Ellwood, M. W. (2024). Levels of Therapeutic Relationship When Working With Male Clients. *Psychotherapy and Counselling Journal of Australia, 12*(1). https://doi.org/10.59158/001c.116699

ARTICLES

# Levels of Therapeutic Relationship When Working With Male Clients

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Keywords: therapeutic engagement, males, men, counselling, gender, psychotherapy

https://doi.org/10.59158/001c.116699

Psychotherapy and Counselling Journal of Australia

Vol. 12, Issue 1, 2024

At a time when men are seeking therapeutic support at increased levels, identifying and responding to the type of engagement sought by male clients increases the possibility for stronger engagement and retention of men in therapy. This highlights the importance of the perceived challenges of engaging and working with male clients, particularly in attempting to overcome the temptation to label such clients as "resistant". In 1988, Steve de Shazer and the Brief Family Therapy Centre proposed that clients present seeking different levels of therapeutic engagement (visitor, complainant, and customer relationships). A more recent solution-focused model originating in Bruges has suggested similar levels of engagement between client and practitioner (uncommitted, searching, consultant, and expert relationships; Isebaert, 2016). This paper compares and discusses the two models of therapeutic engagement levels and considers the clinical implications of these for working therapeutically with male clients.

It is common within therapeutic networking circles, supervision groups, and organisational case meetings to hear the sentiment, "Men can be so challenging to work with as clients!" At the same time, anecdotally it is evident that the number of men seeking support services, often for the first time in their lives, has increased over recent years. To date, limited empirical research has explored the actual rates of contact and engagement by men with mental health and support services; however, those limited studies and reports that do exist suggest a steady increase in this contact over time, such as calls to helplines (Machlin et al., 2017) or contact with a general practitioner or mental health service (Wong et al., 2022). Despite these seemingly increasing numbers, the rate at which men seek support is still substantially lower than that of women (Australian Bureau of Statistics, 2023).

Only in the last several decades has greater attention been focused on men in relation to help-seeking behaviour. Stevens and Englar-Carlson (2006) made the (unsurprising) observation that for the majority of the years of writing about therapy, "knowledge about psychotherapy appeared to be structured from a male perspective about treating women" (p. 5). Typically, the lens through which men's help-seeking behaviours has been explored in

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the literature has focused on gender roles and attitudes. Many attribute the obstacles that men face in seeking help to factors such as levels of emotional intelligence, difficulties engaging in "talk therapies", and intergenerational values and beliefs regarding seeking help. This can be understood further through lenses such as Brannon's (1976) articulations of the expectation of the "blueprint for manhood" (p. 1): the "big wheel" (importance of being successful, p. 110); the "sturdy oak" (being strong and self-reliant, p. 161); "give 'em hell" (being aggressive and competitive in all arenas, p. 199); and "no sissy stuff" (refraining from showing affection or emotion, p. 49; see also Pollack, 1998). Other authors have pointed to "scripts" regarding masculinity such as "strong and silent", "tough-guy", "playboy", "winner", and "independent"—and the resulting potential for enablers of and barriers to help-seeking (Mahalik et al., 2003, pp. 124–127)—or constructs and norms regarding masculinity along with their implications for men seeking and engaging in therapeutic support (Good et al., 2005).

Through these lenses one can acknowledge the potential barriers for men seeking and remaining engaged in support services, such as pre-existing ideas and values in relation to asking for help versus taking responsibility for one's own problems; challenges for some men in acknowledging and discussing emotional concerns or vulnerabilities, including poorer mental health literacy; and perceived shame or stigma existing in certain social circles regarding seeking therapy (Addis & Mahalik, 2003; Cotton et al., 2006; Seidler et al., 2016). An important distinction is acknowledged here between men wanting to seek support (motivation) and men feeling comfortable and able to seek and stay connected with support (engagement). While other studies have focused on how to acknowledge and shift gendered norms and expectations regarding seeking support (Good & Robertson, 2010; Vogel et al., 2011; Wendt & Shafer, 2016; Yousaf et al., 2015), the particular focus of interest here is how men can be more strongly engaged in support when it is sought.

Less acknowledged in practice is the role that clinical practitioners play in identifying and meeting the type of engagement male clients are seeking. Extensive literature has explored the links between therapeutic alliance and positive therapeutic outcomes (Duncan et al., 2010; Horvath et al., 2011; Hubble et al., 1999; Wampold, 2001), including the active role required by practitioners in developing and maintaining this relationship (Ackerman & Hilsenroth, 2003; Baldwin et al., 2007; Boerma et al, 2023), clearly indicating this as a far from passive process, or one that is solely the client's responsibility. Despite this, it is common for practitioners to perceive hesitation or a lack of engagement on the part of the male client as resistance, thus creating frustration for the practitioner (Wexler, 2009). Additionally, an ever-present risk to maintaining therapeutic engagement is practitioners assuming that their approach is an automatic fit for their male clients—indeed, one study (Richards & Bedi, 2015) revealed the major reason

identified by male clients for a weakening of the therapeutic alliance was feeling the therapy was "not the right fit" (32.1%), followed by uncertainty of what to expect in sessions (23.2%; pp. 175–176).

