

A TREATMENT IMPROVEMENT PROTOCOL

Addressing the Specific Behavioral Health Needs of Men

TIP 56



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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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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] 1999c), and 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT 1999d), 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
- State of the Field
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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 (2002a) 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 con-

sumption, 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.

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 2008b) 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 2008b). However, data from 2005 show

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.

that only 25 percent of programs offered any type of specialized services for adult men (OAS 2007a). 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.

2 Screening and Assessment

IN THIS CHAPTER

- Introduction
- Screening and Assessment of Men
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Introduction

This chapter discusses how to engage men in the treatment process and addresses factors that can influence men's behaviors and attitudes toward behavioral health services. It reviews screening and assessment instruments and discusses these processes, including assessment of risk-taking, shame, male sexuality, and anger.

Screening and Assessment of Men

Screening and assessment are used to identify a client's strengths and problems. Normally, screening and assessment occur at intake, and both processes should continue throughout the course of treatment. Routine screening and assessment can identify problems that may arise or manifest after initial intake and can help pinpoint a client's strengths—such as strong marriage or family ties, strong motivation to change, or the absence of pressing crises. Routine administration of these processes is imperative, as the counselor's understanding of a client's strengths and problems significantly influences the type and duration of interventions applied as clients enter treatment in various behavioral health settings.

Screening and assessment are often grouped together, but they are distinct processes. Screening is a formal interviewing and/or testing process that identifies areas of a client's life that might need further examination. It evaluates for the possible presence of a problem, but does not diagnose or determine the severity of a disorder. For instance, screening a man for substance abuse might entail asking him a few interview questions about drug use and related problems and using a brief screening scale for substance abuse and/or substance dependence. When positive indicators are found, schedule the individual for an assessment.

Assessment is a more indepth evaluation that confirms the presence of a problem, determines its severity, and specifies treatment options for addressing the problem. It also surveys client strengths and resources for addressing life problems. Assessment typically examines not only possible diagnoses, but also the context in which a disorder manifests. A substance abuse assessment, for example, assesses the severity and nature of the substance use disorder and may also explore the possibility of co-occurring disorders; the client's family, marital, interpersonal, physical, and spiritual life; financial and legal situations; and any other issues that might affect treatment and recovery. Assessment generally involves indepth interviews and the use of various assessment instruments, such as psychological tests.

Although there has been little research into the differences between men's and women's responses to screening and assessment, some literature (e.g., Cochran 2005) suggests that men present unique difficulties. Masculine gender role socialization can lead some men to minimize difficulties or underreport problems—and some problems, such as depression, can manifest differently in men, thus disguising the disorder and leading to underdiagnosis or misdiagnosis (see Chapter 4 for discussion of this and other co-occurring mental disorders). In addition, different screening or assessment settings (e.g., prisons, outpatient programs, primary care offices) influence whether and how men present their struggles. Culture also plays a role; men from some nonmainstream cultures may be reluctant to share information about difficulties or illnesses. Counselors must be sensitive to these nuances and create an environment in which men feel open to sharing their vulnerabilities or perceived shortcomings.

This chapter focuses on screening and assessment processes and instruments specifically

applicable to male clients. Certain well-established physical, mental, and social assessments that are useful regardless of gender are also briefly introduced. When possible, the reader is referred to other Treatment Improvement Protocols (TIPs) that cover screening and assessment activities relevant for both male and female clients.

Comprehensive Screening and Assessment

The Institute of Medicine's (1990) three-step assessment process for problematic alcohol use offers a useful framework for organizing the assessment of men who abuse substances; see also TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (Center for Substance Abuse Treatment [CSAT] 1997a). Comprehensive substance abuse assessment documents detail the nature of the substance use problem and thoroughly describe the person with the problem so that appropriate decisions about intervention can be made.

The three steps in a comprehensive substance abuse assessment are screening, problem assessment, and personal assessment. The process begins with a screening to identify men in need of a problem assessment. Screening can be provided by any behavioral health counselor who has been trained in the screening process. Problem assessment documents patterns of use; signs and symptoms of substance abuse or dependence; and the social, spiritual, psychological, and medical consequences of use. Problem assessment typically occurs in the substance abuse treatment or behavioral health system. Assessment skills for behavioral health service providers include additional training, experience and clinical supervision in understanding the interrelationships between drug use and other facets of the individual's life, exploring an individual's motivation for and any resistance to treatment, and understanding the

scope of treatment services that might be available in the community behavioral health system. When problem assessment indicates the presence of substance abuse or dependence, a comprehensive, gender-aware personal assessment can add psychosocial data important for treatment.

