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# Social Scientific Paradigms of Masculinity and Their Implications for Research and Practice in Men's Mental Health



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Clinical researchers and practitioners are increasingly aware of the need for quality theory, research, and intervention in men's mental health. Successful work in this area requires an understanding of the multitude of ways that gender, and more specifically masculinities, can be conceptualized beyond a sole focus on sex differences between men and women. Drawing from a range of social sciences in addition to psychology, the authors consider several theoretical, research, and clinical directions that can follow from social learning, psychodynamic, social constructionist, and feminist paradigms. It is concluded that thinking deeply and critically within different paradigms of masculinity is critical for progress in both research and practice. © 2005 Wiley Periodicals, Inc. *J Clin Psychol* 61: 633–647, 2005.

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## Why Men's Mental Health Per Se?

The appearance of this special issue suggests that the psychology of men and masculinity may be gaining the attention of clinical psychologists, and for good reason. Men's issues are increasingly visible in the popular media (e.g., Faludi, 1999). Newspaper and magazine articles continue to appear on topics such as the decreasing number of men in the workforce, or the decreasing percentage of boys graduating from high school and men graduating from college. Television and radio talk shows regularly focus on changing roles for men as women increasingly enter the public workforce and challenge traditional, restrictive, feminine roles. Many popular television programs (e.g., *The Man Show*, *The Family Guy*) present hypermasculine characters that call attention to problematic aspects of traditional masculinity while simultaneously reinforcing them. In short, men's gendered experience is increasingly visible in our day-to-day lives.

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But beyond the creeping public awareness that men's roles are changing, there are additional reasons that clinical researchers and practitioners should be concerned with men's mental health. First, researchers have begun to document significant mental and physical health problems facing men. Men die nearly 7 years younger than women and have higher mortality rates for all 15 leading causes of death (U.S. Department of Health and Human Services [DHHS], 1996). It is possible that biological differences between the sexes account for some of this discrepancy in expected life span, but there is strong evidence to show that men also practice more risk-taking and unhealthy behaviors than women (Courtenay, 2000). In addition to the physical health-related risks facing men, men are almost twice as likely as women to suffer from substance abuse or dependence (Kessler et al., 1994), and men are three to five times more likely to commit suicide (Moscicki, 1997).

The fact that men experience significant mental health problems should not be surprising; men are human beings, and human beings often experience problems in living. But for a variety of reasons, some of which we touch on briefly in this article, historically men's mental health has not been a topic of major research or clinical interest in its own right. It is certainly true that there have been many men treated for mental health problems and many men participating in research studies. However, in the latter case in particular, men's gendered experience itself has not been the focus in theory or method. For example, epidemiologic statistics suggest that for the majority of mood and anxiety disorders found in the *Diagnostic and Statistical Manual of Mental Disorders* (Task Force on DSM-IV, 2000), women are significantly more likely than men to meet criteria for a diagnosis. But why this is the case is not entirely clear (Kessler, 2000). Do women actually experience greater rates of these disorders than do men? If so, why? Are some diagnostic criteria biased to overrepresent problems in women and to underrepresent problems in men? Are men more likely to "mask" emotional distress with substance abuse and violence, two problems for which men clearly outnumber women (Cochran, this issue)? These are complex questions that require an understanding of the way gender, at all its levels of social formation, from the highly personal to the political, cultural, and economic, is linked to the experience and expression of mental health problems. For example, there is a widening body of research linking various aspects of traditional masculine gender socialization to both an increased risk for mental health problems and to an increased resistance to seeking treatment. (e.g., Addis & Mahalik, 2003; Eisler, 1995; Good & Wood, 1995; O'Neil, Good, & Holmes, 1995).

A third reason to increase attention to men's mental health is the simple fact that men underutilize health services relative to women for virtually every mental and physical health problem for which help-seeking has been studied (Addis & Mahalik, 2003). The public health implications of men's reluctance to seek help recently led the National Institute of Mental Health to unveil the Real Men Real Depression public awareness campaign, which is designed to combat the stigma associated with depression and help-seeking in men. There is a strong need to develop and test treatments that reach men, and these must be marketed in ways that are acceptable to men who are resistant to traditional forms of professional help-seeking (Rochlen & Hoyer, this issue). The processes of treatment development and message dissemination should be guided by a firm grounding in theory and research on the psychology of men and masculinity.