In 1988, Steve de Shazer offered a simple yet fundamental proposal to challenge the previously common assumption that all clients seek a similar level of therapeutic engagement with their practitioner or that failure to engage reflects resistance on the part of the client. De Shazer (1988) stated that three types of therapeutic engagement might be experienced between client and practitioner: those of *visitor*, *complainant*, and *customer* type relationships. In a more recent integrated solution-focused model, Luc Isebaert (2016) proposed a revised and expanded version of these levels of engagement, including a new fourth level. While originally proposed within the context of a brief therapy framework, this idea of different levels of engagement has profound implications across all types of therapeutic and client-based work.

Considering the concept of client engagement, a link is often drawn to the idea of *levels of motivation for change*, as identified within the transtheoretical model of change (TTM) proposed by Prochaska and DiClemente (1982; as cited in Prochaska et al., 2008). While the literature has discussed in greater detail some similarities between the levels of therapeutic engagement and the levels of client motivation (McFarland, 1995; Żak, 2022), the distinction here is important because neither de Shazer (1988) nor Isebaert (2016) intended the levels of engagement to reflect client motivation for change explicitly, but rather the type of relationship and engagement that the client is seeking from the practitioner and from therapy more broadly. This difference is typified further when considering the resulting implementation of the concepts. TTM (and the often-associated approach of motivational interviewing) proposes more structured and consistent strategies and tools to assist clients in developing greater motivation for individual change (Petrocelli, 2002; Prochaska et al., 2008; Prochaska & DiClemente, 1982), whereas the levels of engagement concept proposes more flexible and responsive relationship-building considerations between practitioner and client. A further distinction is evident in the language used between concepts, whereby much of the language used in the TTM's conceptualisation of clients is focused on the individual client and on ideas of behaviour change, while levels of engagement, by its very name, uses more relational language. This ties directly back to discussions of the importance and impact of therapeutic alliance and relationship when working with men in help-seeking contexts since it could be argued that attempts to build individual motivation within male clients require strong foundations of therapeutic alliance and engagement to be considered successful (Ackerman & Hilsenroth, 2003; Baldwin et al., 2007; Horvath et al., 2011).

Considering the context of working with male clients in therapeutic settings, the concept of clients seeking different levels and types of engagement becomes even more crucial (Beel et al., 2018, 2020). Operating

on the assumption that all male clients present for support in the same way and seek the same type of engagement increases the likelihood of a therapeutic rupture or the client feeling unsatisfied with the level and type of support offered, and subsequently disengaging. The antidote here, therefore, may align with a better understanding of the different levels of therapeutic engagement as well as an increased responsibility on the part of the practitioner to meet the client at the level at which they are presenting.

The idea of different therapeutic engagement levels has continued to be discussed and debated in subsequent years. The goal of this paper is to revisit de Shazer's (1988) original concept and compare it with a more recent reworking within another brief therapy framework (the Bruges Solution-Focused Cognitive Systemic Therapy model; Isebaert, 2016) to identify relevance to working therapeutically with male clients. In comparing these models, the clinical implications of adopting an understanding of the levels of engagement will be explored as opportunities to engage and maintain clients better within help-seeking contexts. For the sake of linguistic simplicity, the term "practitioner" will be used throughout the paper to encompass a range of clinical roles including counsellor, psychotherapist, and others.

## The Brief Family Therapy Centre Model

### Introduction to Brief Family Therapy Centre Principles

Established in the 1970s by therapists and researchers Steve de Shazer, Insoo Kim Berg, Eve Lipchik, Elam Nunnally, and Alex Molnar, the Milwaukee Brief Family Therapy Centre (BFTC) became the starting point for what was later best known as solution-focused brief therapy. Directly inspired by the previous therapy and research of Milton Erickson, Gregory Bateson, Jay Haley, and the Mental Research Institute in Palo Alto (established by Paul Watzlawick, John Weakland, and Richard Fisch), the BFTC resolved to create "skeleton keys" (de Shazer, 1985) for brief therapists based on the principles of strategic therapy, systems theory, positive psychology, and social constructionism to be implemented through a collaborative therapeutic relationship and within tighter timeframes (often considered an average of 6–10 sessions). Typically, the brief therapy model tends to be goal driven, pragmatic, present- and future-focused (exploration of history is mostly interested in past successes rather than the origins of problems), and interested in how language is used to either restrict or generate options and solutions (Berg & de Shazer, 1993). In particular, de Shazer (1985) argued that people inherently attend therapy wanting to change but that their presenting concern is often related to having exacerbated their initial problem through their attempts to date to resolve it. Therefore, what might previously have been conceptualised as resistance on the part of the client could instead be viewed as a mismatch between ideas about how to change (de Shazer, 1984). This controversial notion of the *death of resistance* was later articulated by de Shazer (1988) as a conceptualisation of the *levels of therapeutic engagement*.

## Levels of Therapeutic Engagement

In the book *Clues: Investigating Solutions in Brief Therapy*, de Shazer (1988) proposed distinct types of client–practitioner relationships that develop from the outset of therapeutic work: visitor, complainant, and customer. While the intention behind these descriptors was to describe a relationship between client and practitioner rather than motivation or "readiness" for therapy, there have been criticisms levelled at the choice of language that depicts an individual rather than a relationship (Isebaert, 2016; Ziegler, 2010). In a more recent revisiting of these concepts, Ziegler (2010) proposed alternative descriptors of visitor/host, complainant/sympathiser, and customer/consultant to depict the bi-personal nature of the relationships better. Nonetheless, for the purposes of this paper the original terms will be used to reflect the original author and his idea. The sections that follow explain these levels of therapeutic engagement using case study examples.

