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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5 Treatment Modalities and Settings

IN THIS CHAPTER

Introduction

The consensus panel believes that substance abuse treatment for men should take into account the impact of gender on use, abuse, and recovery. Treatment components in any behavioral health setting should be gender responsive, examine the role of masculinity, and target the emotional/behavioral issues of most men. This chapter discusses the substance abuse treatment approaches, modalities, components, and settings that are most effective for use with men. Not all modalities discussed are specific to men; research on male-specific treatment is in its early stages. However, by focusing on the man *and* his substance use disorder, providers can tailor treatment to account for the physical, behavioral, and social differences of men.

Detoxification

Research on male and female responses to detoxification is mixed; only a few studies indicate differences between the sexes that might need to be addressed in this setting. In a study of men and women in New York, NY, detoxification programs for heroin and/or cocaine use, Millery and Kleinman (2001) found that levels of current depression among men and women in the program were about equal (despite depression being more common among women than men in the general population [Kessler 2000*a*, 2007]). Similarly, Johnson and colleagues (2007) found similar rates of co-occurring symptoms of mental illness among men and women who used injection drugs and were entering a detoxification program.

A comparison of male and female participants in an outpatient alcohol detoxification program found no significant differences in severity of withdrawal or program completion, although men were less likely than women to have had prior treatment for mental

illness or to have used illicit drugs in the month before entering the alcohol detoxification program (Strobbe et al. 2003).

Other research indicates that men may receive somewhat different services in detoxification programs than women do. Callaghan and Cunningham (2002) found that even though there were few differences in medical conditions between men and women presenting to a large, hospital-based detoxification program (*N*=2,545), women were significantly more likely to receive medical evaluation tests and to be prescribed some medications (i.e., antibiotics and antidepressants). They also found that men were significantly more likely than women to refer themselves to detoxification and to complete the program but significantly less likely, at the time of program entry, to be unemployed or to have dependent children. In another study, which investigated men and women whose detoxification was paid for by Medicaid, men who completed the program were significantly less likely to enter follow-up treatment than their female counterparts (Stein et al. 2009). Rates of follow-up treatment were low for both groups, but this issue deserves particular attention, as detoxification without follow-up treatment is associated with higher levels of relapse to substance abuse.

Providers should expect that men who enter detoxification, particularly for alcohol dependency, will have multiple substance use disorders. Men presenting to emergency departments are more likely than women to be using alcohol in addition to drugs, such as cocaine, opioids, or marijuana. (Substance Abuse and Mental Health Services Administration [SAMHSA], Office of Applied Studies [OAS] 2008*a*). Detoxification, especially from substances like alcohol and barbiturates, is a serious undertaking that can pose a significant health risk. Therefore, on entering a detoxification program, men must be encouraged to give a full and honest substance abuse history.

Physical detoxification from substances usually lasts 3 to 5 days; thus, many decisions about treatment options must be made in a relatively short period of time. In medical settings where there may be few or no individual or group psychosocial interventions, behavioral health service providers and other staff members should try to engage men in dialog that allows them to express their fears and anxieties about receiving treatment. The staff can then provide feedback and information that will help these men make recovery-oriented decisions.

Men sometimes seek physical detoxification from substances because they want to stop other illegal behaviors and/or avoid their consequences. Many men who engage in criminal activities do so to support their substance use, which can lead to incarceration, loss of public housing for them and their families, loss of employment, or loss of child custody or visitation rights. Other men may seek physical detoxification services if they want to give their bodies a break from substance abuse. The time during which these men undergo physical stabilization may be the only real opportunity behavioral health service providers have to encourage them to seek long-term solutions for their substance use disorder(s).

For more information on detoxification for men and engaging them in substance abuse treatment following detoxification, see Treatment Improvement Protocol (TIP) 45, *Detoxification and Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT] 2006*a*).

Treatment Modalities

Most substance abuse treatment programs use a combination of group, individual, or family/couples counseling. Men may present

unique challenges in treatment, many of which have been discussed in prior chapters. Another problem relevant across treatment modalities is men's potential resistance to entering or participating in therapy/counseling; this, along with challenges specific to the three basic treatment modalities, are discussed in the following sections.

Group Therapy

Group therapy is the most widely used treatment modality in substance abuse treatment programs (Etheridge et al. 1997; National Institute on Drug Abuse [NIDA] 2003; Weiss et al. 2004). Groups offer a number of advantages to the treatment program itself (e.g., cost effectiveness) and the clients they treat (e.g., decreasing clients' sense of isolation, providing an opportunity to learn social skills, offering support and encouragement), and research generally indicates that group therapy is as effective as individual therapy for treating substance use disorders (see review by Weiss et al. 2004). TIP 41, *Substance Abuse Treatment: Group Therapy* (CSAT 2005*d*), discusses the advantages and techniques of group therapy.

The importance of encouraging and motivating men to participate in group therapy is suggested by an analysis of outcomes of the Target Cities Treatment Enhancement Project in Los Angeles. The study found that, among 330 men and women who completed a treatment program that included both individual and group therapy, women had lower relapse rates (22 percent) than men (32 percent) in the 6 months following treatment—despite the fact that women in this population showed more risk factors for relapse than men. After controlling for employment, child care, transportation, and several other factors, the only variable that seemed to explain the difference in relapse rates was that the women had participated significantly more often and for longer periods of time in group therapy (Fiorentine et al. 1997).

Single-gender groups for men

Some research suggests that women may do better in single-sex, gender-specific groups (Grella and Joshi 1999; Hodgins et al. 1997; Niv and Hser 2007; Orwin et al. 2001; Zilberman et al. 2003); some clinicians believe that gender-specific groups may also be useful for male clients (Lyme et al. 2008; Wexler 2009). Even so, in a study that compared outcomes for men in a mixed-gender program to men in an all-male program, Bride (2001) did not find significantly different outcomes for participants in the single-gender program. That said, a treatment group that happens to be composed of men is not the same as a treatment group that focuses on treating substance abuse in the context of male gender issues (van Wormer 1989). Groups must be developed to focus on male needs and male approaches to interaction.

Van Wormer (1989) outlines six basic functions of sex segregation in groups treatment:

1. All-male group therapy provides an opportunity for men to relate to other men without being distracted into game playing to impress women. Men also learn to take on caregiving roles, which they might leave to women in mixed settings.
2. Men can experience closer relationships with other men in the pursuit of mutual goals and concerns. Caring and friendship among men are supported.
3. In the absence of women, men can discuss controversial topics (such as child custody, dating, cohabiting patterns) more freely.
4. A male-led men's therapy group is especially appropriate for working on destructive, restrictive aspects of the masculine gender role. Together, men can explore their relationships with women and thereby learn how other men relate to women.

5. Personal topics (e.g., male health problems, sexual needs/dysfunctions) can be explored.
6. Members of the men's group can become sensitized to their feminine as well as masculine characteristics; they can learn to be more flexible in their sex role definitions.

Van Wormer cautions that male tendencies to intellectualize and to avoid intimacy are major problem areas for all-male groups, as are dominance issues. Wexler (2009) adds that male-only groups can become very competitive, and cynicism and disruptive behavior need to be watched. However, this kind of group can also become a laboratory in which individual members can experiment with long-repressed thoughts and feelings that were previously numbed with substances.

Brooks (1996) details some of the ways in which all-male groups can benefit male clients:

- Many men have experiences of bonding with other male peers in a group setting (e.g., a sports team) that can help them become part of a therapy group. Therapists can use the familiarity and attraction of such male group bonding to interest men in the group while not reproducing the competitiveness and hierarchical structure common in male peer groups.
- Many men only share emotions and emotional intimacy with women. Because of this, men can become overly dependent on women for fulfilling their emotional needs or may even experience their own emotions vicariously through women. The male-only group offers men an opportunity to express their emotions to other men, thus building intimacy and trust.
- The group setting can be valuable for encouraging sharing. Men in American society are socialized to avoid self-disclosure, but in a group composed only of men, the male client can see others revealing things about themselves and gradually begin to share his own fears, concerns, and feelings.
- Other men in a group setting provide an example to the male client of how his life can improve with treatment and group involvement, thus instilling hope.
- The male-only group gives men the opportunity to improve their ability to communicate with other men in new and improved ways. It also provides a safe environment for learning which communication styles are ineffective.

