A TREATMENT IMPROVEMENT PROTOCOL

Addressing the Specific Behavioral Health Needs of Men

TIP 56

Substance Abuse and Mental Health Services Administration
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

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Disclaimer

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What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). TIPs are best practice guidelines for the treatment of substance use disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts to evaluate the quality and appropriateness of various forms of treatment. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at http://kap.samhsa.gov.

Although each TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that the field of substance abuse treatment is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey front-line information quickly but responsibly. If research supports a particular approach, citations are provided.

Foreword

The Treatment Improvement Protocol (TIP) series fulfills the Substance Abuse and Mental Health Services Administration's (SAMHSA's) mission to improve prevention and treatment of substance use and mental disorders by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

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Executive Summary

This Treatment Improvement Protocol (TIP) is a companion to TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women.* These two volumes look at how gender-specific treatment strategies can improve outcomes for men and women, respectively. The physical, psychological, social, and spiritual effects of substance use and abuse on men can be quite different from the effects on women, and those differences have implications for treatment in behavioral health settings. Men are also affected by social and cultural forces in different ways than women, and physical differences between the genders influence substance use and recovery as well. This TIP, *Addressing the Specific Behavioral Health Needs of Men,* addresses these distinctions. It provides practical information based on available evidence and clinical experience that can help counselors more effectively treat men with substance use disorders.

Historically, standard behavioral health services for substance abuse have been designed with male clients in mind. As the number of women presenting for substance abuse services increased, clinicians began to understand that women had different treatment needs than men, related to differences in their patterns of substance use and their perceptions of both the problem of substance abuse and its treatment. Researchers began to investigate how standard substance abuse treatment in a variety of behavioral health settings can be altered to improve outcomes for women. In the process, they have gained insight into how men's and women's responses to substance abuse and substance abuse treatment differ. These insights can also improve treatment for men. New research in the areas of gender studies and men's studies can help providers understand why men abuse substances and how to address masculine values in treatment.

Why Are Men at Greater Risk for Substance Abuse?

Men in America today may have advantages that women lack. However, in spite of these advantages, men die at a younger age on average than women; men are also more likely than women to have a substance use disorder, to be incarcerated, to be homeless as adults, to die of suicide, and to be victims of violent crime. Conversely, men are *less* likely than women to seek medical help or behavioral health counseling for any of the problems they face. These significant problems, combined with men's tendency to avoid addressing them, call for a response from behavioral health treatment providers. It is the consensus panel's hope that this TIP will begin to focus providers' and researchers' attention on the diverse

problems that men with substance use disorders face and to serve as both an introduction to the topic and a summary of what is known regarding the subject to date.

How Is the Term "Substance Abuse" Used?

In this TIP, the term "substance abuse" refers to either substance abuse or substance dependence or both (as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, Text Revision [DSM-IV-TR]; American Psychiatric Association 2000) and encompasses the use of both alcohol and other psychoactive substances. Though unfortunately ambiguous, this term was chosen partly because the lay public, policymakers, and many substance abuse treatment professionals commonly use "substance abuse" to describe any excessive or pathological use of any addictive substance. Readers should attend to the context in which the term occurs to determine the range of possible meanings; in most cases, however, the term refers to all substance use disorders described by the DSM-IV-TR.

Who Can Use This TIP?

This TIP is addressed to the variety of behavioral health service providers in a variety of treatment settings who may be involved with helping men recognize their need for treatment, mobilize to access appropriate care, participate in substance abuse treatment interventions, involve their families and significant others in recovery, and continue services in extended recovery. Although traditional substance abuse treatment has been provided in settings that are specific to substance use disorders, this TIP recognizes that treatment for substance abuse today can occur in a variety of behavioral health settings and that there is no wrong door for men to enter and participate in treatment and recovery.

What Is This TIP's Scope?

This TIP covers many topics relating to adult men (defined here as individuals ages 18 and over) and their use of, abuse of, and/or dependence on substances. What this TIP does *not* cover are the substance use patterns and treatment of boys and adolescents, as they form a distinct population with particular treatment needs. TIPs 31, *Screening and Assessing Adolescents for Substance Use Disorders* (Center for Substance Abuse Treatment [CSAT] 1999*c*), and 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT 1999*d*), address substance abuse assessment and treatment, respectively, for both male and female adolescents. Please note, however, that some of the research used in this TIP does include men younger than 18, and in these cases the text indicates the age group referenced.

The TIP represents the view of the consensus panel that a clear link exists between the social and cultural environment within which many boys are raised and the difficulty that many men have in seeking help from others. Pressures on men and boys can stem from expectations to conform to society's view of the ideal man—successful, accomplished, independent, and self-sufficient—which sometimes conflicts with a man's need to seek help. Additionally, when men do need help, such as in substance abuse treatment or other behavioral health services, negative consequences may arise, such as stress, anxiety, shame, rejection, low self-esteem, depression, and other mental problems that have been sedated or disguised by the substance use. These secondary effects can complicate the efforts of many men to seek help for their behavioral health needs.

In recent years, there has been increased awareness of the extent of women's substance abuse, but men in the United States are two to five times more likely to develop a substance

use disorder than women (depending on the study). Research shows men are less likely to seek help for medical or behavioral health problems; even so, the majority of clients entering substance abuse treatment are male.

Chapter 1: Creating the Context

Much of this TIP is premised on the understanding that stereotypes of masculine behavior shape men's attitudes, beliefs, and behaviors (including those related to substance use and abuse). These socially defined concepts of masculinity push men in our culture to restrict their emotional responsiveness, be more competitive, be more aggressive, and be self-reliant. Masculine roles may also hinder some men from seeking needed treatment for a variety of health, and particularly behavioral health, concerns, including those related to mental illness and substance abuse.