### *Visitor*

*Ben presents to an initial counselling session stating that his wife "told me I have to come to talk to someone or our marriage will be over". Ben states that he "doesn't really know why I'm here or what this is all about", and early in the session gives brief responses to inquiries about how he feels the relationship with his wife is doing, looks at his watch several times, and makes limited eye contact with the practitioner. Ben reflects that he believes the relationship "has its normal ups and downs", but that he does not view this as requiring counselling on his part. Ben looks visibly uncomfortable throughout the session.*

Some men present for support because someone else sends or brings them (such as a partner, parent or relative) or because of external coercion (such as probation or parole orders, legal requirements, organisational mandates, threat of divorce, and the like). Hence, these men have not identified that they have a complaint and it could therefore be argued that they are not yet clients. As proposed by de Shazer (1988), it can be more useful to think of these men as visiting rather than attending involuntarily (which would suggest they need convincing of support). De Shazer argued that within this type of therapeutic engagement, therapy cannot begin because no identification of a complaint has been made, nor any request for help. Instead, this can be viewed as an opportunity to build a relationship, creating the potential context for a complaint to be raised later. In an earlier conceptualisation of this level, Fisch et al. (1982) also raised the possibility of "renegotiating the contract" (p. 40), that is, either looking for an issue the client would like to work on or addressing the external pressure as the "problem". Ultimately, de Shazer (1988) suggested the best intervention at this level is to "(1) Be as nice as possible; (2) ... always [be] on the side of the client; and (3) Look for what works rather than what does not" (p. 88).

### *Complainant*

*As Ben continues through several counselling sessions, he acknowledges greater challenges within the relationship, such as more frequent arguments and fights, and a decrease in intimacy and closeness between himself and his wife. As Ben reflects on these changes in the relationship, he identifies that they bother him, but that he believes that "if she would just get off my case about the little things she makes a fuss about, like wanting me to help more around the house, or that I don't listen to her enough, then things would be a lot calmer". Ben states that he "has a lot on my plate at the moment with work and trying to keep a roof over our head, and she just has such unrealistic expectations of what I can do across both work and home—she just needs to cut me some slack and help carry the load".*

Typically, a therapeutic encounter could be seen to be initiated when a complaint is raised. As a result, there is some expectation that a solution is possible because of the conversation, indicating a business-type relationship (de Shazer, 1988). Despite this, at the complainant level of engagement the male client typically demonstrates a sense of the problem being external to themselves—requiring something or someone else to change—or that change is beyond their control (Sharry et al., 2011). There is a stronger sense of the man actively seeking support rather than engaging at the visitor level; however, typically the man would also exhibit less inclination to change themselves. Again, arguing against the inclination to view these clients as resistant, de Shazer (1988) proposed acting from a position of empathy and non-blaming understanding to ensure clients feel validated in their perception of the problem and to start to assist them potentially to think differently rather than do things differently (Sharry et al., 2011).

### *Customer*

*During his counselling sessions, Ben starts to acknowledge his own role in his relationship challenges, while still acknowledging his stress about making ends meet. Ben reflects that "we fall into a pattern of nagging and either withdrawing or fighting" and he identifies an increased recognition that "I don't make that pattern any easier". Ben states that he loves his wife, is worried about the relationship breaking down, and "wants to look at what I can do to help avoid that, as well as what she and I could do together".*

In later years, de Shazer shifted his thinking further into the notion that there is no such thing as a reluctant client, that everyone is a customer for something, even if simply to avoid further therapy (as cited in Ratner et al., 2012). Nonetheless, a customer-level relationship can be otherwise identified as one in which the male client has clearly expressed a concern as well as a desire to do something about it themselves (de Shazer, 1988). Arguably this is where the work of the therapy can truly begin—the problem can be defined, the collaborative goal(s) can be established, and the client and therapist can start exploring options and ways forward.

At the heart of the concept of these levels of therapeutic engagement is the idea that, contextually, clients can and will move between levels, including bi-directionally: a visitor relationship can become a complainant relationship, which can become a customer relationship, which in turn can later move back to a complainant or visitor relationship. Given the collaborative nature of solution-focused work, as well as the identified challenges of engaging and maintaining an effective therapeutic relationship with male clients, the inherent value in the concept remains its ability to identify and work with men effectively at the level they are seeking.

## The Bruges Solution-Focused Cognitive Systemic Therapy Model

### Introduction to Solution-Focused Cognitive Systemic Therapy Principles

At almost the same time that de Shazer (1985) was conceptualising and experimenting with early solution-focused ideas, Isebaert (2016), at the Korzybski Institute in Bruges, was exploring similar concepts based on the work of Milton Erickson (Haley, 1973), developing an early version of what came to be known as the Bruges model of therapy. Upon identifying the links between the underpinnings of the Bruges model and the work of de Shazer and the BFTC, the two centres became more closely aligned. Isebaert integrated more explicit solution-focused principles into his existing model, while de Shazer and several colleagues joined the Korzybski Institute as members of the board and guest trainers. As a result, many of the underlying principles of the Bruges solution-focused cognitive systemic therapy model align with those of solution-focused therapy more generally, including an acknowledgement of client strengths and resources, a valuing of the power of the therapeutic alliance, and an emphasis on the "brief" nature of the work (de Shazer & Isebaert, 2004; Hendrick et al., 2011; Isebaert, 2016).