Comprehensive assessment of men with substance use disorders should be carried out by a behavioral health specialist with a clear understanding of how male gender role socialization broadly influences the psychosocial adaptation, substance use, and help-seeking behavior of men. Behavioral health clinicians performing assessments should understand how chronic substance use affects the biopsychosocial adaptation of men and should be aware of the other social, psychological, and medical problems common among this population.

The screening and assessment instruments presented in this chapter serve to inform readers of current work in different clinical and research settings. The decision to pursue a specialized assessment (e.g., of a client's comfort level with gender roles or history of childhood abuse or neglect) must be made on a case-by-case basis that considers the appropriateness of the assessment, the skill and resources of behavioral health service providers in pursuing such an assessment, and the wishes and interests of the client. Treatment programs need to determine how best to use available resources when assessing clients. When a program is unable to conduct an assessment that providers believe is necessary—a mental health evaluation, for example—it should be able to refer the client to another provider for that assessment.

Assessors should show sensitivity to the values, attitudes, and behavioral dispositions that men share, as well as differences related to age, ethnicity, socioeconomic status, geographic location, disability status, and sexual orientation.

That is, while considering ways in which men are alike because of their gender, clinicians must also account for other characteristics that make them different from one another. See the planned TIP, *Improving Cultural Competence* (Substance Abuse and Mental Health Services Administration [SAMHSA] planned c) for more information on assessing cultural identity and acculturation.

Screening Men for Substance Abuse

The primary goal of screening is to identify men who need a comprehensive problem assessment. In a screening intake, the behavioral health clinician gathers facts by asking simple questions that evaluate whether a person requires further assessment. For screening, clients often fill out self-reports prior to a clinical interview. In such cases, the screener should be sensitive to possible language or literacy barriers by asking clients if they want assistance with forms or if they prefer to fill them out by themselves.

A client with a drug- or alcohol-related driving offense will likely have been screened in the criminal justice system and sent for further assessment and treatment. The clinician can thus move on to problem assessment using the justice system report but should go over it with the client, seeking input with questions, such as “Do you think this report is substantially accurate?” or “What other information would you add?” TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System* (CSAT 2005*b*), discusses treating clients in the criminal justice system, and TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* (CSAT 1998*b*), addresses treatment for clients transitioning from the criminal justice system to community-based treatment.

For listings of substance use disorder screening instruments, see TIP 16, *Alcohol and Other Drug Screening of Hospitalized Trauma Patients* (CSAT 1995a), and TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005c). TIP 24 (CSAT 1997a) addresses conceptual, procedural, and legal issues associated with screening for alcohol and drug abuse. TIP 24 and Alcohol Alert No. 56, *Screening for Alcohol Problems: An Update* (National Institute on Alcohol Abuse and Alcoholism [NIAAA] 2002), also contain lists of proven screening instruments. The Center for Social Work Research at The University of Texas–Austin (<http://www.utexas.edu/research/cswr/nida/instrumentListing.html>) and the University of Washington Alcohol and Drug Abuse Institute (<http://lib.adai.washington.edu/instruments/>) offer comprehensive lists of screening and assessment instruments online.

Clients can be screened by behavioral health service providers in a variety of settings for current or recent substance use using a variety of testing methods (e.g., urine, oral fluid, or hair for drug tests; breath analysis for alcohol). For more on these testing methods, the reliability of testing, specimen collection, and responding to test results, see Chapter 9 of TIP 43, *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* (CSAT 2005a), and Appendix B of TIP 47, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* (CSAT 2006c). Providers interested in laboratory tests for alcohol used in ambulatory medical settings can refer to Alcohol Alert No. 56 (NIAAA 2002).

Screening in other settings

Because substance abuse, especially involving alcohol, is the most frequent behavioral health issue among men in the general population (Kessler et al. 1994), healthcare, legal, educational, occupational, and social service organizations should always carefully screen men for

substance use when they present (see TIP 16 [CSAT 1995a]). Chronic substance abuse often contributes to legal, family, employment, housing, mental health, and medical problems; men with substance use disorders (particularly those reluctant to seek help for their substance abuse problem) may first seek help for related problems outside the behavioral health treatment system. When performed using proven methods, screening need not be expensive or burdensome. In fact, as noted in TIP 16 (CSAT 1995a), effective screening of men who abuse substances can prevent unnecessary expenditure of resources and promote more effective referral of men to the service delivery systems that can best meet their needs.

