I hope that this could contribute in some degree to increasing engagement in men, thereby potentially affecting male statistics in the realm of overdose, suicide, drug use, incarceration, etc. This could also potentially reduce the cycle of violence and trauma – and therefore death and disease. To conceptualize this in a perhaps more coldly economic perspective, this could contribute to mitigating some of the financial burdens associated with trauma, not only reducing suffering but also having a positive impact on the economy (Felitti et al., 1998).

I could also see this paper contributing as a document with information collected in one place that could be used by clients and family members for screening therapists for men to increase the likelihood of a good fit. This is useful in knowing that initial negative experiences with clinicians, such as perceived judgment or lack of understanding, can discourage continued engagement with other practitioners (Kwon et al., 2023).

Another potential contribution is more consideration of masculinity, positive and negative, and how to bring masculinity into the modern era in a healthy way. Although this is beyond the scope of the paper, I do explore the need for this and hope this could encourage more thinking on the topic of positive masculinity rather than simply our current focus on negative masculinities. The final potential contribution to the field is identifying and highlighting gaps in the literature and research so that we can begin to fill those gaps and learn more about the impact of masculinity and how to go forward.

Reflectivity and Positionality Statement

I was drawn to this topic as a male therapist in a field that is made up of mostly female practitioners ("Therapist Demographics," 2025) and female clients (Terlizzi & Zablostsky, 2020; Vankar, 2024). I became curious why it is that less men attend and persist with therapy than

women. What is it about us, our masculinity, or our mental health systems that influence this? These questions are especially important when considering the harm that is done to men due to this gap in mental health care. Why do men disengage and how can we meet men where they are at? I am interested in past, present, and potential future conceptualizations of masculinity and the stigma surrounding it and how to find alignment between our institutions and our identities where we do find gaps.

I have personally witnessed many men I know suffer through mental health crises who are unwilling or unable to seek professional mental health. This research is also close to my heart as my brother-in-law died by suicide during the early stages of writing this paper. He did not seek help and there are too many cases like his. This was tragic and confusing and makes this research feel even more urgent to me as we witness many more men die by suicide each day.

I am aware that, as a man, I am at risk of extrapolating my own experience with masculinity onto other men and making assumptions. I also believe that it gives me some unique insights into the issues as well. I will have to be careful to balance these two considerations. Masculinity and the experience of being a male is vast and varied but also seems to reveal reliable trends in mental health behaviours.

I am also a white heterosexual male of European descent of a specific generation in a specific region of Canada. There are generational and cultural differences in the masculine identity influenced by the ever-changing effects of socialization as culture shifts. My masculinity is different than my father's, and although I inherited some of his perspectives, I also developed my own based in current day perspectives. I try to honour diverse masculinities and experiences while acknowledging trends in male help-seeking, male psychological attributes, behaviour, and development. Some of these are socialized and some are perhaps more innate to male biology.

This paper in its scope inevitably requires generalizations and a lack of nuance. This means that it is likely there are male populations and experiences where these findings may not apply, especially considering the limitations of research often conducted on insufficiently diverse populations (e.g., western, educated, industrialized, rich, and/or democratic [WEIRD] participants; Henrich et al., 2010).

I will have to be careful to be open to the various aspects and conceptions of masculinity, being careful to be aware of when my own masculinity, and the values associated with it, may skew my interpretation and analysis of the research. For instance, there is a certain amount of frustration I feel with the assumption that men have less of a capacity to feel and express emotion because of socialization. I personally feel a lack of emotional intensity and it does not feel as though it is an unhealthy suppression of emotions that are there. My point is not that I am right, but that this could have biological roots, be an influence of inherited traditional masculinity, or both. We must be careful to encourage openness and push back against constrictive masculinities while also being aware of who men *actually* are.

For example, there is sometimes an assumption that men should experience and express their emotions like women, but perhaps men have unique and valuable ways of communicating and sensing their emotions. I appreciate the need for vulnerability among men, but vulnerability requires a certain amount of safety, and men may have different ways of sensing safety when communicating vulnerable feelings and experiences, especially to other men. Perhaps it is not so important to parse socialization or biology, as what is important is addressing the trends we see preventing men from seeking help and engaging.

There are many iterations of masculinity depending on culture and race. Some cultures have more conservative expectations surrounding who and what men are while others value

more fluidity. I think there can be benefits and drawbacks to both approaches. I will attempt to follow the research with respect and humility, and will be careful about generalizing and letting my own experience and frustrations skew my opinions about the current state of research. I am aware that bias may still surface in my exploration and writing and invite any reader to identify these limitations and find what is of value to them. My intention is to remain agnostic as to the origin of these traits and advocate for more curiosity and fewer assumptions. Some men suppress emotions due to fear of being perceived as weak, some men naturally do not feel so much emotion, and some men feel a great deal and are open about it. I am hoping to advocate for an openness to the legitimacy of traditional aspects of masculinity *and* more modern forms of masculinity as well as the influence of culture *and* biology. This is a sensitivity of what is common to men and what is diverse between different groups of men and how these influences interact. My hope is to follow what works for real men, not for an ideal man.

Definition of Terms

Co-Regulation: Is a reciprocal process in which two nervous systems attune to and regulate (or dysregulate) each other. It is a mutual regulation of the physiological states of individuals (Porges, 2017).

Disengagement: Engagement is the client's commitment to the therapeutic process and cooperation with the therapist to work towards improvement in one's condition (Lizardi & Stanley, 2010). Disengagement is therefore a lack of cooperation and presence in the therapeutic process and environment.

Double Bind: This is a dilemma in which a person receives conflicting messages or demands which make it impossible to respond in the correct way without negative consequences.

Drop-Out: Drop-out is a premature exit from psychotherapeutic work, often unexpected or without prior communication of intent.

Emasculation: This occurs when a man feels his masculinity is being threatened or questioned, reducing his sense of confidence, identity, or self-worth. For example, it may feel emasculating for a man that values his strength to be unable to open a jar of pickles, or for a man that values stoicism to ask for help.

Gender: Gender refers to the social, cultural, and psychological behaviours and identities with being male, female, or non-binary. Psychology appears in both sex and gender as it is influenced by both biology and culture, sex and gender.

Help-Seeking: This is the process of reaching out to access mental health services to help with significant issues in one's life.

Masculinity: I will be using this term to refer to the socialized and cultural norms and expectations governing how men ought to, or feel they ought to, act. This is a personal identity that includes qualities, behaviours, and roles. Traditionally, these may include traits like independence, strength, responsibility, assertiveness, or stoicism but vary widely across societies and individuals. Masculinity tends to encompass both biological and social dimensions and their interactions. We see cross-cultural similarities and differences, which suggest universal male attributes as well as unique and socially driven social conceptions of masculinity. It is expressed in diverse ways and does not remain fixed.

Mental Health Concerns: I will be using this term to refer to struggles involving mental health to avoid loaded valanced terms such as 'mental illness'.

Neuroception: Neuroception is a term created by Porges (2004) in polyvagal theory to describe the subconscious process by which we assess the safety of our environment.

Polyvagal Theory: Polyvagal theory was developed by Porges (1995). It is a theory about the hierarchical nature of the nervous system and the function of the vagus nerve in mobilizing us for danger and survival or demobilizing us for rest and social connection. There are three states: safety and social engagement, fight/flight, and shutdown (freeze)/dissociation. This theory helps us to understand where we sit in the hierarchy based on cues and perceptions, and how to find the way back to a state of safety and rest.

Resistance: Resistance is a barrier to therapeutic change work. It may involve a mistrust of the process or the therapist and prevents the client from committing or engaging with therapy.

Safety: Safety is a state of the nervous system that is at rest and enables one to engage socially, emotionally, and intellectually with the environment and other people (Porges, 2022). It is both an objective state of the nervous system and a subjective state of mind.

Self-Stigma: This is the internalization of negative social prejudice or stereotypes, causing shame, reduced self-worth, or self-doubt (Sheikh et al., 2024).

Social Stigma: This is the negative social prejudice against individuals or groups, exerting pressure to conform characteristics that deviate from social norms and expectations.

Sex: Sex refers to the biological, physiological, and psychological characteristics that distinguish males, females, and intersex individuals.

Chapter Outlines

In the next chapter I will review the literature in a systematic way. First, I will describe the state of male engagement. Following this I will explore the significant issues men are facing and why it may be important to mitigate disengagement. After this, I will explore why this is happening to men specifically, with special attention to the concept of masculinity. Then I will explore current recommendations on mitigating disengagement and effectively engaging men.

Finally, I will introduce how I believe polyvagal theory could be used in this service. After the literature review in chapter two, I will turn to the practical applications of this research in chapter three. This will be in the form of a workshop outline that addresses the state of male engagement and how to work with men, specifically outlining polyvagal techniques to increase a sense of safety and social and emotional engagement.

Chapter Two: Literature Review

This literature review contains a deeper look at the research indicated in chapter one. It will be organized in order of what the problem is, why it is important, why it may be happening, and how best to address it.