In addition, the Bruges model indicates an integration of influences from systems theory, existential therapy, cognitive behavioural therapy, and common factors research (Isebaert, 2016). As a result, the types of strategies or interventions that might be seen within the approach can similarly be viewed as integrative in nature, tied to the primary underlying principles but varying from solution-focused approaches to cognitive and strategic therapies or systemic strategies, depending on the nature of the client's concern. In particular, the approach identifies the importance of context (both the context in which the client's concerns are situated as well as the creation of a context in which clients may find solutions) and a distinction between problems (an aspect the client may reasonably be expected to be able to solve) and limitations (something for which there is no feasible solution, such as biological, social, or cultural limitations). Moreover, it emphasises that therapy involves clients changing habits or handling themselves differently in their interactions with reality (Isebaert, 2016).

## Levels of Therapeutic Engagement

Since it is strongly influenced by the earlier solution-focused schools of thought, the Bruges model similarly suggests levels of therapeutic engagement that can be recognised when working with clients. Three of these are closely aligned with the original BFTC levels (visitor—"uncommitted" relationships; complainant—"searching" relationships; customer—"expert" relationships), while the Bruges model suggests a fourth level that sits between the earlier complainant and customer levels ("consulting" relationships). These levels are explained below and illustrated with case studies.

### *Uncommitted Relationship*

*Jeremy attends his initial therapy session showing clear indications of wariness. He asks several clarifying questions about confidentiality and wants to know more detail about the practitioner's professional training and background. Jeremy identifies that he had been reluctant to attend the session but had been encouraged to by a close family member who had expressed concern. After some gentle exploration by the practitioner, Jeremy reflects on an experience of seeking professional support many years before, during which he felt invalidated, even blamed, and left that initial session questioning his competency and sense of worth. Jeremy states that he feels there is no solution for his work-related dilemma and that "maybe there's not much point talking about it".*

Similarly to how male clients present in the BFTC concept of a visitor relationship, some male clients in an uncommitted relationship may not present voluntarily and therefore are not identifying the existence of a problem. Other men may, in fact, present voluntarily but may not make a request for help. Isebaert (2016) suggests examples such as psychosomatic clients (seeking help but not of the "talk therapy" sort), clients who do not believe that a solution exists for their concern, and clients who distrust the profession or the process. A defining question according to the Bruges model is "Has the client asked for our help?" Again, with great similarity to the original BFTC model, the Bruges model suggests several practical responses within this type of engagement, including demonstrating interest and respect, considering the referrer as the real client, and attempting to create an alliance with the client to help satisfy the referrer (Isebaert, 2016). Ultimately the goal, again, at this level is to create a context in which a request for help might later emerge.

### *Searching Relationship*

*Jeremy provides more information about his struggles at work—a situation involving a direct superior who owns the private company and who has bullied and belittled Jeremy for many years—and discusses the impact these experiences have had on himself, including feelings of low self-worth, incompetence, and a belief that he himself is to blame. Jeremy's presentation reflects his feelings of powerlessness, and he spends the greater part of a session lamenting his*

*circumstances, identifying how he "relies on this job to survive" and stating that he "is not qualified to work somewhere else". Jeremy states how he "wishes things could change" but that he "just can't see how this will happen".*

At times, men may present with a request for help while communicating (directly or indirectly) an expectation that the practitioner is responsible for solving the concern. This stance is similar to that held in the BFTC concept of a complainant relationship, in which help is sought, but the responsibility for change is external to the client. Deviating from this original concept, Isebaert (2016) also suggested additional categories of presentation here for when so much or so little information is provided that a clear and workable goal cannot be established, or when the client feels powerless to bring about change. The suggested strategies as proposed by the Bruges model are generally divided into two orientations: present-focused (what is the client already doing that they want to do?) and future-focused (how would the client wish things to look in the future?). Regardless of which orientation is focused on, the resulting strategies and techniques draw directly from solution-focused concepts such as searching for exceptions (de Shazer, 1988), identifying current strengths/skills, scaling (De Jong & Berg, 1998), and the "miracle question" (de Shazer, 1991). The goal at this level is to create a context in which the client can articulate clear and workable goals and subsequently agree to working on these.

### *Consulting Relationship*

*During his therapy sessions, Jeremy starts to communicate a greater sense of empowerment in changing his circumstances at work, including a greater acknowledgement that while he himself is not to blame for his boss's behaviour, he has some agency and control over his responses to this, including seeking changes to his circumstances. Jeremy starts to reflect on and identify strengths and strategies that he found effective when he felt bullied as a child; however, he also reflects that "these were from a different time in my life and different circumstances—I can't exactly go running to the teacher at work!" Jeremy expresses a greater sense of hope while still identifying a sense of "stuckness" regarding how to utilise these existing resources in his current situation.*

In a variation from the original BFTC model of therapeutic engagement, the Bruges model proposes an additional level—the consulting relationship. At this level of engagement, men express a desire for help as well as an acknowledgement that they cannot remain passive in seeking change (Isebaert, 2016). At the same time, while it would be acknowledged that the male client possesses the resources to create change, there may be a sense of not knowing how to utilise these resources in the pursuit of change. The Bruges model proposes the analogy here of the client "purchasing" the practitioner's expertise as a consultant, that is, the practitioner brings no new resources per se, but helps the client to develop ways of utilising their own resources to bring about desired change (Isebaert, 2016, p. 136). At this level of engagement, similar strategies can be utilised as for the previous searching level. This level also offers greater integration of cognitive and systemic

influences such as cognitive behavioural therapy, acceptance and commitment therapy, and strategic therapy. The goal at this level of engagement is to help the client to develop the skills through which they can utilise their existing resources and develop their own "therapy" moving forward.