Conversely, mixed-gender groups have their benefits. In these groups, men can develop healthy, nonsexual relationships with women. Men may feel more comfortable expressing emotions when women are present and may hear responses from female clients that give them a different perspective than other men would give. The use of mixed-gender groups has been associated with greater variations in interpersonal styles for male (but not female) participants (Hodgins et al. 1997).

Exhibit 5-1 describes one of the few group interventions specifically for men in substance abuse treatment: a short-term group intervention that helps men with substance use disorders improve intimate relationships. Time Out! For Men (TOFMEN) can reduce attitudes associated with rigid socialization and gender role conflict (Bartholomew et al. 2000); the consensus panel believes that it shows promise.

Other group activities for men in treatment

In addition to traditional group therapy models, behavioral health counselors should consider organizing other structured group activities for male clients. Activities like attending a ball game or movie together, working on a group craft project, or playing a sport can offer opportunities for men to bond with one another and practice social interactions

Exhibit 5-1: Time Out! For Men

TOFMEN is a group intervention for male clients in substance abuse treatment that promotes the reexamination of gender stereotypes, social pressures, and sexual misconceptions to help men improve their relationships with their partners. TOFMEN was developed in 1996 by Bartholomew and Simpson as part of the Drug Abuse Treatment Outcome Study (DATOS) project funded by NIDA. The intervention is designed to be run by a substance abuse or other behavioral health counselor; a training module is available online (http://www.ibr.tcu.edu/pubs/trtmanual/tofmen.html). TOFMEN is a short-term intervention designed to be implemented over eight sessions.

- **Session 1:** This session focuses on creating a bond among group members and exploring male and female gender roles. Specifically, group members examine what they need and want in their intimate relationships and what role socialization plays in their values and choices. The counselor asks each man to create a list of the characteristics that make an ideal man and woman; group members use these lists to look at how gender role stereotypes affect their relationships. Men are challenged to implement and discuss what they have learned via a take-home assignment. After session 1, group members are given worksheets to help them identify their needs and how they can meet the needs of their spouses or partners.
- **Session 2:** Men start by reviewing their homework from the day before. After, they concentrate on building communication skills to achieve and maintain an assertive attitude. They discuss the disadvantages of aggressive and passive communication styles and the differences between "I-statements" and "You-statements."
- **Session 3:** This session focuses on listening, a key skill for maintaining good relationships. Group members participate in listening exercises to help them decipher common listening problems and identify good listening habits. In one exercise, an item (e.g., a mug) is passed to the participant who has the floor. The next group member to receive the item then restates what he heard the previous speaker say.
- **Session 4:** Participants discuss feelings and how to accept and express them. After making a list of feeling words, group members identify and discuss which feelings are hard or uncomfortable for them to talk about.
- **Session 5:** Men discuss how to resolve conflicts. They are encouraged to seek solutions instead of assigning blame when conflict arises and are taught how to fight fairly with others.
- **Session 6:** This session uncovers misconceptions about sexual and reproductive health and how they can affect attitudes and values about sexuality. Clients are taught how unnecessary concerns about normal body functions, sexual responses, and sexual feelings can cause undue stress on relationships.
- **Session 7:** This session continues the discussion of sexuality as the men address common concerns about and the effects of substances on sexual functioning. They also examine stereotypes concerning the man's role in sexual relationships and try to devise self-help solutions for sexual problems in relationships.
- **Session 8:** The last session focuses on increasing self-esteem (e.g., by writing affirmations) and reviewing communication skills covered in previous sessions. The men are encouraged to keep building these skills. The workshop closes with a graduation celebration; group members are awarded certificates for completing the intervention.

Source: Bartholomew and Simpson 2002.

while abstinent. Although research on this topic is limited, Burling and colleagues (1992) found that male veterans who were homeless, in a substance abuse treatment program, and participating in a community-based softball team were more likely than men who did not participate in the sport to complete the program and were also more likely to maintain abstinence, remain employed, and have housing 3 months after treatment. However, this may, in part, reflect the benefits of exercise for people in treatment, one of which is longer

duration of abstinence following treatment for men who exercise compared with those who do not (Weinstock et al. 2008).

Individual Therapy

Individual counseling has been used extensively in substance abuse treatment but, in most programs, it is used less commonly than group therapy. According to DATOS data (Etheridge et al. 1997), the average number of individual sessions offered was significantly less than the average number of group sessions offered in most types of treatment (with the exception of outpatient methadone programs, which offered slightly more individual sessions on average). Etheridge and colleagues (1997) found that the average ratio of individual to group sessions per month was smallest for long-term residential programs (7.2 group and 4.5 individual sessions) and largest for outpatient drug-free programs (14.8 group and 3.3 individual sessions).

Individual therapy is an important intervention for men in substance abuse treatment. In the National Treatment Improvement Evaluation Study—which included 2,019 men and 1,123 women from 59 different treatment sites—89 percent of programs serving men offered individual counseling at least once a week, and men (but not women) in those programs had significantly lower rates of substance use 12 months after treatment than men in programs that did not offer individual counseling (Marsh et al. 2004).

Individual counseling can offer benefits that group therapy does not, and the panel encourages programs to make use of both group and individual therapy options when working with male clients. In a multisite study that investigated four psychosocial treatments for cocaine dependence, Crits-Christoph and colleagues (1999) found that participants exposed to various forms of individual counseling and/or therapy in addition to group counseling had significantly better outcomes than those who participated in group counseling alone. For some men, it is much easier to discuss sensitive issues (e.g., gender-related concerns) and reveal emotions and tears in private with a trained professional than with a group of peers they will have to face again after exposing aspects of themselves that they normally do not share with other men. The counselor is not seen as a peer or potential friend, but as someone providing a service in a way that is personal yet limited. Although group members are bound to confidentiality, clients in an individual therapy setting can establish a different level of trust with their behavioral health counselor, given the counselor's legal and ethical responsibilities. Also, in individual counseling, clients receive individual attention and can focus on their own needs to a greater degree than in group settings. Some clients (e.g., men with social anxiety disorder) may be much more comfortable in the presence of one other person (the counselor) than in a group. Research also suggests that men and women in substance abuse treatment respond better to different styles of individual counseling: Fiorentine and colleagues (1999) found that men generally responded better to a counselor using a utilitarian style, whereas women generally responded better to a more empathic style of counseling.

As with all treatment methods, some potential disadvantages to individual therapy exist. For instance, if a client only participates in individual therapy, much of what occurs in the course of treatment is solely dependent on the skills, knowledge, and experience of the counselor and how they fit with the needs of the client. This leaves the client without the opportunity to receive input from his peers. Counselors with little practical information or lifestyle knowledge related to a particular substance of abuse may find it difficult to recognize when

someone is being dishonest. In individual treatment, a client might not be held as accountable for problematic behavior as he would in a group setting. Group members can introduce the client to substance-specific coping skills and abstinence strategies of which the counselor may not be aware.

Whether men can benefit more from work with a male or female counselor is dependent on a variety of factors, including the expressed preference of the client, the setting in which the counseling occurs, and the nature of the topics to be discussed. A more extensive overview of the impact of counselor gender is presented in Chapter 3 of this TIP.

Family and Couples Therapy

Men are ideal beneficiaries of family or couples therapy, as marriage and family appear to have a protective function against substance abuse and relapse for men. Having a family role (as either spouse or parent) is associated with less alcohol consumption for men (Kuntsche et al. 2009), whereas men who are widowed, separated, or divorced are more likely to engage in binge drinking (Blazer and Wu 2009*a*). Other research indicates that men who enter treatment while married are less likely to engage in daily substance use than those who were never married or are divorced, separated, or widowed; the opposite is true for women entering treatment (SAMHSA, OAS 2008*b*). For men who complete treatment, being married is associated with better outcomes (Walton et al. 2001). Men who relapse are less likely to do so in the presence of romantic partners than when with male friends, although the opposite is true for women (Rubin et al. 1996). McCrady and colleagues (2004) found that marital happiness during posttreatment follow-up was associated with a significantly greater percentage of days of abstinence among married men with alcohol use disorders; greater marital happiness prior to treatment had no relation to abstinence rates.