Concepts of masculinity affect different men to different degrees, but no man is unaffected by them or by the ways in which proper masculine behavior is defined at a societal level. Not all effects of masculine ideologies are negative, however, and traditional masculine values can be helpful or beneficial. Also, although there are certain masculine values that are dominant in contemporary American culture and fairly common across cultures, some cultures may define masculinity differently. Masculine values may also differ according to the role a man is filling (e.g., father, brother, friend).

In addition to explaining some of the research on masculinity, the first chapter defines other key concepts, such as gender, sex, and substance use disorders. It also presents some basic information on men's substance use and abuse in relation to that of women. Finally, it discusses the current state of the behavioral health field in regards to male-specific substance abuse treatment, what the future may hold for male-informed treatment, and how various audiences can use this TIP.

Chapter 2: Screening and Assessment

The screening and assessment of substance use disorders is an important and ongoing facet of treatment that should be adapted to the needs of the individual client. Part of this process of tailoring screening and assessment to client needs is being aware of how a man's beliefs and concerns about his identity *as a man* affect how he responds to screening and assessment questions and procedures—by doing so, clinicians will be better able to engage men in this process.

This chapter reviews three parts of a comprehensive screening and assessment process, which are:

1. The screening.
2. An assessment of the presenting problem (e.g., substance abuse) and its social, spiritual, psychological, and medical consequences.
3. A personal assessment that investigates other behaviors, values, attitudes, and experiences that may influence treatment in behavioral health settings.

Throughout this process, clinicians should be aware of the ways in which male gender roles influence men's psychosocial adaptation, substance use/abuse, and help-seeking behaviors.

Men are often ambivalent about seeking help for health problems (whether related to behavioral or physical health), and clinicians should acknowledge and possibly discuss this ambivalence with the client before assessment commences. Furthermore, many men are typically embarrassed or reluctant to talk about feelings. Providers can acknowledge this difficulty and work with clients to make the process less threatening. Because men are often action-oriented and focused on the concrete, it is

helpful to present specific goals in the assessment process and sometimes to use visual representations of their problems and past experiences.

Although screening for and assessment of substance use disorders are among the primary goals of behavioral health service providers, there are a number of other factors that can affect treatment that need to be investigated as part of a comprehensive personal assessment. Some of these areas will be investigated in almost every case, others will be pursued if particular information surfaces during the screening, and still other areas will only be investigated if the client expresses interest or concern. The chapter briefly considers the following areas of assessment:

- Work/employment history
- Housing status and needs
- Criminal justice involvement and legal issues
- Physical health
- Functional limitations
- Co-occurring mental disorders
- Trauma histories
- Motivation to change
- Relapse risk and recovery support
- Spiritual and religious beliefs

In addition, the chapter provides a more in-depth consideration of the assessment of family history (including both childhood abuse and current domestic violence), male sexuality, and shame.

Chapter 3: Treatment Issues

Chapter 3 explores issues that may affect substance abuse treatment for most, if not all, men. It begins with a discussion of some general considerations about how masculine roles may affect men in treatment, men's treatment-seeking behavior, and methods of engaging men in substance abuse treatment.

The chapter then discusses at length the issue of gender dynamics, transference, and countertransference for male and female behavioral health counselors working with male clients. Case examples are given to highlight some potential problems that can arise. The chapter also discusses the pros and cons of having either male or female counselors working with male clients. Because the majority of substance abuse treatment clients are male but most counselors are female, the chapter also includes some ideas about recruiting male counselors.

A variety of social and behavioral issues can affect men's patterns of substance use/abuse as well as their success in treatment. These issues include counseling men who have difficulties expressing emotion and men who feel excessive shame, both common problems for men in substance abuse treatment. Male roles and training may result in difficulties accessing some or all emotions, or in problems reacting appropriately to some emotions, such as anger. Men are affected by different kinds of shame and social stigma than women, and men are expected to engage in different rituals or rites of passage, many of which involve alcohol.

Men's behaviors relating to sexuality and violence are often important issues in treatment. Men are much more likely to commit violent acts than women, and those acts of violence are often associated with substance use/abuse. Violence, criminal behavior, and anger are factors that often need to be addressed if a man is to remain substance free. Although providers may be aware of the possibility that men may commit violent acts, they are less likely to consider that men are often victims of violence as well. Clinicians often do not look for—and men are rarely forthcoming about—histories of childhood physical or sexual abuse or current victimization by domestic partners, and

yet these are factors that can have a strong negative effect on treatment.

Men's sexual behavior is also often affected by their substance use/abuse, and this chapter helps behavioral health service providers understand the relationship between sexuality and substance use. It also discusses sexual dysfunction, the effects of substance abuse on the male reproductive system, sexual identity, compulsive sexual behaviors, and other issues.

Behavioral health service providers have become more aware in recent years of the importance of parenting and child custody for women entering treatment, and they have responded with the creation of programs that work with mothers and their children together. Children and other family members can also play an important role in encouraging men to enter treatment, and fears about losing custody of children can inhibit treatment entry. Men's substance abuse can have lasting effects on their children as well as themselves, and behavioral health services provide an opportunity to improve their parenting skills that many men will gladly take. This chapter provides some guidance to clinicians who want to address parenting in treatment programs for men. Reproductive responsibility, child support, and family court involvement are also discussed.

A holistic approach to treatment involves addressing men's spiritual and/or religious beliefs. Despite conflicting views among researchers and other professionals in the field about the link between spirituality and health, the consensus panel believes that spiritual beliefs and/or practices do influence some men's desire to abstain from using substances. Alcoholics Anonymous and Narcotics Anonymous are 12-Step organizations that use participants' reliance on a higher power to aid in the recovery process. These and similar groups have helped many individuals, both men and women, make tremendous progress on their road to recovery. This chapter discusses the spiritual element of 12-Step groups and the relationship between spirituality and health.

Chapter 4: Working With Specific Populations of Men in Behavioral Health Settings

Numerous social and cultural factors either contribute to or help moderate men's substance use, including their degree of conformity to masculine roles; culture, race, ethnicity, and related issues, such as racism and acculturation; family roles (e.g., son, partner, husband, father) and history; sexual orientation; geographic location; education; and professional background. Other factors related to some men's specific circumstances (e.g., behavioral and physical health problems, unemployment or type of employment, criminal justice system involvement, homelessness) may play a significant role in men's treatment and recovery plans.