### *Expert Relationship*

*Jeremy presents to sessions with an increased sense of energy and purpose including a noticeable change in his presentation and affect. He uses sessions to explore his ongoing efforts to "take charge" of his experiences with his boss including brainstorming and problem-solving potential strategies together with his practitioner. Jeremy, more often than not, comes to sessions having reflected on possible options or solutions to his interactions with his boss and identifies that he "wants to trouble-shoot and plan these out" with the practitioner.*

At an expert level of therapeutic engagement, men present with an active request for support, an expressed willingness to take responsibility for the change themselves, clear and workable goals, and a sense of both the resources and the skills needed to bring about the desired change. The practitioner at this level, similarly to how they function at the customer level of therapeutic engagement in the BFTC model, acts as a type of supervisor to the client in creating their own "therapy" and conversations are viewed as occurring between two experts (Isebaert, 2016). The Bruges model particularly highlights the challenge for experienced practitioners here in avoiding the risk of attempting to impose one's own "clever" changes and solutions over the client's own or attempting to extend the therapeutic work beyond the point at which the client expresses confidence in continuing by themselves (Isebaert, 2016).

## Discussion and Clinical Implications

By synthesising the two models of therapeutic engagement levels (see Table 1), two particular points can be identified. Firstly, what becomes immediately clear as a factor in increasing the level of engagement is the level of active participation by the client. A similarity across both models at the higher levels of engagement is the importance of client autonomy, responsibility for change, and utilisation of personal resources. This aligns with the underlying principles of solution-focused and brief therapy practices—that clients are situated within the centre of therapeutic practice and hold expert knowledge about their lives and circumstances, including their available strengths and resources. The role of the therapist, therefore, inherently becomes that of a facilitator or consultant, working collaboratively with the client to assist in bringing about change.

Secondly, another evident point across both models is the emphasis on the practitioner's ability to identify and acknowledge the presenting level of engagement for the client and ensure their approach fits with this presentation. While this may appear self-evident, many therapeutic approaches (and practitioners individually) still insist at some level that the client fit the model, rather than the model fit the client. The Bruges

Table 1. Synthesis of Models

| Level of engagement | Suggested focus/strategies |
|---|---|
| Visitor/ uncommitted | Build relationship; explore strengths; possibility of referrer as client.<br>*Create context for a request for help to evolve.* |
| Complainant/ searching | Explore client's conceptualising of the "problem"; utilise solution-focused therapy strategies to identify current strengths and/or potential futures; work towards client developing clear goals.<br>*Create context for workable goals to be generated.* |
| Consultant | Identify current goals and client resources; utilise solution-focused therapy strategies to explore and build strategies for client to use resources in working towards goals; integrate additional therapeutic approaches when relevant and helpful.<br>*Create context for client to generate skills to utilise resources.* |
| Customer/ expert | Guide and "witness" client taking own steps towards desired outcomes; facilitate client in developing own needed approach to change.<br>*Create context for client to work towards change independently.* |

model articulates this particularly well given its acknowledged influences from common factors research and the client-directed literature explored by Duncan et al (2010), Hubble et al (1999), and Miller (2003).

What appears to be generally absent across both models is the considerations of client concerns that are, in fact, outside of their control or responsibility. Examples of this include major life events, trauma, grief and loss, and similar external forces or circumstances that arguably lie beyond personal changes made by the client. The Bruges model does acknowledge this in part through recognising the difference between a problem and a limitation—that is, a problem could be considered reasonably within the domain of client control or influence, while a limitation could be considered a situation or circumstance beyond this, requiring a different response, such as establishing a level of acceptance or coping (Isebaert, 2016). Another example of such an acknowledgement lies within the work of solution-oriented therapy, especially the ideas proposed by author and therapist Bill O'Hanlon (2010) about applying solution-oriented principles to working with trauma. O'Hanlon proposed that, counter to popular perception, brief solution-oriented strategies might be helpful and effective, particularly in working with clients' responses to trauma symptomatology, if not working through the processing of the trauma itself. Examples include helping clients connect to a more hopeful future, encouraging small increments of change rather than large leaps, and investigating and substituting (unhelpful) solution patterns (O'Hanlon, 2010).

Another apparent absence within the descriptions of both models of therapeutic engagement are clear explanations of how and when to identify accurately the level at which the client is presenting. The visitor and uncommitted levels of engagement can arguably be determined more readily because of the implicit or explicit involuntary nature of the client's presentation (whether through mandated or coerced attendance); however, less detail is provided by the Bruges model on when and how to identify those clients who present voluntarily but still make no active request for help. Similarly, less detail is provided in either set of original literature concerning

when and how a complainant, searching or consultant level of engagement is sought by the client. While descriptions are provided, clarity is essential to meet the client accurately at the level they are seeking, particularly in light of the existing challenge of engaging and maintaining a therapeutic connection with male clients. Like the visitor and uncommitted levels of engagement, a customer or expert engagement may again be easier to identify owing to the clearer communication by the client of a request for change, a desire to engage with a change process, and a clear set of goals for the therapeutic work as developed collaboratively with the practitioner. However, the process for assessing the distinction between a client seeking a consultant and expert level of engagement within early client sessions is less clearly articulated. These challenges have direct implications for initial sessions with male clients because this is the primary point at which the therapeutic relationship can be made or lost.