Firstly, I will explore research supporting the idea that men are less likely to seek help and more likely to disengage or drop-out of therapy prematurely. Then I will explore research relating to why mitigating this data may be important, focusing on research around male violence, incarceration, substance use, overdose, suicide, loneliness, and the cycle of trauma. After this, I will explore some of the reasons for the data around disengagement, including masculinity, biology, and our mental health systems. Following this, I will describe the state of current recommendations on working with men to increase engagement. Finally, I will explicate the current research on polyvagal theory and how it might be integrated into this context to mitigate male resistance to psychotherapy.

Engagement

The starting point and foundation of my capstone is the idea that men are more resistant to and disengaged with the therapeutic process and help-seeking more generally. Therefore, the first piece of the puzzle is exploring its grounding in research. Do men seek help less than other populations? Do men exhibit more disengagement with psychotherapy? Do they tend to drop out prematurely? I will explore these questions in turn.

Help-Seeking

Firstly, is it supported by the evidence that men seek help less than women? In my research I found plenty of research that confirmed this across age groups. Despite our understanding that delayed engagement with health services contributes to poorer health

outcomes for men, young men continue to engage in patterns of health care service usage that reduce opportunities to prevent disease and promote health (Palmer et al., 2024). In a study exploring the impact of teaching mental health literacy around the signs and symptoms of depression and anxiety, which account for 50% of suicide deaths, they found that this intervention did not increase help-seeking in men (Elliott & Owens, 2023). Even though men are more likely to die by suicide, accounting for 75% of suicide deaths (Public Health Agency of Canada, 2023), they are less likely to seek professional help when they are depressed, especially as they age (Mackenzie et al., 2019).

For adolescents, male gender plays a significant role in lack of motivation to seek professional help for mental health problems (Haavik et al., 2019). Furthermore, less than 1/3 of college men seek psychological help each year when experiencing mental health concerns (Heath et al., 2017). A study based in Australia explored rates of access to mental health treatment during Covid-19 and found that they increased. When investigating the variables, however, they found large sex differences in the increase. The increase was mostly made up of young women while access from men between 18-25 reduced (Gao et al., 2023). Findings also revealed that male veterans are less likely to engage in help-seeking behaviours or to receive adequate mental health treatment, delaying treatment for post-traumatic stress disorder (Silvestrini & Chen, 2023).

When men *do* engage with mental health services, it seems they overcome significant and various help-seeking barriers, often associated with masculine socialization (Berke et al., 2020), a topic we will explore further in my section on barriers.

Disengagement

This leads me to consider my next question: do men exhibit more resistance to therapy? From the perspective of therapists, emerging research highlights that even when men do push past these help-seeking barriers, therapists experience difficulty engaging and retaining male clients in talk therapy (Seidler et al., 2021b). That is to say, once men decide to begin psychotherapy, the socialization processes or systemic barriers that inhibited their help-seeking behaviours exert continued influence (Owen et al., 2013), perhaps leading to disengagement or drop-out.

Engagement in this context can be defined as the client's commitment to the therapeutic process and cooperation with the therapist to work towards improvement in one's condition (Lizardi & Stanley, 2010). Men have reported that psychological treatment often fails to engage them (Johnson et al., 2012).

Focusing on the qualitative accounts of the therapists working with men found that male and female therapists tend to report discomfort when working with male populations (Seidler et al., 2021b). Men have been described by therapists as being more unmotivated to engage, aggressive, abusive, or emotionally closed than compared to working with women (Beel et al., 2018; Johansson & Olsson, 2013; Vogel et al., 2003). Furthermore, some therapists have described that men tend to initiate treatment when problems have become crises and moreover have high expectations for rapid improvement (Stiawa et al., 2020). Support for the presence of disengagement can be seen in one of its symptoms: premature drop-out.

Drop-Out

A clear sign that men are disengaged with the therapeutic process would be to look at rates of drop-out. I define drop-out as discontinuing psychotherapy prematurely, unexpectedly,

or without consulting the clinician. Continuing with therapy requires a degree of commitment, hope, or the service meeting some need. Therefore, my next question: do men tend to drop out prematurely?

This disengagement is evident as we see that even when men overcome these barriers to seeking help, drop-out is found to be high among the male population. This suggests that men tend not to seek help, may find it difficult to engage, and often leave prematurely. One study found that more men in Australia were accessing mental health services, however, the sustainability of male therapy engagement was variable as many men did not respond to follow-ups (Seidler et al., 2021a). This same study found that men exhibited a therapy drop-out rate of around 44%. Men seem to be particularly vulnerable to dropping out prematurely. This points to the idea that public health efforts to mitigate barriers to help-seeking for men experiencing mental health issues do not ensure that the treatment services provided are attuned and engaging for men. Furthermore, once an approach fails to engage these men, the chances of re-engagement in other services is low following a negative experience (Calear et al., 2011).

Importance

Given the research just explored, that men are less likely to seek-help and are more likely to disengage or drop out of counselling services prematurely, we may wonder why this is a problem. Could it be that men require less therapy than women? I argue no. If we consider the evidence, it is clear that this is not the case. This section is dedicated to exploring how men are struggling, why this is an issue, and why mitigating disengagement could have an important impact on men’s mental health and society at large. I will consider the rates of suicide, incarceration, use of violence, substance use disorders, overdose, and loneliness.

Suicide

Firstly, and perhaps most strikingly, the majority of suicide deaths worldwide occur in men (WHO, 2019). In Canada, men account for 3 out of every 4 suicides. This means that roughly 8 men take their life every day in Canada, amounting to 3,000 deaths per year (Public Health Agency of Canada, 2020). In the US, the rates of male suicide death are 5 times higher than women, which means 100 men a day die by suicide there (Ehlman et al., 2022). Therefore, around 50% of the population accounts for nearly 80% of suicide deaths (CDC, 2024). For men under 50 years of age, suicide is the 2nd leading cause of death in Canada (Statistics Canada, 2020). This in and of itself is astounding and supports the idea that there are male specific barriers, internal or external, to getting help and addressing their issues.

Violence

Another indication of male specific issues is the data on male perpetrated violence and aggression. Archer (2004) states that men are consistently more aggressive and violent than women on almost every known measure. Men are found to be more violent in many different areas of offense than women (ABS, 2021). For example, 1 in 4 violent crimes reported in Canada involve intimate partner violence (IPV). Women account for around 80% of the victims while men make up 83% of the perpetrators of this violence (Sinha, 2013). Risk factors for IPV perpetration include experience with maltreatment in childhood such as neglect, abuse, and exposure to IPV (Godbout et al., 2019; Millett et al., 2013; Renner, 2021; Smith et al., 2011). Although obviously these do not guarantee perpetration of violence, there seems to be a strong correlation. The connection between men and violence, *and* trauma and violence, suggests that there are issues that can be, and are worth, exploring with men that could impact IPV or violence more generally.

Incarceration

In a similar vein, men make up 93.3% of the prison population in the United States (Federal Bureau of Prisons, n.d.). I acknowledge complexity in the systemic, political, and cultural components of the prison systems in the US, but it seems clear that men are committing more crime and becoming incarcerated much more frequently than women. Similar data is found in Canada with men making up 85% of those admitted to custody provincially and 93% federally, with men aged 20-39 representing over half of men taken into custody federally or provincially (Malakieh, 2020).

Addiction, Substance Use, and Overdose

Addictions, substance use, substance use disorders (SUDs), and overdose seem to be more prevalent among men as well. Illicit drug use is significantly more common among men than women (Center for Behavioural Health Statistics and Quality [CBHSQ], 2016). Men also experience higher rates of SUDs than women (Vasilenko et al., 2017) with a M:F ratio around 2.5:1 (Whitley, 2021). For alcohol, a Canadian survey found that 4.7% of men had alcohol-related disorders whereas only 1.7% of women did (Pearson et al., 2013). Although the gender gap in SUDs and overdose seem to be tightening, men continue to dominate overdose deaths (Eeckhaut et al., 2020; McHugh et al., 2018). In Canada, most accidental deaths due to opioid toxicity occur among men, making up approximately 72% of the overdose deaths (O'Donnell et al., 2017; Public Health Agency of Canada, 2024).

If we explore addictive behaviours more generally, men have higher rates of addiction in not only substance use (e.g., opioids, cannabis, and alcohol), but also for addictions such as gambling and gaming (Whitley, 2021). With addiction, we found that men have more severe symptoms, earlier ages of onset, and older ages of remission (Whitley, 2021).

Loneliness

There has also been an increase in loneliness in men, although findings can be contradictory. Men seem to be more isolated throughout the life course (Umberson et al., 2022). They were found to have higher rates of loneliness (Cigna, 2020) and more frequent loneliness than women (Ernst et al., 2021). Maes et al. (2019), on the other hand, found similar levels of loneliness between genders. This could be due to different degrees of openness with reporting loneliness; however, this is a sign that further research is needed.

This potentially male over-represented loneliness may be related to substance use as men seek dissociation from loneliness or community in substance use communities (Ingram et al., 2020; Whitney & Whitney, 2021). This is also likely related to the rates of suicide among men, especially young lonely men (Baretto et al., 2021; Ernst et al., 2021). We see that loneliness has significant negative effects on mental and physical well-being (Leigh-Hunt et al., 2017).