Often, the presenting problem indicates a need for problem assessment. For example, men warrant referral for further assessment when they present in the legal system after driving under the influence, in the emergency room after being injured while under the influence, or in a primary care practice with medical problems directly related to substance abuse. Service systems can integrate simple, structured screenings with clear markers of need for further assessment into their admission procedures (see TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* [CSAT 1994b]).

Substance Abuse Assessment Procedures for Men

When screening suggests the presence of a substance use disorder, problem assessment will help better define the nature of the client's problems. In many ways, assessment procedures for men and women do not differ significantly. Nevertheless, at each stage of the assessment process, providers should consider how gender may have affected a male client's past behaviors and how it may affect current

treatment. Assessment for substance abuse or dependence should focus on:

- Historical and situational factors contributing to the onset of the substance use.
- Patterns of use.
- Common signs and symptoms of a substance use problem.
- Consequences of use.

Comprehensive assessment also investigates other factors related to the client's substance abuse; these factors are discussed in this chapter under the heading "Gender-Aware Personal Assessment."

A variety of standardized approaches can be used in problem assessment. Retrospective methods using timeline follow-back procedures (Fals-Stewart et al. 2000*b*) define the nature and consequences of substance use during a circumscribed period of time. Because some men are more comfortable analyzing visual information, visually representing substance use and consequences of substance use along a timeline or on a calendar may be a better method of collecting and displaying information for male clients. Laboratory studies may also be used to document recent use, obtain markers of chronic use, and document medical consequences of chronic use.

Most standardized assessment instruments were developed largely with male client populations, and most are normed for men. Readers are referred to resource guides developed by NIAAA (Allen and Columbus 2003) and the National Institute on Drug Abuse (1994), which contain listings of clinical and research tools that can be used during problem assessment. The Center for Social Work Research at The University of Texas at Austin has also assembled a valuable list of screening and assessment instruments (<http://www.utexas.edu/research/cswr/nida/instrumentListing.html>).

Gender-Aware Personal Assessment

Once the nature of the substance abuse problem has been clearly established, the assessment process moves to the personal assessment phase. A comprehensive personal assessment routinely includes a complete physical examination, an exploration of significant events in the client's life that could affect treatment and recovery, the client's history of mental health or developmental problems, and an evaluation of his close relationships. In each of these areas, client strengths should also be assessed. Personal assessment aims to distinguish values, attitudes, and behavioral dispositions that the individual may share with other men or that make him different from other men. The first step should be a broad-based, gender-aware screening to identify substantive areas in need of more detailed assessment, such as those described in the following paragraphs.

Employment status and work history: Employment before and during treatment has been associated with better retention and improved treatment outcomes (Platt 1995; Sterling et al. 2001), especially for men (Arndt et al. 2004). Chapter 3 of TIP 38, *Integrating Substance Abuse Treatment and Vocational Services* (CSAT 2000*a*), discusses the assessment of vocational goals and training needs. Providers should also talk with clients about current and past employment and education to get a better understanding of what roles these factors may have played in the clients' substance abuse as well as how they might be used in promoting recovery.

Housing status and needs: A significant number of clients entering substance abuse treatment lack adequate housing or are at risk of losing housing. TIP 55, *Behavioral Health Services for People Who Are Homeless* (SAMHSA 2013), discusses issues relevant to the assessment of men who are homeless.

Criminal justice involvement and legal issues: Providers should understand what outstanding legal problems clients face, any past history of involvement with the criminal justice system, and the roles these issues have played in their clients' lives. Counselors should also ask if a client is currently on probation or being monitored in the criminal justice system, how often the client is required to report to probation or parole officers, and the conditions under which the counselor might be required to report the client's progress to the criminal justice system. During assessment, inform the client of what information you are required to provide to representatives of the criminal justice system (e.g., probation officers), such as the results of positive urine drug screens or threats to self or others. Chapter 4 discusses how to address these issues in treatment.