It is important to highlight the limitations of the levels of therapeutic engagement concept, particularly regarding the visitor/uncommitted level of relationship. Acknowledging that the general suggestion at this level is to communicate empathy and validate the experience or perspective of the client in order to build a stronger relationship, this has concerning implications when working with men who engage in behaviours such as violence, coercive control or other abusive patterns of behaviour. The importance of building the therapeutic relationship is still crucial; however, communicating any potential validation of controlling or abusive behaviours becomes counter-productive to the therapeutic work and even dangerous in promoting or condoning such behaviours implicitly. While this area of work has not been explicitly identified within the literature on the levels of engagement concept, a recommendation in line with other research and literature specific to working with male perpetrators is one of balance—between "being personable and being purposeful" (Kozar & Day, 2012, p. 483). Practitioners should be mindful of clearly delineating "behaviour" from "person" in attempting to build empathic understanding of the thoughts, feelings, beliefs, and experiences of the male perpetrating client, while simultaneously communicating purposeful and assertive messages about safe and unsafe behaviours.

Currently, a gap exists in the literature in relation to the levels of therapeutic engagement concept. While some similarities to associated concepts such as the TTM have already been addressed earlier in this paper, such models apply a more structured approach to increasing client motivation and readiness, thus lending themselves more to empirical studies. Some existing studies have explored the relationship between engagement levels and other associated solution-focused themes more generally, rather than specifically exploring the effectiveness of engagement levels themselves (Corcoran, 1997; Odell et al., 2005; Sharry & Owens, 2000; Żak, 2022). Given that further research into the effectiveness of the therapeutic

engagement levels concept would be useful to the field, it is also acknowledged that the more flexible nature of the concept creates challenges in this sense.

Considering the models within the context of working with male clients, some clinical implications are apparent. Despite the origins of both models within solution-focused approaches, it is suggested that the concept of differing levels of therapeutic engagement has applications for working with male clients regardless of therapeutic approach or model since it implies a responsiveness to the client's worldview and expressed need in seeking support no matter how this may be enacted in practice. While the specifics of how the practitioner may work with the client within these levels may relate more directly to the chosen approach, the key should be aligning these strategies with the presenting level of engagement and creating a context for increasing this engagement (de Shazer, 1988; Isebaert, 2016).

Connected with this is consideration of when the acknowledgement of the level of engagement is most pertinent. It is proposed that this has significance at two levels. Firstly, the importance of recognising and working within the presenting level of engagement from the outset of therapeutic work cannot be overstated when working with male clients particularly, as previously identified through lower rates of men seeking support and identified barriers to help-seeking behaviours. Research findings regarding therapeutic alliance indicate that the highest risk of disengagement from therapy is present during the initial sessions (Bachelor & Horvath, 1999), suggesting a level of vulnerability of the therapeutic relationship unless explicitly discussed and explored on a regular basis. Therefore, particular attention should be paid during the initial session with male clients to the language they use when describing their attendance, the concerns they present with, and the goals (or lack thereof) they express in seeking support (Bedi & Richards, 2011; Tyler, 2021). Secondly, as indicated earlier in this paper, part of the significant value of the concept of engagement levels is the possibility of increasing these to higher levels over time, either through direct work during sessions or through creating a safe and welcoming context to which the client may return later. Therefore, it is proposed that due attention should be paid to seeking ongoing feedback and regularly evaluating where the male client is currently positioned within the levels of engagement (Miller et al., 2006, 2008). One way to consider this is to situate the responsibility for change with the client but the responsibility for creating the context for change with the practitioner.

## Conclusion

This article has revisited the brief therapy concept of levels of therapeutic engagement, particularly in relation to better engaging male clients in therapeutic work. Further research in this area will provide additional support for the clinical effectiveness and usefulness for practitioners when working in this important area. Acknowledging the potential barriers for male clients seeking support and considering the possibility of men presenting at different

levels of therapeutic engagement provides hope for increased access and ongoing therapeutic support in a way that best fits the needs of each male client, rather than assuming a universal approach. While specific contexts and presenting concerns will pose more unique challenges and opportunities for this work, it is hoped that the concept more broadly offers hope and directions for better meeting the needs of men in therapy.