Conclusions

These subheadings are interrelated in complex and dynamic ways. For example, loneliness is related to SUDs (Ingram et al., 2020), social isolation is related to suicidal ideation (Barreto et al., 2021), and violence is related to incarceration and trauma (Godbout et al., 2019; Renner, 2021), among other nuanced and complex interconnections including socioeconomic and cultural nuances. However, it would seem there are important male-specific issues that men would benefit from addressing in safe and effective therapeutic environments and relationships.

These issues have complex roots in culture, biology, policy, politics, history, and much more. I am not suggesting that mitigating resistance to psychotherapy is the solution to these issues, but I do believe that making it more accessible to men could be a small step towards mitigating some of the causes and effects of them. There is much work that needs to be done

systemically, politically, and culturally beyond the scope of this paper and what psychotherapy can do. However, if we can help men feel safe enough to seek help, break their silence, and speak about the issues behind the statistics I have outlined, we may be able to begin mitigating some of the statistics for male over-representation in suicide, incarceration, violence, addiction, substance use, overdose, and social isolation.

Additionally, if these statistics can be even minorly mitigated, we may begin to affect the cycle of trauma as experiences of childhood trauma can lead to further perpetration of violence and trauma. As previously mentioned, men who witness IPV as children are more likely to perpetrate as adults (Godbout et al., 2019; Millett et al., 2013; Renner, 2021; Smith et al., 2011). Men who are mistreated as children are more likely to repeat patterns of violence (Malhi et al., 2020). Those who experience adverse childhood events, such as physical abuse, sexual abuse, emotional neglect, and parental separation/divorce, are more likely to suffer from SUDs (Maël & Daniel, 2022; Whitely & Whitely, 2021). Moreover, we see in the landmark Adverse Childhood Experiences (ACE) study (Felitti et al., 1998) that adverse childhood events play a significant role in health risks, comorbidities, and death. This suggests that mitigation might not only have some impact on the cycle of violence in men and women, but also on public health more generally. Trauma does not guarantee further violence, but it can carry with it significant health costs personally and increase the burden on our economic and health-care systems. Peterson et al. (2023) conducted a modern ACE study estimating the economic burden of adverse childhood events, placing it at 14.1 trillion dollars in the US annually.

Further research might demonstrate if psychotherapy has effects in mitigating these statistics, but reviewing this data is sufficient to show that attempting to mitigate barriers is worth doing for men and society. Now that we have seen that helping mitigate barriers to

psychotherapy for men may help begin to address some serious issues for men and society at large, we can consider why it is that these discrepancies exist in help-seeking, engagement with therapy, and drop-out rates.

Barriers

So far, we have seen that men face significant barriers to help-seeking and engagement in therapy, often ending in premature drop-out. We have also seen that men are overrepresented in the statistics on some serious issues. Therefore, despite a significant need for men to address issues in a safe therapeutic environment, men find it challenging to seek-out, commit, and share in these spaces. Perhaps, if we can learn to help men surpass these barriers and engage in therapy, we may be able to begin to address these serious issues from a psychotherapeutic perspective.

However, to surpass these barriers, it is important to explore what they are and why they are male-specific. Therefore, in this section I will broadly explore why many men might find it hard to ask for help and engage in psychotherapy. I argue that the reasons are found in both biological and cultural dimensions of men and masculinity (Meyers-Levy & Loken, 2015). I will also address how our current mental health systems fail to interface with male attributes and needs. I will divide my exploration into these three subthemes: culture, biology, and systems.

Culture

Here I will explore the literature around why men have difficulty attending and engaging in therapy with a focus on socio-cultural reasons. This is primarily focused on internalized traditional expectations of masculinity and socialization. Social norms around masculinity and how men should act have been found to significantly negatively impact attitudes towards help-seeking in men (Piatkowski et al., 2023; Yousaf et al., 2015). Two major barriers within this

theme were masculine norms and self-stigma (Sheikh et al., 2024). Masculine norms represent external pressure to conform, whereas self-stigma is an internalized form of this pressure. Although norms and values external and internal are essential to functioning human culture and society, they can become restrictive and outmoded as our world and needs change.

Pressure to conform or rigid adherence to masculine norms, such as emotional stoicism, toughness, self-reliance (Reily et al., 2023), and independence can play into stigma and the belief that seeking help is weak, thereby reducing use of mental health services (Pederson & Vogel, 2007; Schneeberger et al., 2023; Sheikh et al., 2024; Wahto & Swift, 2016). Conformity to dominant masculine gender norms or ideologies leads to self-stigmatization in depressed men who feel that they should be able to cope with their illness without professional help (Latalova et al., 2014). Men's socialization to be mentally and physically strong (i.e., tough) may contribute to their tendency to hide symptoms of depression and explain avoidance of help-seeking (Smith et al., 2016). Another study found that higher conformity to traditional male roles is associated with lower use of psychotherapy, increased self-stigma, and causing poorer mental health outcomes for men (Schneeberger et al., 2023). Masculine norms may be a significant factor in how mental illness is perceived and impacts whether men seek help (Lynch et al., 2018). Masculine traits such as self-assuredness, independence, and competitiveness can undermine the perception and legitimacy of mental illness for men (Mostoller & Mickelson, 2024).

In communities with higher levels of traditional masculine identification, we have found increased stigma surrounding help-seeking for mental health issues, for example, in the military (Silvestrini & Chen, 2023) and the police (Terrizzi, 2024). These populations also experience higher levels of PTSD and paired with reluctance to seek help, these professions experience significantly higher levels of suicide than the general population (Veterans Affairs Canada, 2024;

Violanti & Steege, 2020). Often, men report that they should be able to take care of their issues without help, causing seeking help to feel like admitting weakness or it may feel embarrassing or emasculating (Sheikh et al., 2024). Counselling is therefore seen as a last resort, causing men to show up in therapy when issues have progressed to a critical degree where they are in crisis or specialist help is required (Sheikh et al., 2024; Stiawa et al., 2020). This, paired with high expectations for rapid improvement and success (Stiawa et al., 2020), could be detrimental to engagement and increase rates of drop-out when psychotherapy falls short.

In terms of engagement, we also found that increased conformity to traditional masculinities leads to increased ambivalence, therefore not only decreasing help-seeking behaviours but also the ability to confront and address emotionally laden content (Lorber & Garcia, 2010) and increasing reluctance to discuss mental health issues (Stiawa et al., 2020). We also found that alignment to dominant masculine ideals can affect men's ability to connect with or verbally express emotions and increase behaviours that interfere with therapy such as low emotional disclosure, lack of attendance, hostility, criticism, and denial of issues (Danielsson & Johansson, 2005; Englar-Carlson, 2006; Seidler, 2018).

Seidler et al. (2021) also found in a later study that younger age, unemployment, identification with traditional masculinity, and the feeling of being emasculated all predicted premature drop-out. Burgess (2024), focusing on adolescent boys, found that they are socialized into recognizing social consequences for expressing emotions and seeking help. These consequences are seen to outweigh the benefits of receiving support. Yousaf et al. (2015) found that when participants' masculinity attitudes were corrected for in the analysis, the gender gap in help-seeking disappeared.

In a qualitative study interviewing mental health professionals (MHP), including psychiatrists, psychologists, and counsellors, there were some interesting findings (Stiawa et al., 2020). MHP's found that men are typically less familiar with conversations about emotions, mental health, and communicating their needs. They are often not used to disclosing mental health issues with another person. It is particularly difficult for men to express the presence of depression, and often they do so only after a crisis, such as a suicide attempt. The MHP's also described men as having a poorer understanding of mental health problems and services, often holding prejudice against them. They also found that often it is not the man that initiates treatment, but partners or family members who urge them to attend.

To inject some nuance into the discussion, despite much evidence considering the negative effects of traditional masculinities on help-seeking, Smith et al. (2016) discuss the one-dimensionality of blaming traditional masculinity and urges more attention and research to be directed at the positive aspects of traditional masculinity in mental health treatment to create a more differentiated understanding of masculinity. For example, traditionally masculine traits like ambition, self-reliance, assertiveness, stoicism, and competitiveness have deep potential for fostering positive progress and change (Seager & Barry, 2019). This allows for some room to avoid fully throwing out our current and traditional concepts of masculinity but instead adjusting it in ways that validate who men are, what they value, and ultimately contribute to their well-being.

As studies gain more resolution and nuance surrounding masculinity, we will likely find that some traits are protective and some destructive, or both depending on the context. For example, self-reliance being a virtue for attaining goals and making progress but being detrimental when applied to severe mental health issues. We need more research exploring

cultural dimensions of masculinity, traditional and modern, positive and negative. Some masculine traits may increase male risk of poor mental health outcomes and avoidance of support, while others may have protective effects (Iwamoto et al., 2018; Wong et al., 2017). For example, toughness may contribute to resilience to depression but is also associated with increased substance use (Sileo & Kershaw, 2020). I will discuss this more in the next section on current recommendations as an approach to making therapy more accessible to men regardless of their masculinity.

Although there seems to be overwhelming evidence, there is debate and further research needed to confirm how influential gender role is in male help-seeking and engagement. Nagai (2022) acknowledged a gender difference in help-seeking between men and women but found that gender role identification may have minimal impact in this difference, suggesting an overestimation of the power of masculinity in causing this difference. He suggests that the difference might represent gender differences in other factors, such as subjective distress. This study was conducted on Japanese college students with low generalizability. However, it does highlight a need for more cross-cultural research in this area.