It may be particularly important for men with substance use disorders to maintain relationships with their partners and family during recovery, as there is some evidence that married men who enter substance abuse treatment—particularly those with children under age 18—are much more likely to stay with their partner after completing treatment than are women who complete treatment (Orloff 2001). As noted in Chapter 4, family and partners can play important roles in motivating men to enter treatment and can help promote recovery during and after treatment. In addition to promoting abstinence, couples interventions for fathers who have substance use disorders and their spouses may also improve the emotional state of children living with that couple, even if the children are not included in the counseling sessions (Kelley and Fals-Stewart 2002).

The National Association for Children of Alcoholics (NACOA) produces a variety of resources for counselors and other helping professionals on the impact of adverse childhood experiences, including substance abuse in the family, on childhood development. The NACOA Web site (http://www.nacoa.org) offers counselor resources that support family involvement in recovery.

Couples therapy

Clients are most likely to accept and complete couples therapy (O'Farrell and Fals-Stewart 1999) if they:

- Have a high school or better education.
- Are employed or willing to be employed.
- Live with their partners or are willing to reconcile for therapy if separated.
- Are older.
- Have substance abuse problems of a longer duration.

- Enter therapy after a crisis, especially one that threatens the relationship's stability.
- Have a partner and other members of their household who are without substance abuse problems.
- Are free of other serious mental or emotional illness.
- Are not violent.

Not all men are suitable candidates for family therapy or want to involve their family in their treatment. Men under a restraining order from a court to refrain from contact with their partners, and those who have inflicted or received significant physical abuse, should not be considered for couples or family therapy. If there is current evidence of domestic violence, there may even be State regulations prohibiting the use of family or couples therapy.

Family therapists or other behavioral health counselors who may see men with their female partners may find the men to be more difficult to work with than the women. Because therapy relies on verbal communication skills, particularly the discussion of feelings, and because men have difficulty asking for help, women may appear to be more engaged in therapy. The counselor will thus need to be careful to speak to the man's concerns as well as the woman's and use language that is comfortable for the man, such as by making use of his words and expressions or talking about behaviors as well as feelings (Shay and Maltas 1998). Clinicians should be mindful of how the man does contribute or could contribute if an opening were made for him.

DATOS data indicate that most community-based treatment programs evaluate the family treatment needs of their clients and most offer some form of family intervention (Etheridge et al. 1997). However, information from these surveys also suggests that, despite documentation of need across all treatment modalities, family interventions occur on a limited basis—primarily within short-term inpatient and residential programs (Fals-Stewart and Birchler 2001). As clinicians complete comprehensive personal assessments to document their clients' family concerns and problems, they should consider how family counseling can benefit clients and how to provide it when needed.

Behaviorally oriented couples interventions that have been particularly well evaluated and generally found effective in reducing substance use and improving marital relations for men who have substance use disorders include behavioral couples therapy (BCT) and variations upon it (behavioral family counseling, alcohol behavioral couples therapy, behavioral relationship therapy, and behavioral marital therapy). A meta-analysis of multiple studies on BCT (Powers et al. 2008) concluded that immediately after treatment, BCT improves relationships (according to couples self-reports) and that this, in turn, results in greater long-term substance use reduction compared with many standard individual treatments. In the most recent of these studies (not included in the meta-analysis), Epstein and colleagues (2007) found that men who had drug use disorders and received BCT with their female partners reported significant decreases in the frequency of drug use, alcohol use, and number of drugs used 9 months after treatment; 55 percent reported improved marital functioning. Variations on BCT have also been found to improve outcomes following treatment, especially when added to other services (Epstein et al. 2007; Fals-Stewart et al. 2000*a*, 2005; Fals-Stewart and O'Farrell 2003; Lebow et al. 2005; McCrady et al. 2004; O'Farrell et al. 1998; Powers et al. 2008).

Network therapy is another promising intervention that makes use of family (as well as friends) and has been associated with better treatment outcomes for men in treatment for cocaine use disorders (Galanter et al. 2002)

and men with opioid use disorders on buprenorphine maintenance (Galanter et al. 2004).

Other approaches to family and couples therapy can be useful in treatment settings; these are discussed in TIP 39, *Substance Abuse Treatment and Family Therapy* (CSAT 2004*b*).

Family therapy

A number of authors (Lazur 1998; Levant and Philpot 2002; Levant and Silverstein 2001; Philpot 2001; Philpot and Brooks 1995; Philpot et al. 1997) have suggested that family therapy pursued with men must be sensitive to how gender role socialization affects family life, from patterns of communication to the division of household tasks to the parenting of children. Building on women-centered approaches to family intervention, these authors suggest how to use current understanding of gender, particularly male gender, to successfully engage men in couples and family therapy.

In one study, an expert panel of male and female family counselors endorsed 131 of 339 proposed techniques as appropriate and potentially effective ways to work with men in couples and family counseling (Dienhart 2001; Dienhart and Avis 1994). They agreed that clinicians should increase their ability to consider the influence of gender role socialization on presenting problems, promote shared responsibility for change, and actively challenge stereotypical attitudes and behaviors. Some specific techniques endorsed by this group of therapists are listed in Exhibit 5-2.

Family therapy should acknowledge how gender role socialization may complicate family problems associated with clients' substance abuse. All types of family-oriented interventions should be sensitive to the ways gender roles in a family may vary with age, culture, ethnicity, social class, and sexual orientation (Greenan and Tunnell 2003; Krestan 2000; McGoldrick et al. 2005).

Men with substance use disorders may need help talking with parents, children, siblings, and members of their extended family about their substance abuse and related problems. When substance use by men is pervasive within a family, it may be useful to hold a family-oriented counseling session with just the male members of the family to discuss their common legacy of substance use (Brooks 1998). These male-only family meetings may help to secure support for abstinence from substances.

Substance abuse counselors can consider encouraging relatives, spouses, friends, or others affected by a person's substance abuse to seek help and support through such resources as Al-Anon Family Groups, Nar-Anon, Families Anonymous, Co-Anon Family Groups, or Adult Children of Alcoholics.

Family interventions to motivate men to enter treatment

A variety of interventions aim to involve family members and others in the process of motivating men to seek treatment. Some of these interventions can be implemented relatively easily. For example, Garrett and colleagues (1999) outline a procedure for responding to telephone calls from people concerned about the substance use of a family member. The "concerned other" call is a chance to help them leverage a person who appears to have a substance use disorder into treatment.

The Johnson Institute intervention (Johnson 1986) teaches the family to talk actively with men who have substance use disorders about the problematic nature of their substance use and their need for treatment. The confronters are given formal training and rehearse the intervention. They learn to emphasize their care and concern for the target, the damage his substance use has caused, and the actions they will take if he does not accept help. The intervention comes as a surprise for the person who

Exhibit 5-2: Goals and Techniques for Working With Male Clients in Couples and Family Therapy

GOAL—Develop perceptual and conceptual skills:

- Clarify your own values concerning gender socialization.
- Become aware that all men are not alike—they are in various stages of transition along a continuum, with some men being open to change and others being more resistant.
- Define family as inclusive of all the many types of families in America (e.g., traditional families, single-parent families, extended families, gay or lesbian families).
- Become aware of and challenge any tendency to protect men in the system.
- Familiarize yourself with men's writing about men.
- Focus on the anxieties that underlie men's defensiveness.
- Be aware of patterns of power assertion on the part of male clients.

GOAL—Promote mutual responsibility:

- Ask couples historical questions on the formation and development of responsibility in the presenting family.
- Have couples evaluate their options for changing the division of responsibilities.
- Determine who initiates sexual interaction.
- Use direct teaching to introduce the reciprocal nature of gender interactions and the constraints of the larger sociocultural context.
- Design interventions that are directed at all parts/members of the involved treatment system (e.g., helpers, members of the extended family).