Chapter 4 explores some basic differences in men's patterns of substance use/abuse based on various demographic factors. Men typically begin using substances at a younger age than women do, and this appears to be a major factor in greater rates of substance use disorders among adult men than among women. Boys and young men may also turn to substance use/abuse for different reasons than girls and young women do. For example, early use of substances by men may be attributable to the fact that they are not adept at addressing emotional pain constructively. A man's family background, sexual orientation, and cultural/ethnic identities may also affect his choice of substances and the possibility that he will develop a substance use disorder.

Men are less likely to have a serious mental illness than women are, but men make up the majority of adults with co-occurring substance

use and other mental disorders in behavioral health settings. This chapter considers rates of different co-occurring mental disorders among men and discusses how the course and presentation of different disorders may differ between the sexes. The chapter also looks at the related problem of suicidality, as men are more likely than women to die of suicide despite being less likely to attempt suicide. Physical illness or disability may also affect men's substance use/abuse; treatment may need to address those issues.

Masculine roles vary by age, as does men's substance abuse. This chapter covers special treatment needs of young men (ages 18 to 24) and older adult men (ages 65 and older). Research suggests that patterns of substance use/abuse for gay and bisexual men may differ from those of heterosexual men; a discussion of the treatment needs of gay and bisexual men is also included.

Employment has been shown to be especially important for men's success in recovery, and substance abuse is considerably higher among men who are unemployed. Rates of unemployment are very high for men entering substance abuse treatment. In some cases, occupation may also affect substance abuse for men who are employed. The chapter also discusses the role economic and cultural factors play in men's substance use/abuse.

The specific needs of male veterans are also addressed. Advice to behavioral health counselors for helping veterans access U.S. Department of Veterans Affairs (VA) services is provided, and the impact of combat stress reactions is discussed.

The special dynamics of men entering treatment through the criminal justice system or men who may interact with the criminal justice system while in substance abuse treatment are also addressed in this chapter. The criminal justice system is the largest single source of referrals to substance abuse treatment for men, and many other men receive treatment while incarcerated in jails or prisons. It is essential that behavioral health counselors understand the criminal justice system and how to interact with it appropriately.

Men typically enter substance abuse treatment with multiple needs that result, at least in part, from years of substance abuse. To address these needs, providers will often have to interact with other systems, such as the criminal justice system and the housing/homelessness services system. Homelessness has been associated with substance use disorders and co-occurring disorders among men. Men make up about four-fifths of homeless individuals in substance abuse treatment, but many programs cannot meet their particular needs—this chapter discusses ways programs can improve treatment outcomes for this group of men.

The chapter ends with coverage of broad cultural groups in the United States and the ways in which men's culture can affect their substance use/abuse and concepts of appropriate masculine roles.

Chapter 5: Treatment Modalities and Settings

Chapter 5 describes some treatment methods that researchers and providers have found useful in helping men recover from substance use disorders. It covers men's treatment needs in the context of different modalities (e.g., group therapy, individual therapy, family therapy) and settings (e.g., outpatient, inpatient) and some of the specific types of services that may be used by programs treating men (e.g., enhancing motivation, money management).

Men tend to be more reticent in group settings than women and less willing to attend such sessions, which can account for somewhat better treatment outcomes for female

clients. Providers should try to increase men's participation in groups. There are both benefits and potential problems involved in male-specific groups, and the chapter discusses some of these considerations.

Family and significant others often play an important role in motivating men to enter treatment. Once in recovery, men appear to stay with their partners more often than women who enter recovery. Couples and family therapy can therefore be important options for men in treatment. Men who are best suited for couples therapy:

- Have a high school or better education.
- Are employed or willing to be employed.
- Live with their partners or have partners willing to reconcile if they enter therapy.
- Are older.
- Have long-term substance abuse problems.
- Have recently had a crisis that may have threatened the relationship.
- Have a partner and/or other member of the household who does not abuse substances.
- Do not have other serious mental or emotional illnesses.
- Are not violent.

Some of the goals that providers should have when conducting family or couples therapy with men who are in substance abuse treatment include (1) developing perceptual and conceptual skills, (2) promoting mutual responsibility, and (3) challenging stereotypical behaviors and attitudes. Readers are cautioned that couples and family therapy is contraindicated for clients where there is a history or risk of domestic violence.

Chapter 5 covers family interventions that help men enter treatment. These range from simple methods (e.g., fielding calls to an agency from concerned significant others) to formalized intervention models (e.g., the Albany-Rochester Sequence for Engagement and Community Reinforcement and Family Training).

Chapter 5 presents information on some common treatment strategies (e.g., motivational enhancement, relapse prevention) and how they may be adapted for use with a specifically male clientele. Men often relapse for different reasons than women; relapse prevention techniques may need to take those differences into account. Men's participation in mutual-help groups is also considered.

1 Creating the Context

IN THIS CHAPTER

- Introduction
- Defining Sex and Gender
- Defining Substance Abuse and Substance Dependence
- Conceptual Frameworks of Masculinity and Male Roles
- Gender Role Conflict and Masculine Role Stress
- Men's Substance Abuse
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Introduction

This Treatment Improvement Protocol (TIP) examines the history and theories of male socialization, changes in perceptions of masculinity and male roles, fatherhood, and other factors related to men's substance use, abuse, and treatment. It emphasizes the fact that there is no single concept of masculinity or male identity appropriate for all men. Many factors besides gender status influence men's identities—age and cultural background, for example, affect how men view what it means to be male. While recognizing that there is tremendous variation among men, this TIP also discusses how American cultural norms shape the way many men evaluate themselves and how this relates to patterns of substance use or abuse and to treatment provided by behavioral health counselors.