Masculinity differs between cultures and generations, which allows room for valuable comparative research. The research I reviewed here explores diverse populations, however, there is still generally a bend towards WEIRD participants in at least a few domains (Henrich et al., 2010). This is significant as identity is intersectional with identities like race, socioeconomic status, generation, culture, and sexual orientation all potentially attenuating the effects of masculinity on the statistics on engagement, overrepresentation in prevalent issues, and the recommendations proposed in the next section. For example, socioeconomic status seems to attenuate help-seeking behaviours, with lower income men finding it more difficult to access

mental health services (Gao et al., 2023) and Black people being overrepresented in the Canadian criminal justice system (Saghbini &Paquin-Marseille, 2023)

Biology

Masculinity is created and perpetuated by culture through norms and expectations. This being the case, it is also influenced by biological differences between men and women in brain and behaviour rooted in our evolutionary past. It is not the case that masculinity is fully a product of culture as some male traits and ideals derive from evolutionary conditions.

Physically, we see that male brain development has a different course than female brain development. The prefrontal cortex of adolescent boys matures about 2 years later than in girls, influencing executive functioning and risk-taking, and the cerebellum about 4 years later, which influences emotional and cognitive regulation (Akyurek, 2018; van Tetering et al., 2020). Psychologically, this can play out in numerous differences in behaviour which can be hard to disentangle from the varying societal expectations we have of boys and girls, however, both nurture and nature have an influence, so the question is more *when* and *how much* rather than *if*.

For example, Buss and Schmitt (2019) describe how men and women evolved different mating strategies based in their biology. Men and women have different minimal obligatory parental investment. The male can reproduce as much as he would like as his sperm is low cost and replenishable, requiring one sexual act. The female, on the other hand, ovulates once a month and when the egg is fertilized, she must carry and grow an infant for nine months, give birth, and nurture them. This is a significantly higher opportunity cost and investment than the male in terms of carrying genes into the next generation. It is theorized that this asymmetry in opportunity cost causes differences in mating strategies. For example, women may be more

careful in choosing a man and men may be more sexually promiscuous and competitive to be chosen, among other traits.

The relationship between men and women and reproduction is theorized to be part of the foundation of many of our psychological mechanisms (Buss & Schmitt, 2019). These are often more complex than portrayed above but can play into traditional roles such as the 'male provider' or the 'jealous boyfriend'. We have inherited many of these tendencies and although they are attenuated by modern culture in complex and nuanced ways, they persist. Men may not only feel the pressure of society's expectations, but also internal drives to fulfill specific roles. This does not mean masculinity is confined to our evolutionary past, as it is quite flexible, but it tends towards certain traits and preferences. Sex differences can be magnified or muted by culture (Reeves, 2022).

These can be positive or negative depending on how they interface with modern culture. Men often find meaning through providing for their families, protecting them, and being self-reliant. As our culture shifts, these ideals and norms are shifting away from patriarchal assumptions about how families or countries should be run. This is positive in the equality it affords; however, it can also be difficult for men who may no longer feel a strong sense of their role in society. Reeves (2022) suggests that a difficulty facing men may be father's losing their traditional role in the family. This may contribute to a double-bind in men who feel they are still socially expected to be traditionally masculine through providing or being strong, while also receiving modern social pressure and messaging to be vulnerable and that being the provider is outdated. Men may feel they are expected to be both stoic and vulnerable which causes internal conflict and confusion. This is another complex topic beyond the scope of this paper, however, it is interesting and useful to consider who men are biologically and how that aligns with cultural

expectations about who men should be and what roles are available for them to inhabit. If we forget about who men are and what they need, culture could fall out of step with male senses of meaning and well-being based in ancient human development. This could be part of why we increasingly see men struggling with identity and meaning. We need concepts of masculinity that integrate who men are biologically with our current cultural values and goals, and not an unrealistic ideal cut-off from our primal and biological needs. How men feel and act are not completely malleable as we sometimes expect they are. For example, expecting men to be more emotionally expressive and understanding can be a good thing, but it can also be misattuned and oppressive for men who may naturally have different emotional experiences and needs than women. Similarly, stoicism can be a strength, but it can also be oppressive. We need nuance and balance.

Some of these biological traits contribute to masculinities that are incompatible with current standards of psychotherapy. Some of these traits are malleable, but others are who men tend to be regardless of culture. This means that a certain amount of work needs to be done to update our concepts of masculinity and challenge traditional expectations, but other work needs to be done to help systems accommodate who men are *now*, regardless of their masculinity, biologically or socially derived, it does not matter. We need to engage men no matter their identity. This leads me to the final barrier, a mental health care system that may be unaccommodating to men and masculine attributes. It is not simply that internalized traditional masculinities cause less help-seeking, but that the health care system might be unapproachable to male needs and fears.

Systems

Finally, it is worth considering how these barriers are caused not simply by men and masculinity but by the systems they are avoiding. It is important to consider that these systems also play a part in pushing men away through prejudice, insensitivity, or unaccommodating design.

Elliott and Owens (2023) found that men are often deterred from seeking help as treatment is not felt to cater to male needs. Traditional talk therapy is heavily focused on emotional exploration and discussion, sitting across from another in a vulnerable one-on-one conversation. This may not be a form of psychotherapy that feels initially safe or accessible for men and boys who have little experience with this form of communication and may not be naturally inclined to it (Stiawa et al., 2020). Psychotherapy, as a profession now predominately made up of women serving women (Terlizzi & Zablostsky, 2020; "Therapist Demographics," 2025; Vankar, 2024), may bend towards female modes of communicating, helping, and interacting. Men may have different ways of communicating about these things and addressing their problems. It does not matter how much it is socialized or innate, we need to find ways to engage these male modes of feeling safe and communicating their needs.

An additional barrier is bias and prejudice within the system. Wahto and Swift (2016) found that not only adherence to masculine gender roles, self-stigma, and negative attitudes towards help-seeking deterred men from seeking help, but also social stigma. This supports the idea that men stigmatize themselves but also experience external stigma and expectations from society more generally, tending to internalize these ideals. Men therefore experience internal and external stigma (Silvestrini & Chen, 2023). Men can therefore be deterred by their fear of being weak and of being perceived by others as being weak. These external pressures serve to cause

men to consider the benefits of seeking help versus the potential consequences of being perceived to need help, perhaps often finding that it is better to avoid seeking help (Burgess, 2024). This stigma can be perpetuated in subtle and unconscious ways throughout society and media.

This fear of external judgment is not unfounded, even within mental health settings. The qualitative study previously mentioned from Stiawa et al. (2020) that focuses on MHP's experiences with men found that stigma and prejudice were also perpetuated in the attitudes of MHP's. This was seen in how they spoke about men and their language around 'typical' men and 'non-typical men', acknowledging the difficulties of typical traditional men while typing non-typical men as feminine and weak. This shows that there is a widespread perpetuation of masculine norms and stigma, even within the mental health professional community, explaining perhaps some of why it is difficult for men to attend and engage in therapy when they feel judgment from their therapist and the systems that they are encouraged to be vulnerable in.

Recommendations

Considering all of what we have explored surrounding men and the barriers to their engagement with therapy, I will now turn from support for the presence of a problem to current recommendations on how to address this problem and successfully engage men to mitigate some of the data we have seen so far.

As we have seen, there are three major contributions to the barriers men experience: culture, biology, systems, and the interplay between them. These are also, therefore, three routes that we can take to mitigation. To address culture, we may seek to address masculinity by either challenging it or working with and supporting it depending on the context. For biology, we may seek to understand men and who they tend to be, not seeking to force change on them beyond

who or what they want to be or desire. Finally, a systemic approach would explore how to mitigate stigma and prejudice, making these systems more accessible and approachable to men.

Some of the general considerations and recommendations I explore, based in the literature that could serve to mitigate this resistance and engage men in therapy, include: challenging masculine norms, working with and respecting masculinity, cultural considerations, addressing systemic bias and barriers, early intervention, and safety and trust. This final point will lay the groundwork for the final section which introduces how polyvagal theory could be an effective guide to engaging men quickly and effectively.

Challenge Masculine Norms

As we have seen, traditional masculinity seems to pose a significant barrier to help-seeking and engagement for men. Therapists must understand how masculine norms influence male behaviour, help-seeking, and therapeutic experience (Beel et al., 2019).
Therefore, one recommendation for working with men is challenging traditional masculinity in sensitive ways by exploring its socio-cultural context and masculine narratives that hold men (Seidler et al., 2018) and boys (Burgess, 2024) back. This is a delicate balance since mental health practitioners must balance an awareness of socialization while respecting each man's diverse masculinity and values (Beel et al., 2018). Challenging these norms prematurely or insensitively could be felt as threatening and play a role in disengagement and drop-out. On the other hand, addressing some of the associations with, for example, self-reliance or feelings of being weak for seeking help could counteract drop-out and self-stigma. Future research, therefore, could explore therapy that actively challenges traditional norms and engages men in redefining masculinity in the context of modern mental health (Sheikh et al., 2024). Ideally, we could do work that moves beyond traditional stereotypes of masculinity to encourage expressions

of emotional engagement and vulnerability (Seidler et al., 2018), thus loosening the grip of constricting identities.