Health status/physical health: Because chronic substance abuse is associated with poor physical health, comprehensive substance abuse assessment *must* include a complete physical examination (and is required for admission to most healthcare facilities). Ideally, the examination will include laboratory studies to screen for health problems associated with the use of specific substances (e.g., hepatitis C and HIV/AIDS for men who use injection drugs, cirrhosis and pancreatitis for men who abuse alcohol) and those health problems most common among men. If the male client is being seen in a hospital or residential setting, a physical examination with laboratory studies will undoubtedly be part of the routine admission process. In ambulatory settings, the initial interview should include questions about health history, general nutrition, sleep patterns, weight changes, last physical examination, and last dental examination. Men who have access to primary health care should be referred to their primary care physician upon admission to an ambulatory setting. Otherwise, programs should work with clients to help them access

needed care through other channels, such as public health clinics. One health-related area that can pose particular problems for clients in substance abuse treatment is chronic pain, the assessment of which is discussed in TIP 54, *Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders* (SAMHSA 2011*b*).

Functional limitations: Assessment should determine if the client has any functional limitations due to co-occurring physical and/or cognitive disabilities (Schrimsher et al. 2007). The behavioral health service provider must be able to accommodate a client with special needs. For example, a provider can accommodate a client who has lower back pain (which may not necessarily be described as a disability by the client) that is exacerbated by sitting for extended periods by giving the client permission to stretch or stand during long group therapy sessions. Similarly, a person with limited skills in reading or writing English may require modified versions of written client material. TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998*e*), offers more information on screening individuals for functional limitations.

Co-occurring mental disorders: Rates of co-occurring mental disorders among substance abuse treatment clients (both male and female) are high, and these clients often require special behavioral health services for effective treatment (see TIP 42 [CSAT 2005*c*]). Details on the assessment of mental disorders and co-occurring disorders are available in Chapter 4 of TIP 42. Additionally, TIP 50, *Addressing Suicidal Thoughts and Behaviors With Clients in Substance Abuse Treatment* (CSAT 2009*a*), presents information on screening potentially suicidal clients, and TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (CSAT 2008*b*), discusses

screening specifically for depressive symptoms. Chapter 4 of TIP 48 also discusses rates of specific co-occurring disorders among men and provides some insight into assessing and treating specific disorders in this population.

Trauma histories: Men with substance use disorders often have experienced multiple traumatic events during their lives. Men are more likely than women to be exposed to trauma, and substance abuse may increase the risk of trauma exposure (Breslau 2002). Even if past traumas have not resulted in a mental disorder, such as posttraumatic stress disorder, traumatic events can have lasting effects. Behavioral health service providers should be aware of a client’s trauma history to better understand his substance abuse and better aid him in recovery. The planned TIP, *Trauma-Informed Care in Behavioral Health Services*, includes a chapter on assessing trauma histories (SAMHSA planned g). The assessment of childhood trauma, specifically, is discussed later in this TIP as well as in TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000b).

Motivation to change: A client’s motivation to seek and comply with treatment is a key factor in predicting a successful outcome. TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999b), includes valuable information on a variety of assessment instruments that evaluate a client’s level of motivation and readiness for treatment.

Relapse risk and recovery support: Although it may be left to later stages of treatment, an assessment that evaluates a client’s risk factors for relapse and supports for recovery can reduce relapse risk and promote long-term recovery. The planned TIP, *Recovery in Behavioral Health Services* (SAMHSA planned e), focuses on this important topic.

Spirituality: At minimum, spiritual assessment should determine the client’s denomination, beliefs, and spiritual practices, if any, and should identify how these might affect his treatment or pose barriers to participation in mutual-help groups or other treatment practices (e.g., meditation). Specific questioning about how spirituality has helped a client through difficult times can elicit spiritual strengths that might positively influence substance abuse treatment. Clinicians can ask clients such questions as, “Who or what provides you with strength and hope? How do you access your sense of ‘higher power’? Is a belief in a higher power important in your life? Has it ever been?” (Joint Commission on Accreditation of Healthcare Organizations 2004). Gorsuch and Miller (1999) provide valuable insights into assessing spirituality in a mental health or substance abuse treatment setting. The Spirituality Competency Resource Center outlines a spiritual assessment that behavioral health counselors may find useful in discussing spirituality with clients (<http://www.spiritualcompetency.com/recovery/lesson7.html>).

Other assessment areas include beliefs about masculinity, family history, sexuality, and shame. These call for male-specific assessment and are thus discussed separately in this TIP.