Finally, when men drink excessively, become angry or violent because feelings of depression are intolerable, or refuse to seek help for an anxiety disorder because they believe they should be able to control their emotions, it is not only men themselves who suffer but also families, communities, and places of work. Increasing our understanding of the ways men experience and express mental health problems, and recognizing treatment-related issues particularly salient for men, will benefit women and children in addition to men themselves.

## Thinking Clearly About Men and Masculinity: Beyond Sex Differences

Effective research and practice in men's mental health requires clear thinking about the various ways gender can be conceptualized. For most of us, when we think of how gender may be related to mental health problems, we immediately think of sex differences. The question, "How is gender related to depression?", for example, is typically understood to mean, "How do men and women differ in their rates of depression?" or "How do men and women differ in some hypothesized mechanism underlying depression?". In effect, such questions subtly frame questions of gender as questions of difference. By following this logic, the study of men's mental health becomes the study of how men and women differ on some psychological trait or behavior or some underlying biologic mechanism.

Focusing on differences as an organizing framework is severely limiting when it comes to understanding men's (or women's) experiences of problems in living. As Liu (this issue) and others have argued, understanding the social context of masculinity (and gender more broadly) is similar to understanding the social context of race and ethnicity. Approaching important questions only from a perspective of difference is a bit like assuming we can only understand one racial, cultural, or ethnic group by comparing it with another. Surely, no one would argue, for example, that a meaningful understanding of Portuguese culture could only be arrived at by comparing Portuguese and American persons on a variety of measures.

In contrast, our assumption is that thinking clearly about men's mental health begins with the recognition that gender (e.g., masculinity) emerges at the intersection of a series of interwoven social formations involving historic, economic, political, linguistic, interpersonal, and psychological threads (Falmagne, 2000). Gender is about much more than sex differences between men and women on interesting dependent variables. Recognizing this can be particularly difficult for psychologists because, in many respects, we have remained isolated from epistemic and methodological developments in analyses of gender in other social sciences. It is encouraging that current research directions in the psychology of masculinity often reflect a concern not with sex differences but with variability within a gender category (e.g., between-men differences in adherence to restrictive masculinity norms, see Mahalik, Talmadge, Locke & Scott [this issue]).

One of our central goals in this article is to expose clinical psychologists to the variety of ways masculinity can be theorized and studied in the context of men's mental health. We consider four different paradigms and for each one discuss current directions in theory, research, and intervention. For the latter two directions in particular, many of our ideas are speculative and suggestive. The reason for this is straightforward; research and practice in men's mental health is a relatively young field. The work to date has yielded numerous insights into links between masculine gender role socialization and men's mental health, but much remains to be done. Finally, at the risk of stating the obvious, none of the paradigms we consider is "right" or "best." Each makes more or less salient the formation of masculinity at different levels of social organization. As a result, each provides a different window into the experience and expression of mental health problems in men, both in and out of treatment.

Two of the paradigms we consider, social learning and psychodynamic frameworks, are close to the traditional individually and interpersonally focused frameworks of psychology. The other two, social constructionist and feminist frameworks, are further "outside the box" and bring psychologists closer to contemporary theory and research in other social sciences including sociology, anthropology, women's studies, and other disciplines. Each of the articles in this special section draws on elements contained within the different paradigms to address substantive clinical issues. It should be noted, however,

that these are by no means the only paradigms available for understanding men's experience. Evolutionary psychology, for example, has also been applied to the study of both masculinity (Buss, 1992; Wilson & Daly, 1992) and mental health problems (Trevathan, Smith, & McKenna, 1999). We chose the current four because, at present, they are the most widely used paradigms in the social sciences for understanding masculinities and men's experience. In addition, these four paradigms epistemologically and methodologically represent a diverse array of perspectives on men's mental health. Finally, theorists and researchers within each of the paradigms have emphasized the diversity of men's experience along the lines of social categories such as race, social class, and ethnicity. We have chosen to explore issues of diversity primarily in the discussion of social constructionist and feminist frameworks. This decision is largely a practical one, given constraints on space, and it also reflects the greater degree to which race, social class, and ethnicity have been addressed within these paradigms.