Working With and Respecting Masculine Norms

In a similar vein, it may be essential to not only explore how internalized traditional masculinity may be impacting the lives of these men in negative ways but also leveraging the positive aspects of traditional and diverse ranges of masculinities.

Men may avoid therapy for fear of being judged and feeling vulnerable. They are not going to therapy to have their masculine identity challenged and disrespected. It may be important to be accepting of whatever masculinity is presented and begin with strength-based approaches before approaching how their masculinity may be a barrier to thriving. This may look like building on traditional strengths such as courage, self-reliance, and resilience to complement therapeutic interventions (Seager & Barry, 2019; Sileo & Kershaw, 2020). This could also look like reframing help-seeking or working on oneself as an action of strength (Englar-Carlson & Kiselica, 2013).

Of course, it should not be an assumption that their masculine identity is an issue. We do not want to risk further bias and paternalistic attitudes towards the men we work with. It is recommended that we avoid emasculating language and develop the ability to adapt to traditional masculine ideologies with respect, humility, and curiosity. In service of this, therapists should avoid language or actions that could be perceived as undermining masculinity (Pederson & Vogel, 2007; Schneeberger et al., 2023). Therapists should strive to incorporate diverse masculinities in interventions, emphasizing a nuanced understanding of traditional masculinity, including its protective and detrimental dimensions (Iwamoto et al., 2018; Sileo & Kershaw, 2020). We should be accessing diverse expressions of masculinity within and across male clients

to broaden their coping strategies and identities (Seidler et al., 2018). Our interactions and therapeutic environments can therefore acknowledge and respect traditional masculine norms while gently challenging restrictive beliefs that hinder engagement, encouraging emotional expression (Beel et al., 2019; Boerma et al., 2023; Burgess, 2024). The specific balance of this will depend on the client and the therapeutic relationship.

Aligning with values and goals men often hold, therapists may be able to effectively frame therapy as a tool for resilience, self-improvement, and problem-solving (Boerma et al., 2023; Burgess, 2024), motivating self-reflection and change (Beel et al., 2019). This normalizes help-seeking and may counteract a sense of weakness by reframing emotional expression and getting help as resonating with masculine values, increasing engagement (Beel et al., 2018).

Another way of attuning to and respecting masculinity is tuning into the kind of therapy that they want to do. This may look like engaging men in intervention development to ensure it meets their needs, thereby increasing client retention (Sheikh et al., 2024). It is generally important to be client-led, as well as being informed about how men generally approach therapy and what they expect from therapy. Men often prefer a practical approach, with practical applications and outcomes using solution-oriented techniques (Beel et al., 2018; Beel et al., 2019; Seidler et al., 2017). This may include strength-building and equipping men with practical tools to enhance resilience and emotional awareness and expression (Beel et al., 2018; Seidler et al., 2021b). Action-oriented, problem-solving, structured therapy may align more with male needs and preferences, whereas women may tend to favour emotionally focused therapies that emphasize empathy and relational connection (Liddon et al., 2018). This is a broad generalization and would also require sensitivity to the individual client’s needs.

Another simple way of engaging men is adjusting the language we use to resonate more with men and boys. To help engage adolescent boys, Burgess (2024) suggests that MHP's should use relatable, practical, and goal-oriented therapeutic language to improve engagement. Seidler et al. (2021) suggest the same for men, tailoring language to this goal and action-oriented values. It may enhance engagement if we adapt our language to include male-oriented metaphors and themes, resonating with male experience (Seidler et al., 2017). This could look like framing counselling as something closer to coaching than therapy. This does not have to be the stereotype of the 'sports metaphor' approach but would depend on sensitive awareness of who our clients are and what is meaningful to them.

There are also some more alternative somatic strategies that prove promising. Considering the idea that traditional therapy may not align with male modes of relating or expressing, one recent study focused on the effectiveness of dance and movement-based therapies, considering how to bypass verbal resistance, enabling emotional expression without requiring emotionally laden conversations. This may align more with masculine norms or male tendencies (Turrell-Celente, 2024). This could help men recognize and process emotions and promote self-awareness in a less confrontational way. Despite its benefit of bypassing potentially unsafe or vulnerable conversations, it may not align with traditional masculinity and its attitude towards dancing. Additionally, it may align with active and athletic values for many men. Moreover, this can be done in group settings which foster peer connection and can normalize and destigmatize vulnerability as men often have difficulty reaching out and talking with other men. This practice could increase self-compassion and decrease self-criticism, addressing internalized pressure and making future help seeking more likely (Sheikh et al., 2024). Again, individually client-led sensitivity is essential to engaging men, and though there is no one size fits all in

therapy, we can be aware of research and tendencies in populations that aid in initial interactions and more quickly move past unhelpful approaches.

Another more modern and prevalent recommendation for increasing accessibility is utilizing and improving teletherapy services. It was found that young men often find it easier and more accessible to connect with psychotherapy online. Therefore, having the ability to engage effectively in teletherapy and tailoring interventions to online modalities could lower barriers and provide access to a wider range of men (Sheikh et al., 2024).

Diversity Considerations

Another important consideration to bring into any therapeutic approach are cultural and racial considerations. Different stereotypes and levels of stigma are associated with masculinity across racial, generational, and cultural contexts (Nagai, 2022; Sheikh et al., 2024). To build an attuned therapeutic relationship, being aware of and acknowledging this with humility and curiosity would lead to more integrated and attuned interventions and relationships. Struggles and barriers are not equally divided between men. For example, Black men and boys experience more systemic injustice and increased generational stigma due to systemic prejudice and more traditional forms of masculinity (Reeves, 2022). Our models of masculinity should incorporate intersectionality to provide more nuanced and attuned understandings of the men we work with (Seidler et al., 2018). Each masculinity, perhaps depending on generation or culture, may have their own level of comfort with emotional expression. Therapists should strive to adapt to these differences and meet men where they are at without judgment (Beel et al., 2019).

It is not about judging each individual's masculinity but exploring how these identities interact with their life in positive or negative ways, looking at the wider socio-cultural context. This could help make the process of identification a choice rather than simply inherited and

socialized. Although it is important to consider groups and identity, awareness of diverse masculinities helps tailor approaches to individual clients (Beel et al., 2018). Therapy is a balance between understanding individuals as a part of groups while also tuning into their unique experience without assumption, judgement, or stereotyping.

Systems and Bias

Another barrier faced by men comes from the systems themselves and the bias within them. As we have seen, not only is there bias and socialization occurring in our culture to perpetuate aspects of masculinity that may be maladaptive, there is also bias from within the mental health system that can deter men from feeling safe enough to be vulnerable and engage. It is important that we recognize and address practitioner bias. Mental health practitioners must reflect on and work on their own biases, ensuring equitable treatment and avoiding stigmatization (Stiawa et al., 2020). This means that, like therapy in general, practitioners must engage in self-reflective practices surrounding their beliefs and attitudes towards men and how these are communicated within the therapeutic space to ensure effective and respectful interactions (Beel et al., 2018).This may look like reflecting on assumptions around men being difficult to work with and understanding that engagement improves with the right approaches (Seidler et al., 2021b).

Although not directly therapeutic, advocacy is an important part of social justice and removing barriers for men. Due to the fact that men experience less awareness of mental health issues and the services available, advocacy may look like increasing awareness of mental health issues and the importance of seeking help through schools or community programs (Burgess, 2024). Awareness campaigns that promote mental health, frame help-seeking as a strength,

challenge stigma, promote acceptance and early engagement, and seek to increase mental health literacy among men are needed (Kwon et al., 2023; Rice et al., 2020; Seidler et al., 2017).

Moreover, another necessary practice is to build peer support programs that create networks and community tailored to men's preferences where men can share with and encourage each other (Kwon et al., 2023; Rice et al., 2020). Leveraging peer influence by encouraging peer discussions and support may work to normalize mental health conversations within their social groups (Burgess, 2024). Furthermore, policy changes that enhance access to mental health services for men can be promoted (Rice et al., 2020). These are all aspects of addressing the barriers men face outside of the therapy room. This may be done by therapists, but also other professionals, advocates, and the public in general.

Another essential part of addressing the system and the bias within are programs that enhance therapist training in this area. This would look like providing gender-specific training which could address topics such as traditional masculinity, its influence, and common male issues around discomfort with emotional expression and vulnerability (Seidler et al., 2021b). It would also strive to educate healthcare practitioners about men's unique barriers, which could work to foster a more supportive atmosphere (Rice et al., 2020). Moreover, it would serve to educate practitioners on the role of gender in mental health and specific training on masculinity's complex effects on mental health (Stiawa et al., 2020). This has been found to bridge gaps in engagement and increase positive outcomes for male clients (Seidler et al., 2021b). Providing therapy tailored to gender-specific preferences can increase effectiveness and engagement for both men and women (Liddon et al., 2018). This could look like developing services that cater to men that include, for example, targeted outreach, male-friendly environments (Rice et al., 2020), or an ability to adapt to male-oriented language, themes, metaphors, and goal-orientation

(Burgess, 2024; Seidler et al., 2017). According to Seidler et al. (2018), our systems and how they operate currently require comprehensive and rigorous evaluations to explore and ensure the effectiveness of male-centred approaches and that they are actually improving outcomes and meeting the diverse needs of men.