GOAL—Challenge stereotypical behaviors and attitudes:

- Teach men to ask for help.
- Discuss the benefits that men can get from changing stereotypical behaviors and adopting new attitudes, roles, and behaviors.
- Encourage father–daughter and mother–son bonding, especially during adolescence.
- Discuss problems men with absent fathers have in being fathers to their own children.
- Examine couples' experience of socioculturally supported behaviors in their own relationships (e.g., Are men satisfied with working long hours? Do they long for more time with their children?).

Source: Dienhart and Avis 1994.

is using substances. This method, using significant others, has proven to be more successful than coercion by an employer or judge. It was designed to enroll people with substance use disorders in inpatient treatment; it is labor-intensive and thus more expensive than less intensive interventions (Loneck et al. 1996). The intervention is very limited in its scope and may be too confrontational for some families (Fernandez et al. 2006).

Garrett and colleagues (1997) developed the Albany-Rochester sequence for engagement (ARISE) method to provide a more supportive, less confrontational approach to involving significant others in an initial intervention (see also Garrett et al. 1998; Landau et al. 2000). ARISE is more conducive to helping clients engage in outpatient treatment. The intervention begins with a call from a concerned other to the treatment center, which is followed by a modified Johnson-type intervention. If the person who is abusing substances enters treatment, the members of the intervention group agree to continue to provide support. ARISE differs from the Johnson intervention in that the planned intervention is not kept secret from the potential client, and the treatment plan is negotiated with him during the intervention. It is also more flexible and, even

though it can use a confrontational approach, it need not do so (Fernandez et al. 2006).

Another intervention that holds promise for engaging men in treatment is community reinforcement and family training (CRAFT). Developed by Meyers and colleagues (1996, 2001), CRAFT is based on the community reinforcement approach to substance abuse intervention. In the conceptual model outlined by Meyers and colleagues, concerned significant others receive training in techniques that:

- Promote self-care.
- Decrease the risk of domestic violence.
- Evaluate situational factors promoting substance use.
- Improve communication between significant others and the individual with a substance use disorder.
- Reinforce the efforts of clients with substance use disorders toward effectively daily functioning.
- Discourage substance use.
- Increase motivation.
- Reinforce awareness of the need for treatment.

Meyers and colleagues (2001) studied significant others affected by a family member's substance abuse. They found CRAFT to be more acceptable and more effective at getting the potential client into treatment than other approaches that were more confrontational or potentially disengaging.

Unilateral family therapy (UFT; Thomas and Ager 1993) is another family-based intervention that uses elements of both the Johnson intervention and CRAFT but is more flexible and focuses more on improving family functioning (Fernandez et al. 2006). The intervention consists of 11 to 30 sessions delivered over 4 to 6 months, and it provides a series of graded steps the family can use prior to confrontation. UFT helps family members strengthen coping skills, enhance family functioning, and facilitate greater abstinence on the part of the person using substances.

Chapter 4 of TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*b*), contains more information on the Johnson intervention, CRAFT, and other family interventions designed to motivate people to enter treatment. Fernandez and colleagues (2006) review research on these interventions and mutual-help approaches like Alcoholics Anonymous (AA), noting both benefits and limitations of the use of each.

Treatment Strategies

A variety of interventions may help male clients; many (e.g., relapse prevention) are already in use in most treatment programs but may be improved by adapting them specifically for men. Others (e.g., money management) may only be needed for some segments of the male treatment-seeking population.

Enhancing Motivation

In treatment, motivation has traditionally been identified as something within a person, some type of energy or attitude a person possesses that can facilitate change. Motivation—more than any other single factor—can determine a person's success in recovery. Lack of motivation is often given as a reason by people who fail to enter or do not succeed in treatment.

Men are generally more reluctant to seek substance abuse treatment or counseling than women and also tend to end treatment earlier (Addis and Mahalik 2003; Berger et al. 2005; Blazina and Watkins 1996; Mansfield et al. 2005; Pederson and Vogel 2007). This may be because men use alcohol and drugs as problem-solving strategies. Substance use may be considered a more masculine way to deal with stress than self-disclosure and dialog. The resistance men show to substance abuse treatment is partly a response to their perception

that they are being asked to abandon something that helps define their masculinity. Treatment that addresses how a man's substance use relates to his concept of himself as a man may prove more effective in motivating men than treatment that does not, as increased stress about male gender roles has been shown to correlate with increased substance use (Blazina and Watkins 1996; Isenhart 1993).

External factors (such as workplace and family relationships) can greatly undermine men's motivation to change substance-related behaviors. In some occupations and workplaces, a lunchtime cocktail or a drink with coworkers after work is considered normal; everyone is expected to partake. If drinking or using drugs on the job is encouraged or even accepted by coworkers, a man's work environment will decrease his motivation to change. If a man uses substances with his spouse or significant other, that relationship can decrease his motivation to seek treatment (Fals-Stewart et al. 1999).

Behavioral health clinicians exert considerable influence on enhancing motivation for positive change. Counseling style and approach can hinder or enhance a man's motivation. For example, an authoritarian, adversarial, or confrontational style may prove less effective than more client-centered, reflective approaches (Miller et al. 1993, Miller et al. 1998).

How do behavioral health professionals motivate men to overcome commonly accepted male attributes that can deter them from seeking help? One approach is to change the way treatment programs are structured to make them more responsive to the habits and psychosocial needs of men. Programs that allow clients to make decisions about their treatment and allow for different levels of involvement in various components of the program—compared with those where clients have little or no input in what they do in treatment—have proven more effective (CSAT 1999*b*).

Motivational interviewing

The panel believes that motivational interviewing is effective with many male clients (see http://www.motivationalinterview.org for more information). In motivational interviewing:

- The clinician has a directive rather than authoritative role and builds trust.
- The clinician continually focuses on client strengths rather than weaknesses.
- Treatment is individualized and client centered.
- Clients' autonomy and decisions are respected.
- Clients are encouraged to discuss mixed feelings about change openly.
- The clinician helps clients review possible strategies for change and initiate and maintain any change, but the clinician does not prescribe change.
- Clients decide whether, to what degree, in what timeframe, and by what means change will occur (Isenhart 2001).

Client-centered approaches can help alleviate the feelings of helplessness and lowered self-esteem that men tend to express on entering treatment and give them a sense of autonomy, increasing their motivation to change. Motivational interviewing can be especially effective for clients who are ambivalent about ending their substance use (Miller and Rollnick 2002). TIP 35 (CSAT 1999*b*) contains more detail on motivational interviewing, providing incentives, and other interventions aimed at motivating clients; the TIP also explains the process of changing substance use behavior in relation to the stages of change model.

Coercion in treatment

Men who are coerced or mandated into treatment do as well as or better than those presenting voluntarily. It is a misconception that coerced or mandated means forced. Coercion, whether by an employer acting through an employee assistance program or by a drug

court, means the client was given a choice between treatment and the consequences of continued substance use, such as job loss, loss of parental rights, or incarceration. Among men, a choice between two inevitable outcomes is qualitatively different from an order by an authority figure and has a far more positive effect on motivation to enter and stay in treatment (Miller and Flaherty 2000).

Behavioral health counselors should be prepared, however, to work with a male client's anger over being coerced or mandated into treatment. This anger may be expressed directly through verbal tirades about authorities, or it may be expressed passively through missing appointments, coming late to sessions, or not participating in sessions; in other cases, the anger may be buried and the man may deny negative feelings about being coerced into treatment. Behavioral health counselors should not assume that anger does not exist merely because it is not directly expressed, and clients should be encouraged to discuss their anger as part of treatment. Discussing anger, however, is different from expressing the anger in ways that are destructive to oneself or others. Once this anger is resolved, differences in treatment outcomes between coerced, mandated, and voluntarily admitted clients is negligible.