### Psychodynamic Paradigms

#### *Theoretical Directions*

Psychodynamic approaches to masculinity have tended to focus on the early years of men's lives, and particularly on hypothesized formative interactions with caregivers that shape men's subsequent emotional and interpersonal development. These early experiences and relationships with caregivers are assumed to be critical in shaping boys' capacity for relatedness and sensitivity to their own and other's emotions as they develop into adult men.

Whereas Freud's original work on masculinity focused on psychosexual impulses and conflicts, contemporary psychodynamic theorists of masculinity draw more from object relations and self-psychological approaches (Chodorow, 1978; Edley & Wetherell, 1995; Greenson, 1968; Krugman, 1995; Pollack, 1995). For example, by extending the work of Chodorow (1978), Pollack (1995, 1998) focuses on the "traumatic abrogation of the early holding environment" that boys are hypothesized to experience prematurely as a result of pressures to disidentify with their primary caregiver, who is often a woman. Pollack (1995) further characterizes this process as a "normative gender-linked developmental trauma" and quotes Chodorow's description of the process as follows:

Mothers tend to experience their daughters as more like, and continuous with themselves. . . . By contrast, mothers experience their sons as a male opposite. Boys are more likely to have been pushed out of the pre-oedipal relationship and to have had to curtail their primary love and sense of empathic tie with their mother. A boy has engaged and been required to engage in a more emphatic individuation and a more defensive firming of experienced ego boundaries. (Chodorow, 1978, p. 166)

Because the mother is often the primary source from which infants and toddlers develop a sense of safety and intimacy in interpersonal relationships, this premature disidentification is assumed to leave many men with severely repressed emotional needs for intimacy and connection to others.

Theorizing within an intrapsychic framework, Krugman (1995) argues for the centrality of shame as an organizing affective process in men's development. Krugman's argument is complex. One of the main premises is that boys and men are both particularly attuned to shaming responses from others (especially other men) and also very ill-equipped to cope with or transform their own affective experience of shame. This double-bind of sorts can be understood by distinguishing between the experience of shame as a

powerfully overwhelming emotion (shame as a primary affect) and shame as an emotional experience conveying useful information about the appropriateness of recent behavior in a particular interpersonal context (shame as a signal affect). Krugman draws on the processes of disidentification discussed above, as well as some of the socialization pressures identified in social learning paradigms, to explain why many young boys are intensely phobic of rejection by others and will go to great lengths to avoid the possibility.

### Research and Directions

Contemporary psychodynamic perspectives on masculinity could lend themselves well to empirical research on parent-child interactions that may influence boys' development, particularly at the intersection of emotional and social development. For example, Pollack's work on disidentification in boys makes very specific predictions about links between pressures on boys to separate from primary caregivers and the development of ambivalence and conflict over intimacy in subsequent relationships. However, to our knowledge, this hypothesis has never been tested empirically. Similarly, Krugman's assumption that young boys are "shame phobic" has not been verified by empirical research. More generally, the specificity of psychodynamic theories regarding critical processes in boys' and men's development is a strength that makes them well suited as guides for hypothesis-driven longitudinal research on social and emotional development. Although there is an increasing body of research within the general framework of developmental psychopathology, little of it, if any, appears to be guided by theoretical frameworks specific to the psychology of men and masculinity.

### *Intervention Directions*

If empirical support emerges for the harmful effects on boys of pressures for premature disidentification, psychoeducation with parents of infants and toddlers could be a promising direction for intervention. Currently, individual and group therapies are the most common extensions of psychodynamic theories to clinical practice. The approaches described by Pollack (1995, 1998), Krugman (1995), and Bergman (1995) lend themselves to both insight-oriented and process-oriented therapies (e.g., using the therapeutic relationship as a mechanism of change). Group therapies may be particularly helpful for men struggling with a variety of relational issues (Andronico, 1996). All of these potential interventions could and should be evaluated in controlled clinical trials.