Historically, substance abuse treatment services were developed with male clients in mind because most admissions to substance abuse treatment programs were—and are—men. More recently, though there are still more specialized programs and interventions for women than for men (Substance Abuse and Mental Health Services Administration [SAMHSA], Office of Applied Studies [OAS] 2007*d*), the gender studies and men's studies fields have begun to identify possible improvements in treatment services for men.

Men and women abuse substances for many reasons—some gender-related, some not. Reasons overlap in many areas but markedly diverge in others, necessitating different treatment options. This TIP and TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (Center for Substance Abuse Treatment 2009*c*), explore gender-specific treatment needs and services that can address those needs. Note: TIPs referred to in this and subsequent chapters are available at the Knowledge Application Program Web site (http://kap.samhsa.gov).

This chapter explains key issues, such as gender, sex, gender role conflict/stress, and conceptual frameworks relevant to behavioral health services for men with substance use disorders. It also describes concepts of masculinity and associated beliefs. It concludes with discussions of specific patterns of male substance use and abuse and how certain substances affect men differently than women; the current state of male-specific substance abuse treatment; and how this TIP is useful for various audiences of behavioral health service providers.

Although this TIP focuses on men with substance use disorders who are receiving treatment in substance abuse treatment settings, much content is directly applicable to clients with other behavioral health problems and disorders or who have a substance use disorder and a co-occurring mental disorder. The content of the TIP is directly applicable in various settings beyond substance abuse treatment programs, including mental illness treatment programs; criminal justice, vocational, and social rehabilitation programs; settings that primarily address physical health or family issues; and housing programs.

Defining Sex and Gender

One's *sex* is generally assigned according to biological markers. Individuals are typically classified as male or female based on their reproductive organs, but assigning sex based on observable physical or biochemical traits leaves some individuals unassigned due to genital, chromosomal, or hormonal ambiguities.

Gender, on the other hand, is a sociocultural construct that defines expected characteristics of men and women. *Femininity* refers to characteristics ascribed to women, whereas *masculinity* refers to characteristics ascribed to men. Gender is not absolute; masculine behavior in one culture can be the opposite in another. Moreover, notions of gender-appropriate behavior change over time and according to context. For example, in the 19th and early 20th centuries, it was considered appropriate for young boys to wear dresses. Notions of gender-appropriate occupations have also changed. For example, when the typewriter was first invented, male clerks were thought to have innate typing abilities far surpassing those of women. However, those stereotypes changed and in a few decades, working as a typist was considered a female occupation. Nursing, long considered a feminine job, has attracted more men in recent years.

In this TIP, masculinity is defined broadly to include commonly accepted expectations for men in the United States. A number of variables can alter accepted ideas about masculinity: economic status, occupation, geographic location, religious affiliation, education, race, ethnicity, and sexuality, among others. Some men are at odds with dominant notions of masculinity; others embrace such notions. Regardless of individual definitions of masculinity, ideas about gender roles and expectations can affect substance abuse treatment for men.

A person's *gender identity* must also be considered in discussions of masculinity. Gender identity is usually defined as a subjective, continuous, and persistent sense of oneself as male or female, but the importance of gender identity varies from one individual to another.

Defining Substance Abuse and Dependence

Unless otherwise noted, in this TIP, *substance abuse* and *substance dependence* refer to all varieties of substance use disorders described in the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision* (DSM-IV-TR; American Psychiatric Association [APA] 2000). The DSM-IV-TR states that

"the term *substance* can refer to a drug of abuse, a medication, or a toxin"—alcohol is included as a substance as well (p. 191). The text also notes that "many prescribed over-the-counter medications can also cause a substance-related disorder" and that "a wide range of other chemical substances can also lead to the development of substance-related disorders" (p. 191).

Substance dependence is "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems…[in which] there is a pattern of repeated self-administration that can result in tolerance, withdrawal, and compulsive drug-taking behavior" (APA 2000, p. 192). Though not a criterion, "craving (a strong subjective drive to use the substance) is likely to be experienced by most (if not all) individuals with substance dependence" (p. 192).

According to the DSM-IV-TR (APA 2000), the essential feature of *substance abuse* is a "maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances" (p. 198). The text notes that, "unlike the criteria for substance dependence, the criteria for substance abuse do not include tolerance, withdrawal, or a pattern of compulsive use and instead include only the harmful consequences of repeated use" (p. 198). It specifies that "the term *abuse* should be applied only to a pattern of substance use that meets the criteria for this disorder; the term should not be used as a synonym for 'use,' 'misuse,' or 'hazardous use'" (p. 198).

Although there is general agreement that intensive substance abuse treatment is best provided in specialized substance abuse treatment programs, many men with substance use disorders enter and may continue care in a variety of other behavioral health settings. As a result, in both specialized substance abuse treatment programs and other settings, clients may be seen by behavioral health service providers from a number of disciplines, including substance abuse counselors, mental health counselors, psychologists, social workers, professional counselors, ministers and chaplains, physicians, and persons working in criminal justice settings. The general principles discussed in this TIP will be informative for the broader range of behavioral health specialists who work with men who have substance use disorders.

Conceptual Frameworks of Masculinity and Male Roles

Although no one set of behaviors or traits defines masculinity, certain characteristics or expectations are associated with masculinity in a broad range of cultural contexts and across different age groups. Brannon (2005) reviews research on the cross-cultural applicability of gender stereotypes and notes that although diverse cultures label certain characteristics differently as masculine or feminine, there are generally more similarities than differences in gender stereotypes across cultures.

The stereotypical roles that define men within a culture are referred to as *masculinity ideologies* (Good et al. 1994). *Ideologies* are systems of values, beliefs, or ideas shared by a social group and often presumed to be natural or innately true. Masculinity ideologies, then, are a body of socially constructed ideas and beliefs about what it means to be a man and against which men are measured by their societies (Addis and Mahalik 2003; Good and Sherrod 2001).