Since it can be difficult for men to reach out, it is important that their first attempts are met with ease of access by dealing with issues of access such as non-user-friendly and complex processes and interfaces, inflexible appointment systems, or stigma within the healthcare system (Kwon et al., 2023). Often, a negative initial experience with a practitioner, such as experiencing judgment or lack of understanding, can be discouraging and lead to disengagement and less help seeking in the future (Kwon et al., 2023). This is further put into perspective as we have found that over half of men who die by suicide had contact with mental health services before their death (Schaffer et al., 2016).

Initial Engagment

This leads to another area of counselling that requires special attention: initial engagement and a focus on the first session and interactions. It is crucial to have an accurate ability to identify men at risk of drop-out and disengagement to take more proactive approaches if needed. A strong initial connection can disrupt premature discontinuation of services (Schneeberger et al., 2023; Seidler et al., 2021a), which means the first session carries weight for men who are uncertain about counselling. Having this ability to identify would allow the practitioner to address issues relating to commitment or engagement and develop strategies to combat potentially unstable engagement. This could be done by focusing on building trust, emphasizing therapy's practical benefits, and normalizing things such as emotional vulnerability (Seidler et al., 2021b). Practitioners should aim for honest and open discussion about the

importance of therapy fit, what therapy entails, and the possibility of drop-out. Even if the individual drops out, this may help deter future disengagement with professional services (Seidler et al., 2021a). This ties into the next subtheme, building the therapeutic relationship with safety and trust. This is an important part of initial and early engagement to counteract negative expectations and disengagement.

Safety and Trust

Fostering initial trust and a sense of safety may be an essential piece of mitigating the disengagement we see in men, especially early on in therapy. Rapport is an important part of building these two aspects of an effective relationship. As we have seen above, there are specific ways of building rapport with men, but rapport may be generally built through empathy, respect, and a stance of non-judgmental compassion. These attributes could counteract some of the stigma men and boys associate with help-seeking (Burgess, 2024). We found that men desire genuine, respectful, and honest therapeutic settings (Kwon et al., 2023). This suggests, and is supported by the literature, that there is a deep need for building non-judgmental and respectful environments to help men feel more comfortable and safe communicating and experiencing vulnerability without fear of further stigma or judgment (Beel et al., 2019; Kwon et al., 2023). Seidler et al. (2018) highlight the importance of transparent and collaborative therapeutic relationships to increase a sense of control.

Further enhancing normalization, rapport, and safety could be done through personal self-disclosure and normalizing vulnerability through modeling, which works to build further connection and reduce resistance (Seidler et al., 2018). Boerma et al. (2023), focusing on the adolescent male perspective, highlights the need for non-threating environments where this population feels not only emotionally safe to share their thoughts, but also physically in their

body and nervous system. This means building trust through genuine interest, consistency, and active listening. It could also look like, and especially with adolescents, humour, informal language, and relatable topics (Boerma et al., 2023). Another method for enhancing a sense of control and investment may be to involve males in deciding the structure and goals of therapy (Boerma et al., 2023).

Safety and trust are an essential piece of any therapy, but seemingly more potently needed here with the male-specific sense of unsafety with vulnerability in therapy due in part to the potential social repercussions of stigma and the way that men naturally feel safe to engage with the practice of therapy. This is the jumping off point for my own additional recommendation: Using polyvagal theory to quickly develop strong and effective therapeutic relationships early on to mitigate issues such as disengagement and drop-out.

Polyvagal Theory

As we have seen, men have a significantly more difficult time attending and engaging in therapeutic spaces. We have explored how this is due to conceptions of masculinity, male development and biology, and the systems they attempt to engage with. The therapeutic space, for various reasons, does not feel safe for many men and boys to experiment with communicating and experiencing vulnerability. There is a felt sense that something is at risk, like their social standing, how they are viewed, how they view themselves, or their identity as men. They are on guard, and often the benefit of avoidance outweighs the risk of engagement. Safety and trust, therefore, are significant aspects of therapy to develop with men. Especially early-on and with an awareness of the barriers men face and the fears they experience.

This is where polyvagal theory fits in. In this section I will describe what polyvagal theory is and how it can be used in this context to mitigate disengagement and produce strong,

effective, and safe therapeutic relationships/environments. This will not be an extensive exploration of the methods and techniques of implementing polyvagal theory into therapy but rather a brief exploration of some of the theory, approaches, and techniques to highlight the potential usefulness for engaging men.

Polyvagal Theory Overview

Polyvagal theory was developed by Porges (1995). It is a framework for understanding autonomic nervous system (ANS) regulation and its influence on emotional regulation, social engagement, and behaviour. A key component of the ANS is the vagus nerve, which influences our physiological and psychological states. Essentially, there is proposed to be a hierarchy of three systems that the ANS shifts between depending on levels of perceived safety or threat. These are the ventral vagal, sympathetic nervous system, and the dorsal vagal system (Porges, 2022).

Our nervous system state is situated within the ventral vagal system when we perceive safety. It promotes calm, social engagement, and connection. The sympathetic nervous system, or our fight or flight response, is engaged when we sense danger. This system prepares our body to take action. Finally, the dorsal vagal system activates during overwhelming danger which leads to states of immobilization or dissociation. Porges (2003, 2004) outlined ‘neuroception’ to describe the process by which our nervous system senses the relative safety or danger of our environment, influencing our nervous system and our level of regulation. This is thought to be a subconscious process. Neuroception is highly tuned to facial expression, vocal tone, and social cues, which is important for influencing nervous system shifts in clients as we will see later. In cases of trauma, neuroception may be hypervigilant, leading to overactive perceptions of danger (Porges, 2017). When our environment is deemed safe, we can effectively communicate and

socially connect, thereby forming strong trusting therapeutic alliances. This is when the Social Engagement System (SES) comes online (Porges & Carter, 2017). This system regulates things like vocal tone, eye contact, facial expressions, and other behaviours that promote a sense of safe connection and engagement between individuals.

Applying Polyvagal Theory to Men

I hope that the description of polyvagal theory illustrates how this could be indispensable for working with men and mitigating disengagement or drop-out. Through the polyvagal lens, we may imagine that many men often find themselves dominated by their sympathetic nervous system in therapeutic spaces. Their neuroception is vigilant and sensitive to the perceived social dangers of being vulnerable and asking for help. It may be foreign to men to engage in this kind of emotionally vulnerable communication (Lorber & Garcia, 2010; Stiawa et al., 2020).

If MHP's can use tools to help interact with men's neuroception and help them feel safe, we could begin to shift their ANS into the ventral vagal system and therefore help the social engagement system to come online. This could help men make more headway more quickly in connecting with their therapist to create a strong bond and feel calm and engaged in the therapeutic process. With clients in a flight or fight response, it will be much more difficult to sufficiently engage with the process of therapy and build trust and safety or make headway into the presenting issues, perhaps resulting in the belief that therapy is ineffective and potentially leading to drop-out. This is also a trauma-informed approach and can help engage men sensitively where they are at and what they have been through (Porges, 2024).

Deb Dana (2018), a practitioner who lays out methods for integrating theory into practice, describes the four "R's" of a polyvagal approach in therapy: "recognize the autonomic state, respect adaptive survival response, regulate or co-regulate into a ventral-vagal state, and re-

story" (Dana, 2018, p. 7). Porges (2021) also encourages accurate assessment of the client's neural state in order to effect useful interventions and techniques. Applying this to engaging men in therapy, therapists could develop an accurate perception of where each male client is located in the hierarchy of their ANS when they arrive.

There are cues for therapists to tell whether someone feels safe and engaged within the ventral vagus system, is experiencing heightened flight or fight sympathetic responses, or is dissociated or shutdown within the dorsal vagal system. In recognizing the autonomic state therapists can accurately respond to where each client is at and act accordingly. With clients who feel safe, the therapist may be able to take more chances and move more quickly towards some of the recommendations from the previous section. If a client perceives danger and withholds engagement, there are techniques to help put these men at ease, interact with their neuroception of the environment, and attempt to establish a baseline of safety, trust, and social engagement. This may take longer for some, but it may be important to begin this process and identification early-on to increase the likelihood of continued engagement for effective change.

The next "R" Dana (2018) listed is respecting adaptive survival responses. This is related to the recommendations in the previous section about both challenging and respecting masculinity and its norms. There are valid reasons men feel unsafe to be vulnerable in these spaces. Validating the hesitancy men feel could be an important step in verbally creating a sense of safety and trust in the client's felt sense of their body and environment. It can be relieving and validating to understand that the responses we have to protect ourselves from danger are legitimate and serve to protect us, rather than simply make our lives more difficult when danger is no longer present (Porges, 2017). For example, responses that served us in the past may no longer serve us and trauma responses that protected us in a traumatic event may cause difficulties

in present day safe environments. This does not diminish their value. In the case of men, diminished emotional vulnerability is an effective protective strategy in environments where it is unsafe socially to express emotions. Respecting this is important for moving into finding out when it is useful and when it is a barrier.