### Social Learning Paradigms

#### *Theoretical Directions*

Social learning paradigms are probably the most common approaches in psychology to studying gender. Although there are a variety of different social learning frameworks, they all proceed from the assumption that gendered behaviors, beliefs, and attitudes are learned from social environments through basic processes of reinforcement, punishment, modeling, and the acquisition of gendered schemas or belief systems (Eckes & Trautner, 2000; Fagot, Rodgers, & Leinbach, 2000). As Kimmel and Messner (1998) suggest, "We may be born males or females, but we become men and women in a cultural context" (p. xvi).

Social learning approaches to studying men's experience in particular have drawn heavily on the sociological construct of roles which are seen as prescribed repertoires of

behavior that form particular social positions. Rather than viewing masculinity as a fixed set of attributes or personality traits resulting from statistically normal male development, masculinities are seen as historically changing roles supported by gendered norms, stereotypes, and ideologies (Pleck, 1981). For example, O'Neil and colleagues (e.g., O'Neil, Good, & Holmes, 1995) developed the concept of gender-role conflict to describe the psychological consequences of socialization according to restrictive traditional masculine ideologies and norms. These ideologies and norms have been variously described as emphasizing physical toughness, emotional stoicism, antifemininity, a preoccupation with success, power, and competition, as well as rigid self-reliance, and homophobia (Brannon & David, 1976; Mahalik et al., 2003; O'Neil, Good, & Holmes, 1995; Thompson & Pleck, 1986). Although the construct of *role* as a framework for understanding gender has been critiqued (Connell, 1985), the more specific constructs of gender-role conflict (O'Neil et al., 1995), gender role strain (Pleck, 1981, 1995), and gender role stress (Eisler, 1995) have continued to be employed widely as heuristics for understanding the relations between masculine gender socialization and a variety of behavioral and physical health-outcomes.

### *Research Directions*

Of the four paradigms we consider, the social learning framework has generated the largest body of research on issues related to masculinity, psychopathology, and treatment. Epistemologically, the majority of social learning research been conducted within the traditional positivist approach common in modern empirical psychology. Methodologically, studies have tended to focus on quantitative measurement of associations between various masculinity-related individual difference variables, symptoms of various psychiatric disorders, and attitudes toward seeking treatment. For example, higher scores on measures of gender-role conflict have been associated with a variety of negative mental health outcomes including increased symptoms of depression, anxiety, anger, and substance abuse (Blazina & Watkins, 1996; Good et al., 1995; Hayes & Mahalik, 2000), as well as negative attitudes toward seeking treatment (Blazina & Watkins, 1996; Good, Dell, & Mintz, 1989; Good & Wood, 1995). Good, Thompson, and Brathwaite (this issue) and Good, Robertson, O'Neil, Fitzgerald, DeBord, and Stevens (1995) review the results of this and similar research in greater detail.

Although the results of existing work on masculinity and men's mental health from within a social learning framework are encouraging, much remains to be done. The majority of existing research has yielded correlations between individual differences in adherence to traditional masculinity norms and a variety of mental health problems. What remains unclear is why such relations exist. There is a strong need for research on psychological mechanisms (broadly defined) that mediate relations between adherence to traditional masculinity norms and poor mental health outcomes. For example, a strong belief in the value of emotional stoicism may lead some men struggling with depression to perceive emotional distress as shameful and, consequently, to hide their symptoms from others (Magovcevic & Addis, 2004).

There is also a clear need for research on developmental determinants of masculinity ideologies in childhood and adolescence. Masculinity ideologies can be understood as beliefs about both what it means to be a man and what acceptable and unacceptable behaviors are for men (Pleck, Sonenstien, & Ku, 1993; Thompson & Pleck, 1995). Why and how do some boys develop particularly rigid and maladaptive notions of what it means to be a man (e.g., the notion that a *real* man is aggressive and violent) and others

do not? Are masculinity ideologies in childhood and adolescence related to the way boys experience and express subclinical levels of emotional distress? Are patterns of responding to soft emotions such as sadness, loneliness, or grief in young boys related to the way they cope with emotional difficulties as adults? Although there is a fairly extensive body of research on reinforcement of sex-typed behaviors in young boys and girls (Fagot, Rodgers, & Leinbach, 2000), virtually no research has examined the way masculinity ideologies develop in boys and how they affect responses to problems in living.