Masculinity ideologies also affect how men think and feel about themselves, and they influence male roles in a society (Pleck 1981, 1995). Men internalize these concepts from an early age. Through a process of "masculine role

socialization," boys learn how they are expected to act, feel, and think, and they often face negative consequences if they fail to meet those expectations (Addis and Mahalik 2003; Eisler 1995; Good and Sherrod 2001).

Scholars have built upon Brannon's blueprint for masculinity (1976) to classify common, socially accepted male roles (e.g., Levant et al. 1992; Mahalik et al. 2003*b*; Mahalik et al. 2005; Pollack 1998*b*; Smiler 2004). Individual men may identify with several roles or none and may place more emphasis on some roles than others. The next sections examine specific masculinity concepts and their potential relation to substance abuse; these concepts exist on a continuum and may change over time.

Rituals, Rites of Passage, and Alcohol Abuse

Rituals are socially supported events individuals and families use to mark transitions in their lives. The use of rituals is common to all cultures, although specific rituals vary. As Imber-Black (2002) notes, "human beings are ritual makers. Differing from mere routines in daily life, rituals enable individuals, families, and cultures to create and derive meaning through their symbols and symbolic actions" (p. 445).

The potentially beneficial aspects of rituals are considerable. Rituals can reduce anxiety and foster change (Schwartzman 1982), facilitate development of individual identity and attachment to important values and beliefs of one's culture, and contribute to "a shared and necessary sense of belonging" (Wolin and Bennett 1984, p. 402). However, rituals can also be harmful—and certain rituals may harm men differently than women.

For centuries, men have been indoctrinated into manhood through highly ritualized rites of passage. Most cultures (Gilmore 1990) expect men to prove their worth through dangerous, painful tests of bravery. In the United States, men are often called on to prove their masculinity through sports competitions, high speed driving, or sexual conquests. Many such conventional manhood rituals are intertwined with excessive alcohol consumption, with alcohol acting as a lubricant for the behaviors or an end in itself. Indeed, some researchers who examined binge drinking among college students found drinking to be a form of ritualized behavior (Treise et al. 1999).

Critical transitions in men's lives—adulthood, marriage, fatherhood, retirement, deaths—often go hand in hand with excessive alcohol use, especially in the absence of clear guidance or preparation for the change. Although life transitions are ideal times for men to give comfort and support to each other (those who have made the journey already are especially equipped to do so), this rarely happens (Brooks 1995). Far too frequently, alcohol is substituted for open communication and caring. For example, on reaching legal adulthood at age 21, many men celebrate by getting drunk. Job promotions and sports victories are likewise frequently accompanied by drinking, often to excess. The traditional celebration of the transition from bachelorhood to marriage also often involves alcohol and drug use, which many times drowns out a real need for connection and communication among men.

To reduce alcohol consumption among men, the development of new celebrations and rituals that do not include alcohol consumption is necessary. Such changes will take time and effort, but people in recovery already make use of rituals to help them get and remain abstinent. For example, 12-Step groups typically involve quite a few rituals (e.g., opening and closing meetings, celebrating anniversaries, welcoming new members, passing the hat for contributions, giving out small objects such as key chains or coins to symbolize milestones), and these rituals are important in creating a

distinct cultural community that supports its members' abstinence (Wilcox 1998).

Emotional Restraint

Starting in boyhood, many men learn that they should avoid stereotypical feminine characteristics or behaviors and strive to be tough. Some do this by attempting to suppress emotions, thoughts, and behaviors potentially associated with vulnerability. Because of the stigma attached to expressing his emotions, a man who experiences grief and sadness after the loss of a loved one, for example, might resort to substance use as a way of coping (Good et al. 2000; Pollack 1998*b*). Men are more likely than women to respond to emotional stress by drinking (Geisner et al. 2004) and more likely to have a visceral response to alcohol-related cues when experiencing negative emotions (Nesic and Duka 2006). Even men classified as mild to moderate social drinkers report significantly more alcohol craving as the result of negative emotional states than women (Chaplin et al. 2008).

Many men have problems both identifying and expressing feelings, each of which has negative consequences. Difficulty identifying emotions can increase trait anxiety among men (Wong et al. 2006). Unlike women, men often do not develop an adequate vocabulary for expressing feelings; instead, they express them nonverbally (e.g., through violent actions or withdrawal) or suppress them (e.g., through substance use). Certain emotional states (e.g., anger or sadness) may be predictive of violence toward partners, even after controlling for gender role stress (Jakupcak 2003). These problems appear to be pronounced among men with substance use disorders, who often have difficulty recognizing and expressing certain feelings—such as hurt or vulnerability—that might be repressed and out of the individual's awareness. Alexithymia (the inability to experience and/or communicate feelings) is not unusual in substance abuse treatment populations. In one sample of men entering treatment for alcohol dependency, 30 percent met criteria for this disorder (Evren et al. 2008).

Competition and Success

Competition can be a fun and important aspect of recreational activities and a positive attribute in various professional and business settings, but it is also a significant source of stress associated with increased substance use (Blazina and Watkins 1996). Only so many persons can be recognized as the best in any given domain. Boys and men who perceive themselves as falling short in an important area may attempt to suppress feelings of insecurity by using or abusing substances. Conversely, the effort and pressure often involved with being the best leads some men to unwind or celebrate their accomplishments with substance use. For example, higher success, power, and competition orientations are linked with increased alcohol problems among male college students (Magovcevic and Addis 2005), and male college athletes drink more than nonathletes (Martens et al. 2006). In this same vein, men are significantly more likely than women to respond to social stress by drinking (Lemke et al. 2008), and work-related stress is strongly associated with heavy drinking in men (Siegrist and Rodel 2006). The possible tension of living up to various concepts of masculinity likely contributes to, but does not solely cause, a man's use or abuse of substances.