Relapse Prevention and Recovery

A number of studies have shown that despite men and women being about equally likely to relapse to alcohol use, men are significantly more likely to relapse to illicit drug use (see review by Walitzer and Dearing 2006). Research has also found that, following treatment, men have higher rates of relapse than women who attend the same treatment programs (Walitzer and Dearing 2006; Weiss et al. 1997). Walitzer and Dearing (2006) also speculate, based on others' research, that women may recover more quickly from a relapse than men. For these reasons, relapse prevention should be a key component of substance abuse treatment for men.

Various studies have attempted to identify the determinants of relapse (Chaney et al. 1982; Marlatt 1985, 1996; McKay et al. 1996; Miller et al. 1996; Strowig 2000; Zywiak et al. 2006*a*). One popular strategy is to distinguish interpersonal from intrapersonal causes of relapse. Strowig (2000), using a model developed by Marlatt (1985), categorizes interpersonal determinants as high risk events external to the person (e.g., arguing with someone, being around others who are drinking) and intrapersonal determinants as events internal to the individual, referred to as negative emotional states. He found that among White middle-class men dependent on alcohol, the immediate causes of relapse varied significantly; however, depressed mood (an intrapersonal cause) was most often endorsed as the primary cause. The one interpersonal determinant identified by study participants as a trigger for relapse was social pressure.

McKay and colleagues (1996) studied 98 men and women dependent on cocaine and found that negative emotional states were often an antecedent for relapse among men; however, their research indicated that men were also more likely than women to report positive affect before relapse. This may be because men have a harder time expressing their negative feelings than they do positive ones. In this study, men's relapse episodes were longer than women's; men said they were less likely to seek help after initial use because they believed they could control their cocaine use, could get away with more cocaine use, and felt entitled to use more cocaine (McKay et al. 1996).

Other research has found that men are less likely than women to attribute a relapse to negative affect but more likely than women to attribute it to social pressure (Zywiak et al. 2006*b*). This may relate to men being more

likely to relapse while with friends, whereas women are more likely to relapse in the presence of intimate partners (Rubin et al. 1996). It also, however, reflects the fact that men appear to be exposed to a greater number of negative social influences and offers of alcohol or drugs than women, which holds true even after controlling for other background factors (Walton et al. 2001). For these reasons, men should be encouraged to seek help quickly if relapse occurs. Denying or minimizing the potential seriousness of relapse can prolong the episode, making help seeking more difficult (McKay et al. 1996).

Men and women typically have different coping skills, which can play an important role in relapse prevention. Women often enter treatment with fewer resources than men, but over time they appear to do better than men at developing coping skills (Moos et al. 2006; Timko et al. 2005). These researchers followed 230 women and 236 men who had completed treatment for alcohol use disorders for a 16-year period and found that men had worse social resources and coping skills than women during the follow-up period. For men, but not women, a longer duration of treatment was linked with improved coping skills (whereas for women, but not men, continued 12-Step participation had a significant effect). Also, decreases in avoidance coping (i.e., techniques that help one avoid a problem) and drinking to cope were tied to better outcomes for men but not women. Thus, men may need more help developing approach coping skills (i.e., techniques that address the problem) to replace avoidance coping.

The findings on relapse determinants for men are inconsistent, so providers must thoroughly assess each client and determine his strengths and weaknesses. Considering such factors as the presence of mental illness, current relationship problems, or employment difficulties may give practitioners insight into potential stumbling blocks for clients in recovery and allow them to more clearly decide which relapse prevention interventions are likely to be most effective for each individual.

For more information on factors contributing to relapse and those that promote recovery, see the planned TIP, *Recovery in Behavioral Health Services* (SAMHSA planned *e*), which covers relapse prevention and recovery promotion techniques and interventions.

Money Management

Men in treatment can benefit from financial management training, which can include learning to rely on automatic deposit and bill paying. The temptation to use a recent paycheck on alcohol or drugs is strong for some men; education on profitable, positive ways to use their money can help curb it. The literature on this topic generally does not analyze the influences of gender, so it is unclear what issues men in particular may face and what forms of money management training work best with this population.

Some programs use payers—or money managers—who allocate funds received through Social Security or other benefits. Such programs are most common among individuals with co-occurring disorders (Elbogen et al. 2003). The utility and ethics of this approach are, however, debatable (Rosenheck 1997). Rosen and colleagues (2001) found that clients in a mental health center formed therapeutic alliances with both clinical therapists and money managers, although a significant minority reported feeling coerced, which in turn was associated with a weaker therapeutic alliance. Ries and colleagues (2004) also found some reductions in substance use as well as improvements in money management for individuals with co-occurring disorders who were assigned representative payers. However, such programs are

not always available to clients who would benefit from them. In a study of male veterans in inpatient psychiatric hospitals, Rosen and colleagues (2002*b*) found that, despite a high need for money management among substance abuse treatment clients with co-occurring disorders, they were often not provided financial management training or a representative payer.

Treatment Settings

Treatment settings can be broadly defined as inpatient (clients live on the premises) and outpatient (clients reside elsewhere but spend time each day or week at the treatment facility). A shift of interest from inpatient to outpatient treatment in the 1980s largely evolved in response to pressure from funding sources (e.g., Medicaid, insurance companies) to reduce the cost of treatment. Outpatient programs significantly outnumber inpatient programs (OAS 2007*a*), but the debate over the relative efficiency of inpatient (or residential) versus outpatient programs has continued.

An important consideration across treatment settings is whether the program will treat both men and women (i.e., mixed-gender programs) or men alone (i.e., male-specific or single-gender programs). The panel was unable to find research evaluating the advantages and disadvantages, for male clients, of single-gender substance abuse treatment settings, despite the fact that many such programs exist (particularly in criminal justice settings). The discussion of single-gender groups for men (see "Single-Gender Groups for Men" earlier in this chapter) applies equally to determining the pros and cons of single-gender programs.

Outpatient Treatment Services

Besides offering economic incentives to programs that need to cut costs, outpatient treatment provides several benefits not found in inpatient treatment programs. Notably, it enables men to maintain jobs and/or families while in treatment. Men who have stable living situations, are employed, have been court-ordered to treatment, or have concerned spouses involved in their treatment do well in outpatient settings (Finney et al. 1996). Men ages 50 and above have less severe drinking problems than men between the ages of 35 and 44 and also tend to do well in outpatient settings (Neve et al. 1999); older age is also associated with better retention in outpatient treatment for men but not women (Mertens and Weisner 2000). Men who feel pressure to provide for their families may be reluctant to enter inpatient treatment. In any case, men with substance use disorders can and should have a say in determining the type of setting in which they will receive treatment.

Intensive outpatient treatment has become increasingly popular; it provides a higher level of service, along with more frequent and intensive treatment services, than more traditional outpatient programs. Many types of intensive outpatient programs exist, but in general, these programs provide 9 to 15 hours a week of treatment spread over 3 to 5 days per week (CSAT 2006*c*). For more information, see TIP 46, *Substance Abuse: Administrative Issues in Intensive Outpatient Treatment* (CSAT 2006*b*), and TIP 47, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* (CSAT 2006*c*).

Men attend a greater average number of outpatient sessions than women (McCaul et al. 2001), but they are significantly more likely to miss outpatient appointments than women (Coulson et al. 2009). It is likely, however, that the factors associated with better retention in outpatient treatment differ between men and women. For example, Mertens and Weisner (2000) found that for women, better retention in outpatient treatment was associated with higher income, being unemployed, being married, and having less severe mental problems,

whereas for men, it was associated with being older, entering treatment as a result of employer suggestion, and having an abstinence goal.

A European study found that men with alcohol use disorders who completed outpatient treatment had better abstinence rates than women 2 years after treatment (Soyka and Schmidt 2009). Again, however, factors associated with better outcomes are likely different for men than for women. Green and colleagues (2004) found that for men (but not women), the best predictors of abstinence at a 7-month follow-up were the severity of substance abuse, mental problems, and physical health problems, whereas for women, social, sociodemographic, and life history factors were the strongest predictors of outcomes. For men, but not women, living alone was associated with significantly poorer abstinence outcomes.