Once the state of the client's nervous system is assessed and respected, there are a number of techniques that can be used to help regulate or co-regulate the client's nervous system and bring them back in contact with the SES. This is the third "R" of Dana's (2018) recommendations: regulating or co-regulating into a ventral-vagal state. These include mindfulness techniques such as grounding exercises and breathwork as well as co-regulation via mirroring calm body language. The SES is an essential piece of building the trust and safety needed to engage men. Therapists can use relational cues to help engage this system and create a sense of safety through co-regulation. Common ways of doing this include open body language, a soothing tone, and direct eye contact. Therapists must therefore be self-reflective about what their body language, eye contact, and tone are communicating within the therapeutic environment. Co-regulation is an essential aspect of human relationships and connection and is the process by which our nervous systems attune to and regulate (or dysregulate) each other's (Porges & Dana, 2018). A therapist with a regulated nervous system can therefore help to regulate a dysregulated client.

Most of the time, we will probably be interacting with either the ventral vagal system or the sympathetic nervous system. In cases of trauma, we may find men disengage or shutdown in a more immobilizing way. This is when they shift into the dorsal vagal state (Porges, 2022). Recognizing this is important to help clients gently transition back to the SES. The techniques for this are different than transitioning from the sympathetic nervous system involving more up-

regulation than down-regulation, such as low-dose muscle activation (Brantbjerg, 2019, 2021). This upregulation is more directed at reconnecting with what is numb or no longer felt and building engagement with the environment and body rather than being dissociated from it. Psychomotor or creative arts may be effective as well (Haeyen, 2024).

Finally, Dana's (2018) mention of re-storying is a reframing of the personal narratives surrounding past experiences, trauma, and dysregulation once we have gained some skills in regulation and safety. This is a process by which we find new understandings of our autonomic nervous system and its responses. This helps us move from a state of helplessness and survival-based perception to a state of control, connection, and resilience. Overtime, exploring polyvagal theory with men could be an effective way of normalizing emotional responses as biological in nature and not a personal weakness or failure. As we have seen, feeling a sense of control and having a clear understanding of the dynamic processes of the nervous system could help reduce shame and lead to feeling a sense of control through teachable, practical, and attainable techniques to help self-regulate. It can be very empowering to gain the ability to self-regulate. It is important to find out what works best for each client and aligns with their values. The re-storying could also act as a re-storying of masculinity, finding new understandings of it as an identity that can both empower and disempower depending on our understanding of it.

Summary and Synthesis

Following the logic of my literature review, we have seen that men are struggling to engage in psychotherapy. This is worth mitigating because there are many men who are currently experiencing serious issues that affect our society and economy that could potentially be helped with improved engagement with psychotherapy. We explored some of the barriers that prevent men from engaging with psychotherapy and considered why they persist. Following this, we

delved into the literature on current recommendations for practical ways to inform a practice dedicated to becoming more accessible and engaging to men. Finally, we considered how all of this could fit with and support my recommendation that using a polyvagal lens to inform our interactions with men could lead to improved engagement and outcomes for men accessing help.

The literature I have explored and its evidence and recommendations are gathered along a logic that would benefit from being shared, discussed, and practiced. This is why I have decided to develop the framework for a workshop that explores the statistics on men, discusses the importance of addressing the suffering and disengagement that men experience, considers the effects of masculinity and its cultural and biological influences, and actively engages with current recommendations on engaging men, including how polyvagal theory could be an effective influence on any therapeutic approach to engaging men.

Chapter Three: Discussion and Applied Practices

In this section I will provide a framework for a workshop that applies the research and suggestions found in the literature review. This is a general plan for what a workshop might look like to help counsellors understand the issue at hand, engage reflexively on the subject, and learn some practical strategies or tools that can help engage men in therapy.

Logistics

The intended audience for this workshop would be mental health professionals. It would be directed towards counsellors, however, it may be broadly applicable across mental health services. My intention is to increase accessibility, so I decided to create a one-day workshop. This workshop could be applied online as well as in-person allowing for this workshop to be held at low cost and across diverse regions for those interested. Although mouldable to an online format, my framework and language will focus on the in-person iteration of this workshop. This workshop would run from 8am to 5pm on a Saturday to ensure working professionals could attend more easily. The workshop would roughly follow the flow of my literature review interspersed with activities, discussion, reflection, and practice. Not only hearing information, but also manipulating it, integrating it, and reflecting on it. The workshop would attempt to engage diverse learning processes with elements of lecture, visualization, application, and group discussion.

Recruitment would occur through collaboration with agencies and institutions advocating for men's mental health, hopefully gaining traction through academic and professional networks through word of mouth and intentional outreach to professional communities. This could include targeting communities and professionals who identify themselves as working with predominately male populations or for those agencies or individuals that are struggling with disproportionate

disengagement and drop-out from male clientele. Participants who attend will likely have been aware of modern issues with male mental health and engagement in therapy and are curious to understand how to improve their practice and accessibility for all populations. This is a population that would benefit from an exploration of these observations, taking advantage of the benefits this could bring to their practice. It is also my hope that this information would spread to those less aware of issues in men's mental health and practitioners who have less awareness of these trends, therefore, advocacy and active promotion would be necessary.

Framework

The workshop would begin with an introduction. It would then lead into several topics including how men are struggling, why it is difficult for men to access help, what works, and polyvagal theory. Each topic would end with an activity or discussion. The workshop would then close with a recap, invitation to discussion and feedback, a Q&A, and suggestions for next steps, including further resources and learning opportunities.

Introduction

The day would begin at 8am with an introduction, welcoming participants, and explaining objectives. The workshop leader would bring a polyvagal lens to the teaching of the workshop to model a safe and welcoming energy. The leader would express the purpose of the workshop, which is to understand some of the current struggles men are experiencing, their barriers to accessing help, and how we can mitigate those barriers with a special focus on a polyvagal lens. The introduction would also highlight the importance of this topic in the lives of men, society, mental health professionals, and even family members.

Following objectives and a description, the leader would provide an ice breaker or group bonding exercise to initially increase comfort of the group. Increasing a sense of community,

regulation, and shared values, an activity like this will set the stage and tone of further discussion and collaboration. Acknowledging the diverse professional locations and experiences of its members, the leader would encourage each participant to introduce themselves to the group. For example, each member could speak to what they do, what is their experience, why were they interested in this workshop, and what is their experience or observations in working with men. A skilled leader will address important points made, validate, and integrate them into the learning going forward.

How Men are Struggling

To foray into the subject, the leader would begin with a discussion of what the group members are witnessing with respect to men and masculinity in their own lives and relationships and in a broader social scale. Interspersed within this discussion, current mental health statistics and research would be highlighted concerning substance use, overdose, incarceration, violence, loneliness, and rates of suicide. Discussions of demographics and intersectionality could be an important part of the discussion as age, culture, and socioeconomic factors play a role. We would explore the ways that men are struggling and consider the mismatch between this and the low rates of attendance and engagement by men in therapy, exploring how therapy might contribute to mitigating some of the impacts of these struggles and improving the lives of men. Building on this discussion, the group would turn to a discussion of the usefulness of therapy and how it can improve regulation, relationships, satisfaction, increase safety, and save lives (considering the rates of suicide in men). This would be an exploration of the effectiveness of therapy and why it would matter to help men engage in therapy, not only for individual men, but also for society at large.

→ Activity: In groups of two, discuss personal experiences or beliefs in the effectiveness and transformative power of the therapeutic process. Additionally, consider what impact this could have if more men attended and engaged in these spaces.

Why is it Difficult for Men to Access Help?

Here would enter the workshop's exploration of why men avoid accessing help and disengage or drop out. This would include an in-depth look at masculinity, its cultural and biological roots, as well as how it interfaces with modern health systems. Masculinity and the topic at hand can be sensitive due to historical and current patriarchal oppression, modern concepts of toxic masculinity, hegemonic masculinity, and, among a growing population of men, a sense of male disenfranchisement. This topic is political and personal and can be attached to strong opinions and emotions. It would be essential to acknowledge this and create some group guidelines and expectations for exploring this sensitive topic to ensure a space that is kind, non-judgmental, and open enough for productive conversations to occur no matter the differences in opinions and experiences.

After constructing a space that can contain potentially heightened conversation, the group could begin to discuss the concept of masculinity as they personally understand it and how they believe it to be generally understood and reinforced. What sorts of traits are men expected to embody or preform? What are their roles? How are these norms and expectations reinforced? What are traditional masculinities and how might masculinity be shifting positively and negatively? How has the world shifted and men's place in it?

Additionally, masculinity is built by the combination of socialized roles/expectations and biological/neurological tendencies. Despite the nuance of this balance being largely uncertain,

our political dichotomies often lean heavily to one side or the other. For example, arguing that either men are fixed and determined due to biology or that men are totally flexible and can choose their nature, without much room in between. To remain humble is to acknowledge the influence of both without certainty or constraining masculinity one way or the other. Both extremes provide their own issues and pressures on men (i.e., you cannot change versus you have a responsibility to change who you are). Men are both responsible for adapting and have constraints on what is possible. Understanding this balance of internal drives and external socialization can lead to a place of non-judgment and a humility towards the complexity of male identity, drives, and realistic change.