Aggressiveness, Fearlessness, and Invulnerability

Men are often socialized to be aggressive and to appear fearless and invulnerable. To prove their masculinity, some men engage in reckless behaviors, including consuming large quantities of alcohol or drugs. The desire to take risks and the need to avoid showing weakness can affect men's health-related beliefs and

behaviors (Courtenay 2000, 2003; Lejuez et al. 2004). Alcohol is also associated with increased aggression among men, and this effect may be stronger for men than for women. For example, Giancola (2002*a*) found that alcohol, when combined with higher levels of irritability, led to more aggressive behavior in men but not women. Illicit drug use may have a similar effect, given that some drugs (notably stimulants) are known to increase aggression and risk-taking behaviors.

As a group, men do not seek health care during illness or following injury nearly as often as women do (Addis and Mahalik 2003; Courtenay 2003; Sandman et al. 2000). Men are also more likely than women to engage in risky sexual behavior but less likely to take preventive measures (e.g., performing self-examinations for cancer, using sunscreen, wearing seatbelts or helmets, not using addictive substances). These behaviors contribute to the higher death rate among men for all leading causes of death, as well as their shorter life spans compared with women (Case and Paxson 2005; Courtenay 1998; Eisler 1995; Waldron 2005). Additionally, some frameworks of masculinity can exacerbate medical conditions by increasing stress. This could partially explain why Hunt and colleagues (2007) found decreased death rates from coronary heart disease among men who scored higher on measures of feminine traits, despite there being no similar findings for women.

Sexual Accomplishment

The gender socialization process can cause men many problems related to sexuality. Many American men learn from an early age that identifying with girls, women, or anything feminine is not socially appropriate, and emotional intimacy may be characterized as feminine. At the same time, sexual conquest is often presented as an expression of real masculinity. Fear of femininity drives some men to become counterdependent and emotionally vulnerable to no one; in some cases, they emotionally disconnect from others and start to view sex as an achievement or a goal.

Men who hold this outlook on sexuality can have problems with what Good and Sherrod (1997) call "nonrelational sex," or "the tendency to experience sex primarily as lust without any requirements for relational intimacy or emotional attachment" (p. 181). Having multiple partners with whom little communication is shared can result in unwanted pregnancies, higher risk of exposure to sexually transmitted diseases, and the spreading of diseases to multiple partners. Such behaviors add to growing public health problems. Men who engage in nonrelational sex can find intimacy difficult and relationship-building with members of either sex challenging.

Men's use of alcohol and drugs may be linked to their desire to fulfill male gender role expectations of power, dominance, and control over women. Research bears this out. Men who believe they have consumed alcohol are more likely to be aroused by violent sexual images or fantasies (Roehrich and Kinder 1991), and as they consume greater amounts of alcohol, their sexual fantasies are more likely to involve control over others (McClelland et al. 1972). Greater alcohol consumption is also associated with a greater likelihood of sexual aggression among men (Peterson et al. 2009), as well as increased violence toward intimate partners (Foran and O'Leary 2008), both of which are discussed in detail in Chapter 4.

A related aspect of this definition of masculinity is *heterosexism*—the assumption that heterosexual behavior is natural and therefore homosexual men are less masculine. Despite sexual orientation being a separate issue from gender identity, traditional concepts of masculinity equate the two. Heterosexual men may feel that their masculinity is threatened by

homosexual behavior, resulting in *homophobia* (i.e., fear of homosexuality and homosexual persons)—which further contributes to prejudice against gay men and pressures them to at least appear to conform to heterosexual norms.

Independence and Self-Sufficiency

Men are expected to be independent and able to take care of themselves with little or no help from others. Help-seeking for many men implies dependence, vulnerability, or even submission to someone with more knowledge, such as a healthcare professional. The negative mental and physical health effects of internalizing this masculine role, which is perpetuated by cultural messages about masculinity and health, can be seen in men's underutilization of healthcare resources—including behavioral health services (Addis and Mahalik 2003; Berger et al. 2005; Biddle et al. 2004). Men have significantly greater self-stigma related to help-seeking (i.e., believing that seeking help will decrease their self-confidence, cause them to doubt their abilities, and decrease their feelings of worth) than do women (Vogel et al. 2006). In addition, conformity with male gender norms of self-reliance is associated with increased psychological distress and less willingness to seek help for psychological problems (Mahalik et al. 2003*b*).

These attitudes toward help-seeking also affect men's interactions with primary care providers. Despite having a shorter life expectancy than women, men see their physicians less often (Cherry and Woodwell 2002) and ask fewer questions than female patients (Courtenay 2000). Compounding this problem, physicians make less effort to warn male patients about health risks (Foote et al. 1996).

Men consume considerably more alcohol and drugs than women and are thus more likely to have substance use disorders (Grant et al. 2005; SAMHSA 2009; von Sydow et al. 2001; von Sydow et al. 2002). However, men—particularly heterosexual men—are less likely than women to seek help for substance abuse (Addis and Mahalik 2003; Grella et al. 2009*a*). What might explain this discrepancy? Physical differences between the sexes could partially account for the variance in substance use and abuse, as could the socialization process for men and its resulting framework of masculinity. These may also contribute to differences in help-seeking behavior (Isenhart 2001; Williams and Ricciardelli 1999): men with substance use disorders are more likely than women to state that they can handle the problem on their own as a reason for not seeking treatment, whereas women's reasons tend toward concerns about what others might think or lack of time (U.S. Department of Health and Human Services, SAMHSA, OAS 2009*a*).

Acknowledging their illness (such as substance dependence) can cause men to feel helpless—a feeling that directly contradicts societal messages about masculinity (Good et al. 2000; Pollack 1995, 1998*b*). As Isenhart (2001) notes, "given this relationship between alcohol and masculinity, when a man is asked (or told) to give up alcohol, he may feel like he is giving up part of his masculine identity" (p. 250). Some men see health-sustaining practices (e.g., having annual physicals, getting health screenings, performing health self-assessments) as unnecessary or humiliating.