Residential/Inpatient Treatment Services

It makes intuitive sense that isolating men from environments that expose them to people, surroundings, and opportunities that encourage substance abuse helps them maintain abstinence. In contrast to residential treatment, outpatient programs allow men with substance use disorders access to friends, places, and events associated with the use and abuse of alcohol and/or drugs. On the other hand, participation in outpatient treatment enables men to practice coping skills in a real-world environment. Residential programs may vary in some ways, but the American Society of Addiction Medicine (ASAM 2001) defines them as safe, permanent facilities with 24-hour staffing that provide treatment according to "defined policies, procedures, and clinical protocols" (p. 71). Residential programs allow clients to receive the largest, most intense dose of treatment. When considering the efficiency of inpatient versus outpatient treatment for men, take the particular circumstances of the client's life into account. Inpatient treatment may be preferable for people with more severe substance use disorders and those with co-occurring disorders (Rychtarik et al. 2000); men who are homeless or living in environments that encourage or support substance use are also good candidates for inpatient treatment.

Residential treatment, compared with outpatient treatment, is associated with significantly better abstinence outcomes for men but not women, suggesting that it may be an especially important option for some men (Hser et al. 2003). Men entering treatment are less likely than women to have dependent children living with them but also more likely to be employed—both factors that need to be considered when selecting inpatient treatment.

Many residential models exist for men's treatment. Typically, they involve a 5- to 30-day stay in a hospital, other medically oriented facility, or treatment program that provides detoxification and treatment services for all substances of abuse. These programs generally offer group and individual counseling, psychoeducational classes that address substance abuse and related health issues, and a variety of other treatment experiences, including 12-Step groups.

Therapeutic communities (TCs) are a type of residential program that became popular in the 1960s. These usually provide treatment lasting at least 9 months, and often require participants to make progress through specified treatment phases. TCs reward treatment progress by allowing clients progressively more privileges and less structure. TCs have been successfully implemented in criminal justice environments, wherein TC participants can be physically segregated from the at-large prison population and their activities closely prescribed and monitored (for more information, see TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System* [CSAT 2005*b*]). Although many modifications exist,

traditional TCs are defined by their comparatively confrontational treatment approach. For clients with co-occurring disorders or other special needs, a modified TC approach is sometimes needed (see TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* [CSAT 2005*c*], for more information).

Few studies have investigated gender differences in TC outcomes; most are older and may not reflect current conditions (see review in Messina et al. 2000). Messina and colleagues (2000) compared outcomes for men and women who had participated in a TC program (participants were interviewed, on average, 19 months after treatment) and found few significant differences. At follow-up, men were significantly more likely to be employed and to have had a recent arrest, which reflected the same patterns seen at baseline, but there were no significant differences in program completion or in substance use for completers. However, Chan and colleagues (2004) found that men, especially those ages 18 to 25, had significantly lower scores on a composite measure of community involvement and integration into the TC, suggesting that men had poorer engagement in the TC than women.

As with other treatment settings, program completion is associated with better outcomes in residential treatment. In a study of predominantly male clients dependent on heroin, treatment completion as well as greater reliance on coping skills were related to being able to avoid full relapse to heroin use (i.e., regular use as opposed to a single instance of use) at follow-up (Gossop et al. 2002). A study (Maynard et al. 1999) of residential treatment completers, most of whom were men, found that they needed fewer expensive acute care services for medical and mental health needs than before treatment. Male prisoners in an in-prison TC and a community-based transitional TC had significantly reduced recidivism rates after being released, particularly if they participated in residential continuing care (Hiller et al. 1999).

A combination of inpatient and outpatient treatment may be just as successful as long-term inpatient approaches. In a study of 296 men who sought treatment for cocaine abuse, half entered a standard program of 10 months of inpatient treatment followed by 2 months of outpatient treatment. The others received 6 months of inpatient treatment followed by 6 months of outpatient treatment. Client outcomes for both programs were similar; the one factor linked with reduced recidivism was program completion. Men who finished either program were significantly less likely to have been arrested and more likely to be drug free and employed at 12-month follow-up than those who did not finish (Messina et al. 2000).

Comparing Inpatient and Outpatient Treatment Services

In Finney and colleagues' (1996) review of research on the effects of treatment settings, 13 studies on alcohol dependency were analyzed across several variables related to successful treatment outcomes. Seven of the studies reviewed found a significant difference in outcome favoring inpatient over outpatient services, and two found more favorable outcomes for day-treatment outpatient settings than for inpatient programs. No distinction was made between intensive outpatient treatment and traditional outpatient approaches, although behavioral health professionals in the field usually consider day treatment programs to be a form of intensive outpatient treatment. Finney et al. suggest that most rationales promoting inpatient over outpatient programs involve emphasis on why or how each setting produces positive effects. However, the authors advise examining, instead, what type of person benefits most from one setting or another. More specifically, the extent of a man's abuse

of substances, along with his home environment, social competence, physical health, co-occurring mental disorders, and other factors, can affect treatment outcomes relative to setting. Finney and colleagues (1996) note that although some of these mediator variables are represented in ASAM patient placement criteria, which match clients to treatment options, more research is needed to determine the validity and relative usefulness of these criteria.

Although Finney and colleagues' (1996) review supports better outcomes for inpatient programs in general, the authors also note that outpatient clients who had neither a detoxification period nor another brief respite from their usual environment had poorer outcomes than those who did. Variations in treatment intensity and duration also affected outcomes. Inpatients generally received extensive services every day; outpatients may have received only a few hours of services per week. In addition, more inpatients completed treatment than outpatients. Six of the seven studies reviewed found significant differences between the settings, with the more effective setting providing the most intensive treatment regimen.

Research with a largely (91 percent) male group of veterans found that, for individuals with less severe drug use disorders (as determined by Addiction Severity Index scores), outpatient treatment was associated with better outcomes than inpatient treatment. For those with less severe alcohol use disorders, there were no significant differences based on setting, but for those with more severe problems, inpatient treatment was associated with better outcomes (Tiet al. 2007).

Rychtarik and colleagues (2000) found that matching clients with alcohol use disorders to the specific setting that could best meet their needs created the best outcomes. Specifically, they found that people with high alcohol involvement (e.g., greater obsession with drinking, more severe withdrawal, more loss of control when drinking) fared best with inpatient treatment, whereas people with low involvement benefited most from the outpatient program (Rychtarik et al. 2000). However, other studies (Gottheil et al. 1998; Weinstein et al. 1997) failed to show any significant differences for treatment outcomes when comparing traditional and intensive outpatient programs. Providers should expect some problems (e.g., serious health concerns) to be better handled in an inpatient program and others (e.g., less severe substance abuse) to be better treated in outpatient settings.

Mutual-Help Groups

Mutual-help groups encompass a variety of groups organized by people in recovery to help others recover from substance abuse and dependence. These groups generally focus on one type or group of substances but are often accepting of people who have abused other substances. Groups are also available to support family and friends of the person with a substance use disorder. These groups are not treatment interventions, but many treatment programs use them as a support for clients. Mutual-help groups also offer benefits that may be lacking in treatment settings but are useful in building new social networks for clients, enabling them to get advice and moral support from others who have experienced the same types of problems they are facing.

Mutual-help groups benefit many men recovering from substance use disorders (Humphreys et al. 2004; Isenhart 2001; Moos 2008), especially when attended in addition to treatment (Ritsher et al. 2002), but they may not be as effective for particularly ambivalent men. The planned TIP, *Recovery in Behavioral Health Services* (SAMHSA planned *e*), contains more information on the effectiveness of these

groups in improving recovery rates for people with substance use disorders. CSAT's (2008*a*) fact sheet on mutual-help groups offers more detail on some groups mentioned here.

Behavioral health counselors can facilitate a more comfortable transition for clients into mutual-help groups (see advice box below) by preparing them for what to expect. It is important that the counselor take time to review with the client where and when the most convenient meetings for the client to attend are held, as well as what type of meetings are available for him. For example, 12-Step programs often offer meetings for men only. Some clients may express hesitation about attending a meeting where spiritual principles may be discussed; in such cases, the counselor can encourage the client to try both 12-Step and more secular meetings until he finds the combination of meetings he prefers. No client should be forced to attend a mutual-help group in which he feels uncomfortable; the behavioral health clinician should be able to suggest other possibilities if one type of group is not working for the client. Even so, a client should be encouraged to attend enough meetings to become familiar and assimilate with the group before deciding that the group is not working for him.