## References


Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review*, *23*(1), 1–33. https://doi.org/10.1016/S0272-7358(02)00146-0

Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity and the contexts of help-seeking. *American Psychologist*, *58*(1), 5–14. https://doi.org/10.1037/0003-066X.58.1.5

Australian Bureau of Statistics. (2023). *National study of mental health and wellbeing*. https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/2020-2022

Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 133–178). American Psychological Association. https://doi.org/10.1037/11132-000

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology*, *75*(6), 842–852. https://doi.org/10.1037/0022-006X.75.6.842

Bedi, R. P., & Richards, M. (2011). What a man wants: The male perspective on therapeutic alliance formulation. *Psychotherapy*, *48*(4), 381–390. https://doi.org/10.1037/a0022424

Beel, N., Brownlow, C., Jeffries, C., & du Preez, J. (2020). Counseling men: Treatment recommendations from Australian men's therapists. *The Journal of Men's Studies*, *28*(1), 101–121. https://doi.org/10.1177/1060826519861969

Beel, N., Jeffries, C., Brownlow, C., Winterbotham, S., & Du Preez, J. (2018). Recommendations for male-friendly individual counseling with men: A qualitative systematic literature review for the period 1995–2016. *Psychology of Men & Masculinity*, *19*(4), 600–611. https://doi.org/10.1037/men0000137

Berg, I. K., & de Shazer, S. (1993). Making numbers talk: Language in therapy. In S. Friedman (Ed.), *The new language of change: Constructive collaboration in psychotherapy* (pp. 5–24). Guilford Press.

Brannon, R. (1976). The male sex-role: Our culture's blueprint of manhood and what it's done for us lately. In D. S. Brannon & R. Brannon (Eds.), *The forty-nine percent majority* (pp. 1–45). Addison Wesley.

Corcoran, J. (1997). A solution-oriented approach to working with juvenile offenders. *Child & Adolescent Social Work Journal*, *14*(4), 277–288. https://doi.org/10.1023/A:1024546425621

Cotton, S. M., Wright, A., Harris, M. G., Jorm, A. F., & McGorry, P. D. (2006). Influence of gender on mental health literacy in young Australians. *Australian and New Zealand Journal of Psychiatry*, *40*(9), 790–796. https://doi.org/10.1080/j.1440-1614.2006.01885.x

De Jong, P., & Berg, I. K. (1998). *Interviewing for solutions*. Brooks & Cole.

de Shazer, S. (1984). The death of resistance. *Family Process*, *23*, 11–21. https://doi.org/10.1111/j.1545-5300.1984.00011.x

de Shazer, S. (1985). *Keys to solutions in brief therapy*. W. W. Norton & Company.

de Shazer, S. (1988). *Clues: Investigating solutions in brief therapy*. W. W. Norton & Company.

de Shazer, S. (1991). *Putting difference to work*. W. W. Norton & Company.

de Shazer, S., & Isebaert, L. (2004). The Bruges model. *Journal of Family Psychotherapy*, *14*(4), 43–52. https://doi.org/10.1300/j085v14n04_04

Duncan, B., Miller, S., Wampold, B., & Hubble, M. (2010). *The heart and soul of change* (2nd ed.). American Psychological Association. https://doi.org/10.1037/12075-000

Fisch, R., Weakland, J., & Segal, L. (1982). *The tactics of change: Doing therapy differently*. Jossey-Bass.

Good, G. E., & Robertson, J. M. (2010). To accept a pilot? Addressing men's ambivalence and altering their expectations about therapy. *Psychotherapy: Theory, Research, Practice, Training*, *47*(3), 306–315. https://doi.org/10.1037/a0021162

Good, G. E., Thomson, D. A., & Brathwaite, A. D. (2005). Men and therapy: Critical concepts, theoretical frameworks, and research recommendations. *Journal of Clinical Psychology*, *61*(6), 699–711. https://doi.org/10.1002/jclp.20104

Haley, J. (1973). *Uncommon therapy: The psychiatric techniques of Milton H. Erickson MD*. W. W. Norton & Company.

Hendrick, S., Isebaert, L., & Dolan, Y. (2011). Solution-focused brief therapy in alcohol treatment. In C. Franklin, T. S. Trepper, E. E. McCollum, & W. J. Gingerich (Eds.), *Solution-focused brief therapy: A handbook of evidence-based practice* (pp. 264–278). Oxford University Press. https://doi.org/10.1093/acprof:oso/9780195385724.003.0102

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy*, *48*(1), 9–16. https://doi.org/10.1037/a0022186

Hubble, M., Duncan, B., & Miller, S. (Eds.). (1999). *The heart and soul of change*. American Psychological Association.

Isebaert, L. (2016). *Solution-focused cognitive and systemic therapy: The Bruges model*. Taylor & Francis Group. https://doi.org/10.4324/9781315559414

Kozar, C. J., & Day, A. (2012). The therapeutic alliance in offending behaviour programs: A necessary and sufficient condition for change? *Aggression & Violent Behaviour*, *17*(5), 482–487. https://doi.org/10.1016/j.avb.2012.07.004

Machlin, A., King, K., Spittal, M., & Pirkis, J. (2017). Preliminary evidence for the role of newsprint media in encouraging males to make contact with helplines. *International Journal of Mental Health Promotion*, *19*(2), 85–103. https://doi.org/10.1080/14623730.2017.1307774

Mahalik, J. R., Good, G. E., & Englar-Carlson, M. (2003). Masculinity scripts, presenting concerns and help-seeking: Implications for practice and training. *Professional Psychology: Research & Practice*, *34*(2), 123–131. https://doi.org/10.1037/0735-7028.34.2.123

McFarland, B. (1995). *Brief therapy and eating disorders. A practical guide to solution-focused work with clients*. Jossey-Bass.