### *Intervention Directions*

From a social learning perspective, intervention proceeds by helping boys and men to buffer or ameliorate the harmful effects of traditional masculine role socialization. In an individual therapy context, men struggling with particular problems such as depression, anxiety, substance abuse, or relationship conflict can be helped to gain insight into the ways that adherence to particular masculinity norms (e.g., risk taking, emotional stoicism) exacerbates their problems. Men can then develop new ways of responding to emotions and relating to others that are less influenced by negative aspects of traditional masculinity. Researchers within a social learning paradigm have already begun to develop such treatments (e.g., Andronico, 1996; Brooks, 1998; Levant, 2001). However, at this point, none of the treatments have been tested in controlled clinical trials (see Good, Thomson, & Brathwaite, this issue).

Social learning approaches to masculinity can also be used to inform development of psychoeducational and preventative interventions. For example, social norms marketing is an approach to challenging existing norms and belief systems about particular sets of behaviors (e.g., substance abuse) that may prove helpful in reducing the stigma associated with mental health problems among men (see Rochlen & Hoyer, this issue). Because masculinity ideologies begin to develop in early childhood and continue to take shape through adolescence, preventative interventions in school systems are another promising direction for intervention development. Young boys could benefit from psychoeducation on the acceptability of emotional expression and help-seeking behavior, as well as the normativeness of emotional distress among their peers (Addis & Mahalik, 2003). Similarly, psychoeducational programs could be used to educate parents and teachers about the potential harmful effects for young boys of adopting particular masculinity ideologies.

## Social Constructionist Paradigms

### *Theoretical Directions*

Social constructionist frameworks are currently the most common approaches to studying gender in a variety of social sciences other than psychology (e.g., Gergen, 1999; Harre, 1993; Shotter, 1993). Although social constructionist paradigms are often confused with social learning frameworks, there are some critical differences. Both frameworks begin with the assumption that gender is socially formed rather than existing naturally as qualities inherent to men or women. However, whereas social learning approaches focus on the way social environments shape gendered behavior, social constructionist perspectives highlight the different ways gender itself is actively constructed at a variety of social levels from the micro-interactional or dyadic to the cultural. Thus, the emphasis shifts from a view of individuals as respondents to processes of reinforcement and punishment (i.e., social learning) to a view of individuals as active agents who construct particular meanings of masculinity in particular social contexts.

From a social constructionist perspective, masculinities are flexible; they are constantly being constructed and challenged as men “do gender” in ways that mark themselves as masculine (Connell, 1995; West & Zimmerman, 1987). In this sense, gender is interactive and social and can best be theorized as a verb rather than a noun. Gender does not exist as a set of fixed roles set forth by culture or society, nor as a group of stable personality traits, but rather as dynamic repertoires put into action by individuals interacting with their social environments. The social construction of gender also occurs at more macro levels of social organization. For example, professional sports can be seen as a set of cultural practices in which particular meanings of masculinity are constructed through advertising, media coverage, and a wide array of symbols associated with competitiveness, physical prowess, and insensitivity to pain. (Messner, 1990; White, Young, & McTeer, 1995).

A central assumption in social constructionist frameworks is that there is not a singular masculinity but rather multiple competing masculinities that are continuously being constructed and contested (Connell, 1995). For example, White lower-class suburban masculinities may take different forms than Latino urban masculinities, although they may also share some features. Thus, some social constructionist theorists have emphasized the different ways race, ethnicity, and social class are simultaneously constructed alongside different masculinities. In effect, there is nothing called *masculinity*, but rather urban African-American masculinities, White middle-class masculinities, and so on. Finally, social constructionist frameworks allow, and in fact expect, considerable contextual variability in the construction of masculinities. For example, Kupers (this issue) describes a specific form of masculinity he terms “toxic masculinity” that is thought to be common among men in prison.