The next section focuses on 12-Step groups but is not meant to promote or represent one group structure over another, nor to imply limitations for one recovery group compared with others. Given their widespread availability, 12-Step groups appear more in the literature, and a more extensive body of research exists to support their use when combined with a treatment program (Fiorentine 1999; Fiorentine and Hillhouse 2000; Humphreys and Moos 2007; Timko and DeBenedetti 2007; Vaillant 2005; Weiss et al. 2005). Other mutual-help groups are also examined.

12-Step Programs

The best known mutual-help groups are 12-Step programs like AA, Narcotics Anonymous

Advice to Behavioral Health Clinicians: Helping Men Transition Into Mutual-Help Groups

- Take time to review with the client where and when the most convenient meetings for the client to attend are held, as well as what type of meetings are available for him.
- Do not force a client to attend a mutual-help group in which he does not feel comfortable; the behavioral health clinician should also be able to suggest other possibilities if one type of group is not working for the client.
- A client may be hesitant to attend a meeting where spiritual principles may be discussed (as in a 12-Step group); in such cases, the behavioral health counselor can encourage the client to explore, with other group members, the meaning of spirituality as expressed in the program.
- Help clients prepare for their first meeting by discussing concerns the client has about attending.
- In most areas, behavioral health counselors can contact the local AA Intergroup (a regional organizing body) to bring AA orientation meetings to the treatment facility, if desired, or arrange for group members to accompany new clients to their first meeting.
- Each treatment facility should at least have a current meeting list of 12-Step meetings that focus on alcohol and drug use. Behavioral health clinicians are advised to attend both 12-Step and other mutual-help meetings in their area to learn about such groups and to better understand the recovery stories of their clients and others.
- The general public may attend any AA meetings listed as open. Closed meetings are reserved for those who have a desire to quit drinking.
- Men with co-occurring disorders may feel more comfortable in meetings designed specifically for this population (discussed in greater detail later in this chapter).

(NA), and Cocaine Anonymous. These mutual-help programs make use of the 12 Steps for recovery originally developed by AA. Attendance at 12-Step groups is often recommended to men in recovery and can be successful in helping them abstain from substance use and sustain their recovery—either alone or in combination with treatment programs. The 12-Step community teaches men and women how to overcome dependence on substances or behaviors by developing reliance on the group for support. (Sandoz 2000; Vaillant 2005).

One survey (AA World Services [AAWS] 2008) showed that men outnumber women attending AA (67 percent of attendees were male; 33 percent were female). This reflects, in part, the higher incidence of substance use disorders among men (as discussed in Chapter 1). Findings are mixed on whether men are more likely than women to attend 12-Step groups. Simons and Giorgio (2008) found that men entering a substance abuse treatment program were significantly more likely to have previously attended 12-Step groups than were women entering the same program. However, Moos and Moos (2006) found that after treatment, women were more likely to attend AA and attended a greater number of meetings.

Many men feel comfortable with the 12-Step model, and it was originally developed by men for other men. However, particularly ambivalent male clients may have trouble with the only acceptable goal being abstinence, especially with regard to alcohol consumption. Others may have difficulty with the spiritual aspects of these programs (see Chapter 3 and discussion below) or with admitting powerlessness and submitting to a higher power, which can conflict with some masculine norms (Isenhart 2001).

Attending 12-Step meetings (and other mutual-help groups) is free, and meetings are readily available throughout the country, with some groups designated for men only. There are also meetings for gay men, people who speak Spanish, and people with impaired hearing.

Counseling men on beginning a 12-Step program

Men attending 12-Step meetings frequently hear "Don't use, go to meetings, and ask for help." These simple directions provide a basic explanation of how to practice a 12-Step program with men who are new to it. Coming into a 12-Step meeting for the first time can be an unnerving experience involving fear, doubt, and insecurity (AAWS 2001)—feelings that most men were never taught how to deal with effectively. Our society's idea of masculinity suggests to men that they should not have such feelings, let alone talk about them (Pollack 1998*a*; Real 1997). Yet at 12-Step meetings, an open discussion of such feelings is encouraged. Attending 12-Step meetings and admitting one's fears and doubts through fellowship with other 12-Step members is a way for men to grow closer to others safely and to maintain abstinence. For men who have never been able to trust others, let alone reveal their real feelings, mutual-help fellowship (not just in 12-Step groups) is a wonderful means for learning how to do so.

Sponsorship

From childhood on, most men are taught to compete, which leads them to compare themselves to others. Thus, many men with substance use disorders use the self-centeredness that competing and comparing produces as a coping mechanism. This attitude can become a major stumbling block, often causing the man who is new to recovery to resist listening to the others in a group or to refuse to admit that others might have helpful insights to offer about recovery. AA encourages members to learn how to include, rather than exclude, themselves from fellowship with others. One way in which this is accomplished is through

sponsorship. A sponsor is a program participant on whom a group member relies for support and encouragement, especially when new to the program.

Behavioral health clinicians can aid clients by educating them about 12-Step sponsorship. 12-Step programs normally advise newcomers to look for a sponsor with at least one year of abstinence. During treatment, the counselor can suggest that clients look for sponsors with positive attributes, such as humility, gratitude for abstinence, a nurturing personality, or an admirable sense of humor. Men are normally asked to seek male sponsors. The counselor's suggestions for choosing sponsors should be offered to clients in a manner that does not interfere with 12-Step program autonomy. Treatment facilities may be able to use program alumni (with their consent) as temporary sponsors for clients entering a 12-Step program.

12-Step programs and spirituality

In a 12-Step program, steps 2, 3, and 11 are dedicated to spirituality. AA, NA, and similar groups are based on the idea of changing not only behavior, but also beliefs. Spirituality in this context is understood as a three-part relationship: with oneself, with others, and with a higher power sometimes called God (AAWS 2001). Groups promote spiritual awakening and revive hope among the men who participate in them. Men with substance use disorders are often isolated because their disorder has destroyed most or all of their relationships. They often think their past and current life circumstances are unique and hopeless. As these men participate in 12-Step groups, they quickly discover that they are not unique, and they reclaim hope. Thus, the spiritual/religious aspects of life are revived and assist in recovery (Calamari et al. 1996; Connors et al. 2008; Vaillant 2005; Zemore 2008).

AA is not a religious organization, nor is it allied with any religious organization, but most AA members believe that the key to overcoming substance abuse is not through individual willpower but through a power greater than themselves, which group members are encouraged to define for themselves. The program derives some principles and practices (e.g., saying the Lord's Prayer) from the Christian tradition. Although AA's emphasis on turning to a higher power seems, at first glance, to conflict with the therapeutic axiom that clients are responsible for their own recovery, men who attend AA also develop a sense of responsibility for their own actions as they work through the 12 Steps (Page and Berkow 1998).

Clients who are apprehensive about joining a 12-Step program because of the spiritual element may benefit from a discussion of the difference between spirituality and religion (see the "Spirituality and Religion" section in Chapter 4) and the role spirituality can play in recovery. However, such clients should be reassured that their concerns are common and that AA will not demand that they hold beliefs to which they are opposed (AAWS 2001). Alternatively, in many areas, there are other mutual-help groups that do not make use of spiritual principles or that use principles better suited for a specific tradition of faith.

Other Mutual-Help Groups

Antipathy toward the spiritual aspects of 12-Step programs is a major reason some men wish to attend a different type of mutual-help group. Organizations like Self-Management and Recovery Training (SMART Recovery) and Secular Organizations for Sobriety (SOS) remove the spiritual overtones found in 12-Step groups but still focus on fellowship and the importance of helping one another maintain abstinence. Other groups are available that are more sensitive to particular individuals' religious or cultural backgrounds as well.