The Value of Gender Roles

Gender roles are neither all good nor all bad, and they vary according to social role (e.g., a man's role as a father differs from his role as a son), age, and cultural background. Some components are useful, especially in specific situations. For example, men aligned with more traditional masculine roles may have strengths in such areas as logical thinking, problem-solving, risk-taking, anger expression, and assertive behavior. These traits can be

particularly useful in times of crisis (Betcher and Pollack 1993; Levant 1995), enabling him to remain calm and problem-focused or to surrender his personal safety for the greater duty of protecting and providing for his family, community, or country (Good and Sherrod 2001). Conformity to male gender norms also fosters "acceptance from social groups, and [provides] social and financial rewards as a result" (Mahalik et al. 2005, p. 662). For men of color, adherence to gender roles can be a source of pride closely related to their cultural identity, helping protect them against racial and ethnic oppression and stigma (Levant et al. 1998; Ojeda et al. 2008; Saez et al. 2009).

Gender Role Conflict and Masculine Role Stress

Several models attempt to explain how men become socialized. Among these are the theories of gender role conflict (O'Neil et al. 1995) and masculine role stress (Eisler and Skidmore 1987; Eisler et al. 1988), which focus on the negative consequences experienced by men who endorse particular beliefs regarding masculinity (Addis and Mahalik 2003; Good and Sherrod 2001; Pederson and Vogel 2007).

Gender role conflict occurs "when rigid, sexist, or restrictive gender roles result in personal restrictions, devaluation, or violation of others or self" (O'Neil et al. 1995, pp. 166–167). This conflict can be experienced at a cognitive, emotional, or behavioral level, and may be conscious or unconscious. The Gender role Conflict Scale developed by O'Neil and colleagues (1986) gauges gender role conflict in four areas: success, power, and competition issues; restrictive emotionality; restrictive sexual and affectionate behavior between men; and conflict between work and family relations.

As with gender role conflict, the theory of masculine role stress views the socialization of men from a cultural lens. Eisler (1995) notes that:

> Masculine gender role stress may arise from excessive commitment to and reliance on certain culturally approved masculine schema that limit the range of coping strategies employable in any particular situation…. Masculine gender role stress may also arise from the belief that one is not living up to culturally sanctioned gender role behavior. Men may experience stress if they feel that they have acted in an unmanly or feminine fashion. Many men are doubly stressed by experiencing fear or by feeling that they did not appear successful or tough enough in situations requiring masculine appearances of strength and invincibility (p. 213).

Masculine role stress has been refined to include links to shame (discussed in Chapter 3), depression, and anxiety (Liu and Iwamoto 2006; Liu et al. 2005; Wong et al. 2006).

Men's Substance Abuse

Regardless of age or race, men use alcohol and drugs more frequently and in greater quantities than women. Similarly, young adults are more likely to use substances than are their older counterparts. The highest rate of illicit drug use is among young adult men, and the most common illicit drug used is marijuana. According to SAMHSA's 2008 National Survey of Drug Use and Health (NSDUH), young adult men 18 to 25 years of age are also more likely to drink alcohol (64.3 percent) than their female counterparts (58.0 percent) (SAMHSA 2009). Binge drinking (a pattern of alcohol use that is more likely to result in alcohol-related problems) is likewise more prevalent among men. An earlier NSDUH study (SAMHSA 2005) indicated that even though 32.9 percent of men ages 21 and older reported prior-month binge alcohol use, only 14.7 percent of women in the same age group reported binge drinking in the prior month. People who binge drink have a higher incidence of alcohol-related problems (than those who do not binge drink), and men are more

likely to binge drink than women, so counselors need to be aware, particularly when working with younger male clients, that binge drinking may be part of the individual's drinking pattern.

Perhaps reflecting these differences in use, American men are two to five times more likely to develop a substance use disorder than women (Brady and Randall 1999; Johnson and Glassman 1998; SAMHSA 2008; SAMHSA, OAS 2004*a*). In fact, in developed nations around the world, men experience greater mortality and morbidity from alcohol and tobacco use than women, due in part to greater rates of use (Lopez 2004). Worldwide, the health burden for substance use disorders is more than three times greater for men than women (World Health Organization 2004). The economic cost of men's substance abuse is greater as well; men who abuse substances have more criminal justice system involvement than women who abuse substances, and because men are more likely to have jobs, they more often require disability payments (Harwood et al. 1998; Oggins et al. 2001; Timko et al. 2009). When men receive substance abuse treatment, taxpayers benefit: For every dollar spent on treatment, an estimated $9.00 is saved in criminal justice, healthcare, welfare, and disability costs (Harwood et al. 1998).

Given the chance, men and women are equally as likely to use substances. However, men may be more likely than women to use and abuse them largely because they have more opportunities to do so (van Etten et al. 1999). This could, in part, account for higher rates of abuse and dependence among men. Men also generally begin using alcohol and drugs at an earlier age than women (SAMHSA 2005).

Understanding how socially constructed gender role expectations affect some men's choice of substances and attitudes toward treatment can help behavioral health service providers choose more effective strategies. Alcohol consumption, in particular, can be tied to ideas about masculinity and appropriately masculine activities. For young men, a first drink or first episode of drunkenness is often a rite of passage (Blazina and Watkins 1996; Hunt et al. 2005), and drinking is commonly seen as a form of male bonding (West 2001). Such traditional ideas linking masculinity to drinking are prevalent across cultures (Heath 2000) and are associated with greater alcohol consumption among college men (Blazina and Watkins 1996; West 2001) and military personnel/veterans (Burda et al. 1992; West 2001).

Men also respond differently than women to certain substances, and some substances have effects in men that they do not have in women (see Chapter 3). For example, when men and women think about cocaine cravings, their neural responses differ (Kilts et al. 2004); men who use cocaine are also more likely than women to state that cocaine increases their sex drive and that they have more sex when using cocaine (Washton 2009). Findings such as these suggest the possible usefulness of gender-specific treatment approaches for cocaine dependence and other substances of abuse. As with cocaine, there are differences between the sexes in both methamphetamine and opioid dependence. Men show greater loss of mental faculties relating to executive function and memory than women, and these effects persist even after abstinence (Ersche et al. 2006).