### *Research Directions*

Research proceeding from a social constructionist framework typically employs qualitative methods within a nonpositivist epistemology. Because *social reality* is assumed to be in a constant state of construction and reconstruction, there is less concern with objective measurement. Instead, the researcher’s focus is on in-depth interpretation of the way social processes such as gender are constructed, or subjectively lived. In relation to masculinity, researchers have examined issues such as men’s experience of coronary heart disease (Helgeson, 1995) and the way male athletes construct the meaning of sports-related injuries (White, Young, & McTeer, 1995). For psychologists working within a social constructionist framework, research data are typically drawn from naturalistic samples of talk or discourse that occur in particular social contexts and addresses particular issues of importance. For example, Bamberg and colleagues have studied the way adolescent boys construct heterosexual identities through discourse about male to female relationships (Bamberg, in press; Korobov & Bamberg, in press).

There are a variety of ways social constructionist frameworks could guide research on men’s mental health. A useful place to start is examining the ways different men talk about the experience of mental health problems while negotiating the demands of traditional masculine norms and ideologies. For example, it might be expected that traditional masculine ideologies about the importance of solving problems oneself, rather than asking for help, would lead some men to characterize depression or other nonpsychotic mental health problems as signs of “weakness,” or to insist that, “It’s not that bad. I can handle it on my own.” On the other hand, masculinity discourses about active problem-solving and independence can also be appropriated to justify the process of seeking help



(e.g., “I don’t care what people think. I’ll do whatever I need to beat this thing, even if it means seeing a shrink.”).

Qualitative approaches to research on men’s characterizations of mental health problems are well equipped to deal with complex and shifting constructions of meaning in ways that traditional empirical and quantitative methodologies are not. Suppose, for example, that we were interested in understanding the degree to which different men characterize anxiety disorders as significant versus minor problems in their lives. A quantitative empirical methodology would require us to formulate single perceived severity scores, or perhaps factor scores for perceptions of different types of severity such as symptom distress, work or school dysfunction, and so on. Such an approach is not inherently problematic, and there is certainly useful information to be gained by asking men to report, in general, how severe they perceive a problem to be. However, the approach necessarily glosses over variability in the way men may construct the meaning of an anxiety disorder depending on what is at stake in different social contexts. For example, some men may conceal an anxiety disorder from peers at work, characterize it to their spouses as a major problem requiring sympathy and support and, among male friends, construct it as a significant challenge that they have “just had to deal with.” Each of these constructions of the meaning of an anxiety disorder in a man’s life may be linked to the way he experiences and copes with the problem and are worth examining closely.

### *Intervention Directions*

As with social learning frameworks, social constructionist perspectives on masculinity can be used to guide preventative interventions targeted to young boys, adolescents, and adult men. At a macro level, attention should turn to the way masculinity and mental health are constructed in major media forums. For example, the traditional stigma associated with mental health problems in men has recently been challenged by popular male athletes such as football running back Ricky Williams and former quarterback Terry Bradshaw publicly discussing their experiences with anxiety disorders and depression, respectively. At the same time, young boys and men continue to be portrayed primarily as emotionally stoic, self-sufficient, and without significant mental health problems.

At a more micro level, attention could be turned to the ways masculinity and mental health can be reconstructed in young boys’ discourse with family members, teachers, and peers. Teachers, for example, can lead conversations with young boys that explicitly reconstruct masculinity and the experience of mental health problems in ways that conflict with dominant norms and ideologies. For example, teachers may ask questions such as, “Is it possible to be a man and to feel sad, lonely, or depressed? Why or why not? How can a man be strong and independent and ask for help when he faces problems?”

Social constructionist frameworks have been used to develop a variety of psychotherapies that use the construction of narratives as hypothesized mechanisms of change. White describes the importance of narratives in the following way:

It is through self-narrative that persons give meaning to their experiences and achieve a sense of their lives unfolding; it is through narrative that persons structure their lived experience into sequences of events in time—through past, present and future—and according to certain plots. These personal narratives are not reflections of lives as they are lived, but narratives that are actually constitutive of life; they are not stories about life, but stories that have real effects in the shaping of lives and of relationships. (White, 1996, p. 175)

The process of narrative therapies involves a gradual retelling of critical events in the past and possible future life narratives as well. To our knowledge, no narrative therapies have been developed specifically for working with men, or for specific disorders.