Miller, S. D., Duncan, B., Brown, J., Sorrell, R., & Chalk, M. B. (2006). Using formal client feedback to improve retention and outcome: Making ongoing, real-time assessment feasible. *Journal of Brief Therapy*, *5*(1), 5–22.

Miller, S. D., Duncan, B., & Hubble, M. (2008). Super shrinks: What's the secret of their success? *Psychotherapy in Australia*, *14*(4), 14–22.

Miller, S. D., Hubble, M., & Duncan, B. (Eds.). (2003). *Handbook of solution-focused brief therapy*. Jossey-Bass.

Odell, M., Butler, T. J., & Dielman, M. B. (2005). An exploratory study of clients' experiences of therapeutic alliance and outcome in solution-focused marital therapy. *Journal of Couple & Relationship Therapy*, *4*(1), 1–22. https://doi.org/10.1300/J398v04n01_01

O'Hanlon, B. (2010). *Quick steps to resolving trauma*. W. W. Norton & Company.

Petrocelli, J. V. (2002). Processes and stages of change: Counseling with the transtheoretical model of change. *Journal of Counseling & Development*, *80*(1), 22–30. https://doi.org/10.1002/j.1556-6678.2002.tb00162.x

Pollack, W. S. (1998). Mourning, melancholia, and masculinity: Recognizing and treating depression in men. In W. S. Pollack & R. F. Levant (Eds.), *New psychotherapy for men* (pp. 147–166). Wiley.

Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research & Practice*, *19*(3), 276–288. https://doi.org/10.1037/h0088437

Prochaska, J. O., Redding, C. A., & Evers, K. E. (2008). The transtheoretical model and stages of change. In K. Glanz, B. K. Rimer, & K. Viswanath (Eds.), *Health behavior: Theory, research, and practice* (4th ed., pp. 97–122). Jossey-Bass.

Ratner, H., George, E., & Iveson, C. (2012). *Solution-focused brief therapy: 100 key points and techniques*. Routledge. https://doi.org/10.4324/9780203116562

Richards, M., & Bedi, R. P. (2015). Gaining perspective: How men describe incidents damaging the therapeutic alliance. *Psychology of Men & Masculinity*, *16*(2), 170–182. https://doi.org/10.1037/a0036924

Seidler, Z. E., Dawes, A. J., Rice, S. M., Oliffe, J. L., & Dhillon, H. M. (2016). The role of masculinity in men's help-seeking for depression: A systematic review. *Clinical Psychology Review*, *49*, 106–118. https://doi.org/10.1016/j.cpr.2016.09.002

Sharry, J., Madden, B., & Darmody, M. (2011). *Becoming a solution detective: A strengths-based guide to brief therapy*. Routledge. https://doi.org/10.4324/9780203153765

Sharry, J., & Owens, C. (2000). "The rules of engagement": A case study of a group with "angry" adolescents. *Clinical Child Psychology & Psychiatry*, *5*(1), 53–62. https://doi.org/10.1017/S1360641700282488

Stevens, M. A., & Englar-Carlson, M. (2006). An invitation: Bringing the reader into the book. In M. Englar-Carlson & M. A. Stevens (Eds.), *In the room with men: A casebook of therapeutic change* (pp. 3–11). American Psychological Association. https://doi.org/10.1037/11411-001

Tyler, S. (2021). Building the therapeutic alliance with men. *Australian Nursing & Midwifery Journal*, *27*(3), 50–51.

Vogel, D. L., Heimerdinger-Edwards, S. R., Hammer, J. H., & Hubbard, A. (2011). "Boys don't cry": Examination of the links between endorsement of masculine norms, self-stigma, and help-seeking attitudes for men from diverse backgrounds. *Journal of Counselling Psychology*, *58*(3), 368–382. https://doi.org/10.1037/a0023688

Wampold, B. (2001). *The great psychotherapy debate*. Lawrence Erlbaum. https://doi.org/10.4324/9780203582015

Wendt, D., & Shafer, K. (2016). Gender and attitudes about mental health help seeking: Results from national data. *Health & Social Work*, *41*(1), e20–e28. https://doi.org/10.1093/hsw/hlv089

Wexler, D. B. (2009). *Men in therapy: New approaches for effective treatment*. W. W. Norton & Company.

Wong, C., O'Donnell, K., Prattley, J., Jenkinson, R., Tajin, R., & Rowland, B. (2022). Mental health care needs and access among Australian men: A data linkage study. In B. Quinn, B. Rowland, & S. Martin (Eds.), *Insights #2 report: Findings from ten to men—The Australian longitudinal study on male health 2013–21*. Australian Institute of Family Studies. https://aifs.gov.au/tentomen/insights-report/mental-health-care-needs-and-access-among-australian-men-data-linkage

Yousaf, O., Popat, A., & Hunter, M. S. (2015). An investigation of masculinity attitudes, gender, and attitudes toward psychological help-seeking. *Psychology of Men & Masculinity*, *16*(2), 234–237. https://doi.org/10.1037/a0036241

Żak, A. M. (2022). What is helpful: The client's perception of the solution-focused brief therapy process by level of engagement. *Journal of Solution Focused Practices*, *6*(2), 4–19. https://doi.org/10.59874/001c.75017

Ziegler, P. B. (2010). "Visitor", "Complainant", "Customer" Revisited. In T. S. Nelson (Ed.), *Doing something different: Solution-focused brief therapy practices* (pp. 39–44). Taylor & Francis Group.