Some substance abuse mutual-help groups that do not use the 12-Step model are:

- SMART Recovery (http://smartrecovery.org/).
- SOS (http://www.cfiwest.org/sos/index.htm).
- Jewish Alcoholics, Chemically Dependent Persons, and Significant Others (http://www.jacsweb.org/).
- LifeRing Secular Recovery (http://lifering.org).

Mutual-Help Groups for Co-Occurring Disorders

Men who have both a substance use and a mental disorder (or have certain physical disabilities) may find groups composed of individuals who share similar difficulties beneficial. For instance, Double Trouble in Recovery (http://www.bhevolution.org/public/doubletroubleinrecovery.page) and Dual Recovery Anonymous (http://www.draonline.org) are organizations that expand upon and/or adapt the traditional 12 Steps. Dual Disorders Anonymous, Dual Diagnosis Anonymous, and others also use variations of the 12-Step model. For more information on mutual-help and other types of assistance for people with co-occurring disorders, see TIP 42 (CSAT 2005*c*).

Community Influences

Many forces in the community influence treatment success for men. These include the availability of drugs in the community and the attitudes of the community toward substance abuse and recovery, especially in terms of community and workplace support for recovery. In addition, there is a growing recognition of the severe effects of underage drinking, in terms of both the effect of alcohol on the developing brain and the fourfold increase in the likelihood of having symptoms of alcohol dependency in adulthood for those who drink before 15 years of age compared with those who do not drink until they are 21 years old (Grant and Dawson 1997; Grant et al. 2004*a*; Masten et al. 2008; U.S. Department of Health and Human Services [HHS] 2007). Community support and understanding of the importance of reducing underage drinking can help reduce the rate of alcohol dependency in adulthood. Prevention programs that influence the response of communities to drinking prior to adulthood work toward the long-term outcome of reduced rates of alcohol use disorders in adult men. SAMHSA's interagency portal (http://www.stopalcoholabuse.gov), for example, is representative in its role with regard to community efforts that bring together HHS partners and other Departments in an effort to address underage alcohol use.

Community Attitudes and Perspectives

Community attitudes toward substance use, substance abuse treatment, and recovery

Community attitudes toward and understanding of substance use and abuse, substance abuse treatment, and recovery from substance use disorders vary widely. In 2001, the Centers for Disease Control and Prevention (CDC) established its Alcohol Team to strengthen research efforts in the prevention of excessive drinking, binge drinking, and underage drinking and to better understand the health outcomes of these behaviors. The Alcohol Team conducts public health surveillance of risky behaviors and the impact of disease, reviews the effectiveness of population-based interventions, and helps State-based epidemiologists draw attention to these harmful behaviors and strategies to prevent them. CDC also supports experts in evaluating and recommending interventions for community responses to alcohol use; currently, recommendations are available for regulating alcohol outlet density,

limiting days/hours of sale, increasing alcohol taxes, and enhancing enforcement of underage drinking laws (http://thecommunityguide.org/alcohol/index.html).

The impact of the employee assistance field over the past four decades has significantly changed community attitudes toward substance abuse treatment and recovery. By providing an understanding of substance use disorders as treatable illnesses to employees and their families and by fostering treatment and recovery in companies of all sizes (Attridge et al. 2009), employee assistance programs have affected community attitudes and workplace culture (National Institute on Alcohol Abuse and Alcoholism [NIAAA] 1999). Still, stigma remains widespread. An epidemiologic study (Perron et al. 2009) of barriers to seeking treatment found that roughly a quarter of those who admitted the need for treatment but did not seek it stated that being too embarrassed was a factor in their decision.

Community perspectives on men's roles, expectations, and obligations

A man's recovery from addictive illness does not end when he completes treatment. Renewed support for a view of substance use disorders as chronic illnesses (e.g., McLellan et al. 2000) has initiated interest in long-term recovery and extended ongoing systems of care. SAMHSA's Recovery-Oriented Systems of Care (ROSC) initiative helps build resources for men in ongoing recovery and includes initiatives for stronger community support of health care, career development, criminal justice services, relapse prevention, spirituality, and wellness. ROSC increases a community's capacity to address the needs of clients in ongoing recovery from substance use disorders. For information on this process, see SAMHSA's Partners for Recovery Web site (http://www.partnersforrecovery.samhsa.gov/rosc.html).

Drug Availability, Marketing, and Pricing

Conducting research on the ways in which drug availability, drug marketing, and the prices of drugs are associated with drug use and substance use disorder outcomes can be challenging. Researchers often comment on the complex phenomena related to cumulative effects (Hastings et al. 2005) and on the impossibility of absolute certainty or precision, although there is enough evidence to show that addictive goods are sensitive to price (Grossman 2004; Kilmer et al. 2010; Müller et al. 2010). These complexities place a thorough examination of drug availability, marketing, and pricing considerations outside the scope of this TIP, but brief mention of this research in the context of men's substance abuse treatment needs and outcomes is warranted.

Studying three decades of data, Grossman (2004) concluded that cigarette smoking, alcohol consumption, binge drinking, marijuana and cocaine use, and probably other illicit drug use are all price sensitive, especially for high school seniors. For example, after accounting for changes in the minimum legal drinking age and in the lowering of the maximum permissible blood alcohol concentration in terms of drunk driving laws, the 7 percent rise in the real price of beer in the early 1990s due to a hike in the Federal excise tax could still account for nearly the entire 4-percentage-point reduction in binge drinking during that time. Similarly, Hastings and colleagues (2005) warned against categorical statements of cause and effect in social science research but concluded that a compelling picture is developing of the effects that alcohol marketing has on drinking in early adulthood.

In terms of general availability, the ever-growing problem of prescription drug misuse over the past decade is a clear example of how availability may foster substance use disorders.

However, rigorous research on the multiple factors related to availability and use produces complex findings that are not easily summarized. One finding directly related to men is that in counties in Kentucky that limit or ban the sale of alcohol, those convicted of driving while under the influence in those counties were more likely to be male (Webster et al. 2008). From a study of New Orleans evacuees following Hurricane Katrina, it seems as if lack of availability may have played a positive role for some men and women in terms of both cessation and short-term relapse prevention (Dunlap et al. 2009).

With the growth of new forms of social media, the ever-changing aspects of supply and price, and major changes in community attitudes, laws, and regulations, the impact of community influences on substance use in men is likely to be significant. Ongoing studies of drug availability, price, and community responses to prevention and treatment may add to an understanding of these relationships and play a role in policy development and delivery of care for substance use disorders (e.g., NIAAA's Alcohol Policy Information System [http://www.alcoholpolicy.niaaa.nih.gov/]; Kilmer et al. 2010).

Helping Men Live With the Residual Effects of Substance Abuse

The effects of substance abuse are long lasting and extend well into recovery for most men. Many men, particularly those who began using substances in adolescence and young adulthood, lack the interpersonal and psychosocial skills necessary for negotiating adult life in recovery. Additionally, depression, anxiety, trauma syndromes, and other mental illness symptoms may extend well beyond the substance use. In fact, some problems may be more obvious when the recurring crises of substance use have subsided. Problems with relationships, employment, career, management of finances, physical health, and the criminal justice system may likewise extend well into recovery.

As men move beyond initial treatment and early recovery, treatment needs do not diminish; their focus simply changes. Treatment may be more about overcoming developmental lags, managing and maintaining success in life, and coming to grips with psychological trauma. It may involve building on new strengths, taking carefully considered risks, and developing and enhancing new aspects of relationships. It may also include new or altered definitions of manhood and masculine roles. Counselors may shift from leading the client to walking alongside him in a supportive, validating manner.

In a similar vein, recovery does not end when treatment terminates. Recovery and personal growth are lifelong processes. Men in recovery will find new needs emerging continually, such as identifying themselves as parents and developing new parenting skills; becoming involved as citizens in community activities like drug-free coalitions or other community resources; participating more actively in faith-based activities and redefining their sense of spirituality; growing as part of a primary and extended family; rethinking career choices and goals; developing new recreational pursuits; and, above all, recognizing that their histories of struggle and success have led them to be who they are in the present.

Appendix A—Bibliography

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