## Feminist Paradigms

*Theoretical Directions*

Similar to social constructionist perspectives, feminist paradigms view gender as a social formation that can occur at a variety of levels of social organization from the micro-interactional (e.g., dyadic) to the cultural (Falmagne, 2001)<sup>1</sup>. Both paradigms also cross traditional disciplinary boundaries in the social sciences to incorporate sociological, anthropological, historical, and psychological perspectives. Broadly speaking, both paradigms also share some epistemologies (e.g., nonpositivist, postmodern, constructionist) and methodologies (e.g., qualitative methods). Where feminist perspectives on masculinity depart is in the degree to which power differences between men and women are seen as central to any analysis of gender. Gender is understood as a multilevel system that organizes relationships between men and women in such a way that men are economically, politically, and often interpersonally dominant. Thus, masculinity can not be understood apart from men's place as a group in a social order that privileges them.

In terms of men's mental health, feminist frameworks make salient the variety of ways that power shapes men's experience and, in turn, how men's experience and behavior maintains power. For example, men's reluctance as a group to seek help for mental and physical health problems can be seen partly as a function of the desire to avoid appearing "weak" and possibly being exploited or dominated by other men or women (Addis & Mahalik, 2003). Avoiding seeking help also helps to construct men as stronger and better able to handle problems than women. Neither of these need to be conscious processes, nor even psychological in an individualistic sense. They can be seen as routinized practices that maintain power relations between the sexes and are enacted in everyday interactions with the social world.

It is important to note that there is a difference between the existence of power relations between men and women and the subjective sense of power that individual men do or do not feel in a given social context. Although feminist analyses of gender make it clear that as a group men hold positions of power and privilege in society, many men feel subjectively disempowered (Kaufman, 1994). There are at least two reasons why this is the case. First, members of a privileged group are typically the least likely people to be aware of their privilege. In fact, one of the benefits of being in any dominant position is the subjective invisibility to oneself of one's own privilege. In effect, dominant individuals or groups need not attend to their place within a social hierarchy; they are free to behave naturally.

The second reason that many men may feel subjectively disempowered is that there are great emotional costs to the constant striving to erect and maintain positions of power. As Kaufman describes it:

There are many things men do to have the type of power we associate with masculinity: We've got to perform and stay in control. We've got to conquer, be on top of things, and call the shots. We've got to tough it out, provide, and achieve, meanwhile we learn to beat back our feelings, hide our emotions, and suppress our needs. (Kaufman, 1994, p. 148)

Finally, power is not distributed evenly among all men, and a person's social position affects his subjective sense of power. Men facing discrimination by other men on the

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<sup>1</sup>As we use the term here, *feminist* refers not only to political movements seeking equality for women but also to the large body of scholarship in the social sciences and humanities that takes the analysis of gender relations as its primary subject.

basis of socioeconomic class, ethnicity, skin color, or sexual orientation do not have equal access to the variety or degree of social resources available to white, upper class, heterosexual men.

### *Research Directions*

Research proceeding from a feminist perspective would likely explore the variety of ways power plays a role in shaping men's experience and expression of mental health problems. Theoretically, life experiences that lessen individual men's sense of power (e.g., loss of a job, divorce), or reduce their position in a dominance hierarchy (e.g., being demoted, physical injury) should be linked to a greater risk of anger, depression, anxiety, or substance abuse. Although negative life events have been linked to an increased risk for depression (Hammen, 1999; Holahan, Moos, & Bonin, 1999; Kendler, Thornton, & Gardner, 2000), specific power- or dominance-relevant environmental events have not been explored in direct relation to men's mental health.

Qualitative research can help to reveal the way power may be embedded in men's accounts of mental health problems once the problems arise. Power and dominance concerns may be particularly salient for men who adhere to traditionally masculine norms and endorse masculine ideologies of success, power, and competition (O'Neil, Good, & Holmes, 1995). For example, in our own research group we have recently begun conducting open-ended qualitative interviews with lower- to middle-class men experiencing symptoms of depression. As part of the interviews, we ask participants to characterize the experience of depression in their own words. One recurrent theme is the idea that depression reduces status by making a person less gregarious, less easy going, and less *up*. Several participants also characterized depression as inhibiting their ability to be effective "salesmen" in both their professional and personal lives. These statements suggest that awareness of one's social position in relation to friends or business associates may be a salient theme in some men's experience and expression of depression.