Men may use or start to abuse substances for different reasons than women, and male institutions (e.g., fraternities, amateur sports teams) often encourage alcohol use (Brooks 2001). Men who cannot talk about their feelings or manage them constructively sometimes use substances to deal with difficult emotions. Shame, especially, can limit help-seeking behaviors for substance use and mental disorders (Brooks 2001; Pollack 1998*b*).

Exhibit 1-1: Lifetime Substance Use in the General Population Ages 12 and Older (2008)

Substance	% Men	% Women
Alcohol	85.5	79.3
Cocaine (any form)	18.0	11.8
Smoked cocaine (i.e., crack)	4.4	2.3
Heroin	2.1	1.0
Inhalants	11.6	6.4
Hallucinogens	17.8	11.6
Marijuana	45.6	36.9
Methamphetamine	5.2	3.1
Pain relievers (non-medical use)	16	12.3
Sedatives	4.2	3.1
Tranquilizers	9.3	8.2

Source: HHS, SAMHSA, OAS 2009b.

Exhibit 1-2: Treatment Admissions by Primary Substance of Abuse

Substance	% Men	% Women
Alcohol	74.6	25.4
Alcohol with another substance	73.7	26.3
Smoked cocaine (i.e., crack)	58.4	41.6
Other cocaine	65.0	35.0
Heroin	68.3	31.7
Other opioids	53.8	46.2
Methamphetamine	54.2	45.8
Inhalants	67.0	33.0
Hallucinogens	72.7	27.3
Marijuana	73.8	26.2
Sedatives	42.7	57.3
Tranquilizers	46.4	53.6

Source: SAMHSA, OAS 2008b.

SAMHSA's 2008 NSDUH established rates of lifetime use of substances for men and women (Exhibit 1-1); it found that 12 percent of men ages 18 and older met criteria for a substance use disorder in the past year compared with 6.3 percent of women (SAMHSA 2009).

SAMHSA's 2006 Treatment Episode Data Set (SAMHSA, OAS 2008*b*) revealed differences in substance abuse patterns and preferred substances of abuse between men and women who entered substance abuse treatment programs funded through State agencies (Exhibit 1-2). For all drugs listed save sedatives and tranquilizers, most treatment-seekers were male. However, data reported in the exhibit are for the primary substance of abuse, which was not necessarily the only substance a person abused.

State of the Field

Substance abuse treatment was designed for a largely male client population, and greater numbers of men than women continue to be treated in a variety of behavioral health settings. Additionally, much of the research on substance abuse treatment has been conducted with male participants; nevertheless, it has not examined the specific, unique issues of men (e.g., their health, psychological, cultural, and social needs) as related to substance abuse and its treatment. There is a difference between designing a substance abuse treatment intervention for a population—the majority of whom are men—and designing one specifically to address factors that distinguish male from female clients. The study of men's issues is a growing field, and as researchers focus on issues specific to men, our knowledge base—and thus our ability to design treatment interventions for men—will increase.

In 2006, 68.2 percent of admissions to substance abuse treatment programs receiving State agency funds were men (SAMHSA, OAS 2008*b*). However, data from 2005 show

that only 25 percent of programs offered any type of specialized services for adult men (OAS 2007*a*). These data exclude treatment programs for incarcerated clients, an even greater percentage of whom are male.

In 2003, the Addiction Technology Transfer Centers (ATTCs) began offering two trainings related to men's issues in treatment: "Men in Therapy" and "Anger Management" (http://www.attcnetwork.org/learn/education/dasp.asp). Trainings in substance abuse treatment specific to men are also available from other sources, such as the "Counseling Alcohol and Drug Dependent Men" training from the Distance Learning Center for Addiction Studies (http://www.dlcas.com). Men in general, regardless of age or cultural background, are less likely than women to seek treatment and more likely to leave treatment early, so motivational interviewing and treatment engagement skills should be a primary focus when training staff members who treat men.

Audience for This TIP

Because men who have substance abuse problems are a large and diverse group of people, this TIP will be useful to a broad audience of behavioral health service providers, including:

- **Substance abuse treatment providers.** This TIP will help providers reevaluate treatment programs for men and the assumptions on which treatment is based. Providers who understand current social expectations, how clients view themselves vis-à-vis these expectations, and the role that substances of abuse currently play in men's lives can improve men's engagement in and outcomes for treatment.
- **Substance abuse prevention programs.** Substance abuse prevention efforts that focus on men's and boys' issues can use this TIP to help clients learn to interact with one another without using substances and to encourage help-seeking for substance abuse problems.
- **Primary care physicians and primary care providers.** Hospital workers will find resources and suggestions for improving the screening of men for substance abuse, mental health, violence, and related problems.
- **Psychiatrists, psychologists, counselors, social workers, and other behavioral health workers.** This TIP is a useful tool for modifying screening, assessment, engagement, referral, and treatment approaches when working with men who have substance abuse problems.
- **Educators.** This TIP can help students modify and/or challenge how men are viewed, to dispel misconceptions about men who abuse substances, and to encourage critical thinking and discourse about men who have substance abuse problems.
- **Criminal justice professionals.** Professionals associated with courts, prisons, probation and parole systems, and other criminal justice settings can use this TIP as a resource when urging programs to address the multiple needs of men as related to substance abuse, physical and mental health, violence, and other concerns, including vocational and parenting programs.
- **Faith-based organizations.** Content from this TIP can be incorporated into the work of faith-based programs to help men address issues related to substance abuse.
- **Researchers.** This TIP summarizes some of the central issues relating to men's treatment currently being studied and suggests directions for future research.
- **Administrators.** Administrators of agencies, provider organizations, treatment and prevention programs, medical facilities, and businesses can use this TIP to better inform community members not currently involved with the problems of substance use and abuse.

Appendix A—Bibliography

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