This would naturally contribute to an exploration of how some of these social and cultural norms and innate characteristics contribute to the barriers men face to accessing therapy, such as being tough, stoic, and hiding weakness. There may be deep fears of stigma, judgment, and mistrust, preventing vulnerability and social engagement. Men may experience a double-bind socially as they are simultaneously expected to be stoic and vulnerable: Judged for not expressing their struggles and also judged when they do ask for help. The group could explore some of the ways society reinforces these patterns while expecting these patterns to shift. Additionally, an exploration of the systems we work in and that men interact with would provide essential insight into the dual nature of the barriers men face. Not only do men find it difficult due to masculinity, but also because of the way systems are designed and treat men. This would include therapy models that do not resonate with male modes of communicating and enacting change.

→ Activity: Small group discussion; What barriers to accessing and engaging in help do you see in the men you work with or the community/systems you work in? How are traditional and modern societal pressures on men restricting and/or liberating?

What Works?

At this point, the workshop would begin to explore practical ways to address these barriers and help men engage in therapy. We may begin by inviting the professionals in the room to deeply inquire into what they find works, what does not work, and what their strategies in working with and retaining male clients are.

Following a discussion of strategies, successes, and observations, the workshop would turn to current literature recommendations on being sensitive to male needs and barriers in therapy, potentially leading to increased engagement. This may begin with an exploration and discussion of how to sensitively balance challenging masculine norms with supporting and respecting masculine strengths and protective factors. It is a client-centred balance that requires a sensitivity to knowing when to push or deconstruct and when to build-up and support. Moreover, the discussion would also explore therapeutic interventions and approaches that men generally resonate with (e.g., goal-oriented work and functional tool acquisition).

Another important facet to explore and discuss within the workshop are cultural and diversity considerations. This increases nuance and centres social justice and ethics in working with diverse male populations and intersectionality. Culture and identity play a large role in attenuating masculinity. For example, socioeconomic status was found to influence rates of male help-seeking in that lower socioeconomic status predicted less help-seeking (Gao et al., 2023). Socioeconomic status is often connected to race and historical injustices. Different forms of

masculinity are also connected to race and culture and exert different levels of values that may inhibit help-seeking. A discussion surrounding the need for sensitivity to these considerations is essential in helping meet all men where they are at with humility and curiosity. This helps reduce barriers for underprivileged and diverse men, thus increasing accessibility and engagement. This also relates to addressing systems and bias. Further discussion would centre on the barriers that the system itself maintains and methods for advocating and influencing change in the systems that we are embedded in or our clients must interact with.

This portion would close on a discussion of the need for early intervention. Mental health professionals could benefit from improving their sense of which men are at risk of disengagement and drop-out. The more quickly we can build rapport and safety, especially with those men we identify as at risk of drop-out, the better chance we may have at engaging these clients in the therapeutic environment and relationship. For some men we may only have one session. How might it influence the work that we do to know that we have only one hour to engage this client? Following this discussion, we would explore the value of building safety and trust, segueing to the workshop's final recommendation of using polyvagal theory as a route to rapid and effective engagement and safety.

→ Activity: small group discussion; consider which approaches resonate most with you? What might you implement into your own practice? Which approaches do you disagree with? Are there any missing? Which modalities might interface best with these recommendations? Which might not?

Polyvagal Theory

Finally, following an exploration of the importance of initial safety and trust, the workshop would explore the application of a polyvagal lens to any therapeutic approach with men to quickly and effectively develop safety and increase social engagement, thereby mitigating drop-out. This section would include a brief check-in about the varying degrees of familiarity with polyvagal theory in the participants. Attuning to the level of expertise in the room, a description of the hierarchical nature of the nervous system, neuroception, and the social engagement system would be necessary. This can be complex and is a subject larger than this workshop can address sufficiently, so a period for discussion and questions should be available to ensure adequate understanding of its basic assertions.

After familiarizing (or re-familiarizing) the participants with the basics of polyvagal theory, the leader would turn the discussion to how this might be applied to men and why it might be effective in helping them engage more fully and consistently. This would include connecting this to various discussions previously held about the male sense of unsafety in spaces of expected vulnerability and emotionally laden conversations. Moreover, connecting this to the sometimes very short window practitioners have to communicate safety to the male client's neuroception. This would include a discussion of Dana's (2018, p. 7) four "R's": recognizing the autonomic state, respecting the adaptive survival response, regulating or co-regulating into a ventral-vagal state, and re-storying. A discussion at each step of implementing a polyvagal lens would be necessary to envision a more concrete image of how this theory could be implemented in practice.

First would be the essential initial evaluation of the client's nervous system state. Are they in a state of fight, flight, or shutdown? Or are they socially engaged and feeling safe? Each

state will determine the approach taken in the remainder of the session (and sessions). Sensing the state of the client will allow a more targeted, attuned, and effective approach to therapy.

If the client is in a state of survival response, special attention should be paid to cues of safety and how the practitioner's tone and body language support this. While building rapport, and in line with the flow of the therapeutic relationship and session, the practitioner would attempt to validate and acknowledge the sense of unsafety and its reality as an adaptive survival strategy. Being wary of vulnerability and exhibiting its accompanying defence mechanisms may have been important strategies for keeping the client safe in their family, community, or culture. Acknowledging the validity of this hesitance, providing assurance and discussing the role of therapy and the therapist could reinforce the safety of the therapeutic environment as free from stigma and judgment. Actively front-loading expectations could make the space less ambiguous and intimidating.

As the conversation unfolds, the practitioner would either actively regulate or more passively co-regulate. Active regulation would include regulation techniques such as grounding, somatic exercises, or mindfulness, and using psychoeducation and offering tools when necessary (as we have seen men looking for in therapy). This would also include an understanding of the need for up-regulation in cases of shutdown and hypoarousal, or down-regulation in cases of fight or flight hyperarousal. Co-regulation would include a therapist with a regulated nervous system, calm and open, more passively and gradually bringing the client's nervous system into regulated alignment.

Finally, and perhaps a more long-term goal, would be to re-story dysregulation and lack of control into empowering stories of adaptation and control using the techniques and skills of regulation and safety. This could also include discussions of cultural and societal influences of

masculinity and their sense of safety, deconstructing internalized stigma and telling a story of masculinity that aligns with the client's values and goals. Ultimately, this could lead to reinterpreting dysregulation and understanding its sources, learning how to tell when it signifies imminent and real danger, and when it signifies outdated and now harmful survival strategies or internalized self-stigma. This is a step that may take longer and interface well with other theoretical approaches (e.g., narrative therapy or acceptance and commitment therapy).

→ Activity: Practice evaluating and naming nervous system states through videos showcasing hypothetical clients. These videos would be consistently used with informed and recurring consent from real clients that previously showed up for a first session. Discuss the varying approaches following evaluation to most effectively engage each state. Practice different cues of safety and explore unconscious cues that are counterproductive. Explore and practice active regulation techniques and discuss the process of co-regulation. Discuss the application of re-storying and validating survival strategies.

Closing

In closing, the leader would provide a recap of the most important points explored in lecture as well as those in each unique discussion of the workshop group. After a recap, participants would be invited into an open discussion: What resonated most? What might you take into your own practice? What did you learn? An invitation to provide any feedback for the workshop and instructor would be given to ensure an evolving and dynamic workshop that grows through the unique and extensive knowledge and experience of each participant. This would be verbal in class with an additional feedback questionnaire online to provide a space for

anonymous and honest feedback from all. Finally, a Q&A would occur to ensure any remaining questions or confusions could be addressed. Following the Q&A, the instructor would provide direction to resources and next steps for further exploration and learning, for example, recommended books, articles, podcasts, or training opportunities. One such resource, for a specific example, could be Deb Dana's *The Polyvagal Theory in Therapy: Engaging the Rhythm of Regulation* (2018) which applies polyvagal theory to practice, providing a more in-depth exploration and description of integration than could be covered in the workshop. Next steps might look like additional trainings that would support participant's insights around and commitments to engaging men potentially gained through the workshop, such as further poly-vagal training, solution-focused trainings, or male-specific gender sensitive trainings. Next steps may also include information surrounding advocacy, spreading information and enacting change in our systems and policies.

Conclusions

In developing this framework for a workshop, it is my hope that it is both accessible and engaging. Although lecture and psychoeducation are integral to sharing essential data, research, and methods, the intention is that discussion plays a central role in the workshop to develop each individual practitioner's critical thinking and its application to the topic. Engaging in this way will hopefully develop each participant's capacity to build a unique connection and understanding of the subject, allowing for integration with each practitioner's philosophical orientation and therapeutic style. It also involves elements of practical application, with an emphasis on envisioning how these recommendations and techniques may interface and be implemented into each participant's practice. This means taking what works and leaving what does not feel relevant, all the while exploring current literature and statistics to inform these

decisions. Finally, it is also my hope that this workshop embodies humility and curiosity and avoids pedagogy that feels dogmatic or politically stagnant. It would strive to meet participants, their beliefs, and their values where they are at, providing respectful and constructive discussion that encourages perspective taking and productive conversation. This workshop would thereby welcome those of all opinions and beliefs into the discussion to develop a strong foundation to help men engage with therapy and hopefully find safety and growth.

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