Feminist researchers have also emphasized the ways that race, ethnicity, social class, and gender play a central role in shaping all aspects of individual experience, including the experience of mental health problems (Acker, 1999; Nakano Glenn, 1999). For example, African-Americans are less likely than Whites to have private health insurance to cover the costs of psychotherapy or medications (U.S. Department of Health and Human Services, 2001). African-American persons are also more likely to fear mental health treatment (Sussman, Robins, & Earls, 1987) and to be less knowledgeable about depression than Whites (Zylstra & Steitz, 1999). There is a strong need for research that explores links between race, ethnicity, and social class in shaping men's experience of mental health problems (see Liu, this issue).

### *Intervention Directions*

An analysis of the ways power plays into boys' and men's development is a potentially useful starting point for prevention work. For example, adolescent boys' willingness to both disclose mental health problems to others, or to seek help, may be partly a function of the degree to which power dynamics are present in their family and peer systems. Psychoeducation prevention efforts similar to those described in the section on social learning paradigms could be designed and modified to include information about how power and competition among friends can be harmful, while also being a normal part of adolescent male development.

Although the development of feminist psychotherapies has been targeted toward women (e.g., Brown, 1994), there is no reason, from a purely clinical standpoint, why theory and research from a feminist perspective cannot be used to help men in psychotherapy. Men in therapy may be helped to realize the varying degrees to which their efforts to acquire or maintain interpersonal power in their relationships, or economic and other forms of social power in the public sphere, may be causing problems in their lives. For example, the ideas "I should always win" or "I should never allow myself to be influenced by others" could be viewed as cognitive distortions potentially modifiable through standard cognitive therapy interventions (Mahalik, 1999, 2001).

### Some Concluding Thoughts on Paradigmatic Thinking

We have provided what can be described as a whirlwind tour through four different paradigms for approaching research and practice in men's mental health. Out of necessity, we have highlighted only a few of the potential directions that social learning, psychodynamic, social constructionist, and feminist paradigms can take in exploring men's mental health. Apart from considering the theoretical, empirical, and clinical implications of each paradigm, there is a broader question that deserves consideration: What is the value, if any, of paradigmatic thinking in work on men's mental health?

Theoretical grounding is critical in clinical research and practice. In all of psychology, but particularly in the study of gender, stereotypes, popular wisdom, and common sense inevitably shape the way we understand the phenomena that interest us. This is not necessarily problematic as long as practitioners and researchers are aware of the degree to which their thinking is being shaped by stereotypes, common sense, and so on, and also are able to theorize in a more formal manner when necessary. The value of paradigmatic thinking for research and practice is that it forces us to assess the internal logic and the empirical basis of our claims about the nature of men's and women's experience. This is possible, in large part, because there are few limits to how thoroughly a problem can be pursued theoretically, empirically, and practically within a single paradigm. Each paradigm we discussed is capable of guiding a wide array of theoretically grounded research programs and interventions. In contrast, the premature jump to eclecticism often precludes theoretical and empirical advances within individual frameworks.

Of course, paradigmatic thinking can also become overly dogmatic, rigid, and oriented toward maintaining the status quo in research and practice. This is one of the most common arguments for a more eclectic or integrative approach. Despite their popularity, eclecticism and integration can be as problematic as dogmatism when it comes to research and practice. The danger lies in combining theories and constructs that appear compatible on the surface but evolve from incompatible paradigms or root metaphors (Pepper, 1947). Integration at the level of metatheory (i.e., integrating theories themselves) is certainly a worthwhile pursuit. However, premature integration or eclecticism at the level of investigating specific problems in men's mental health is potentially less helpful than rigorous intervention and research grounded within particular paradigms.

Our sense regarding research and practice in men's mental health is that the greatest progress will be made not by blindly adhering to a single paradigm regardless of its actual utility in addressing a problem of interest, nor by loosely picking and choosing constructs from different paradigms and characterizing the work as integrative, but by being able to think deeply and critically within a variety of different paradigms. We must evaluate the utility of particular frameworks by the progress they yield in understanding and working with the problems we seek to solve; in the field of men's mental health, such problems are not in short supply.

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