All assessment should be ongoing with periodic reassessment throughout treatment, but the initial personal assessment can occur over a longer period of time than an initial problem assessment for substance abuse and dependence. Circumstances could require a personal assessment to be deferred. For example, if problem assessment shows alcohol dependence with the need for detoxification, then medically supervised detoxification in a hospital or residential setting should be pursued immediately—personal assessment should be deferred until the individual returns to an

ambulatory setting. Similarly, if a problem assessment done in a medical, behavioral health, legal, occupational, or social service setting shows a need for substance abuse treatment, personal assessment should be deferred to the substance abuse treatment setting. A client's sensitivity to some of the topics discussed in the following sections might also lead to deferral of in-depth exploration until the therapeutic alliance is sufficient to allow the client to be comfortable talking about such issues. In exploring gender and sexuality, clinicians should be sensitive to the degree of discomfort clients might experience. However, if a client shows that these issues are meaningful for him, further exploration enables the clinician to solidify the relationship with the client while also letting him discuss issues of likely importance for his recovery.

Some programs evaluate readiness for treatment in all men but reserve resources for detailed assessment of childhood trauma, cognitive impairment, personality disturbance, and other domains of psychosocial functioning for men who demonstrate a clear and convincing need for such assessments. However, a detailed assessment of personal definitions of masculinity and the relationship among these definitions, their substance use, and their attitudes toward help-seeking will aid treatment planning.

Assessing Personal Definitions of Masculinity

Behavioral health clinicians can examine a client's personal definitions of masculinity during a clinical interview to better address his unique problems and challenges. Using the traditional concepts, roles, and norms of masculinity described in Chapter 1 as a guide, clinicians can determine which roles a client identifies with (if any) and to what extent. For example, if the client pursues success at all costs at his office, does that behavior also carry

over into other aspects of his life— into his relationships with friends and family? Does he expect others to act similarly?

Once the clinician understands the client's personal definitions of masculinity, he or she can then explore the positive function these roles serve for the client. Is the client unusually aggressive so others do not bully him? Is he especially strong and independent so that he feels he does not have to rely on others? The clinician should also examine with the client the possible costs of such behaviors. Are the behaviors hurting the client's life and relationships with others, and, if so, how? Keeping these basic precepts in mind during the clinical interview will help both clinician and client better understand what changes need to be made. They will also help motivate the client to make those changes, thus enabling the clinician and client to develop a more effective treatment plan (Mahalik et al. 2003*a*; Pollack 2001).

A number of rating scales can quantify personal endorsement of traditional concepts of masculinity. In general, these instruments document individual differences in attitudes, beliefs, behavioral dispositions, and internal conflicts commonly associated with traditional concepts of masculinity. Thompson and Pleck (1995) compiled a list of these instruments with comments on the content and potential utility of each. The Male Role Norms Scale (Thompson and Pleck 1986), Gender Role Conflict Scale (O'Neil et al. 1995), and Masculine Gender Role Stress Scale (Eisler 1995) are among the briefer and more widely used measures. The Brannon Masculinity Scale (Brannon and Juni 1984) and the Male Role Norms Inventory (Levant et al. 1992) are longer measures that also quantify personal endorsement of traditional concepts of masculinity. Mahalik and colleagues (2003*b*) describe the Conformity to Masculine Norms

Inventory, a comprehensive measure that documents personal endorsement of the emotional, attitudinal, and behavioral dimensions of traditional concepts of masculinity, which may also prove useful.

Unfortunately, no reliable normative data exist for any of these instruments, and most have been used primarily in research (sometimes with populations that may not reflect the clients with whom many treatment providers work). However, if a client expresses an interest in improving his understanding of issues concerning masculine roles/norms, the clinician may use one of the instruments discussed here to help him explore the topic. In some cases, the client can use these scales and score himself without sharing the information with the clinician—if that will make him more comfortable. The decision to use any of these instruments or to perform an in-depth assessment of masculinity at all must be based on the ongoing sensitivity of the counselor to the client's situation, needs, and current status.

Assessing Family History

Repeated substance abuse by men tends to be consistent across generations within the same family (Kirisci et al. 2001). Consequently, any comprehensive behavioral health assessment of men with substance use disorders should include careful documentation of family history. A family tree can help document the nature and extent of substance use disorders and related problems in both the immediate and extended family (Gerson 2008). Marlin (1989) had men construct family trees to identify destructive, repetitive family processes occurring across generations. For more on family trees and assessing family history, see TIP 39, *Substance Abuse Treatment and Family Therapy* (CSAT 2004b).

Any assessment of family history should explore current relationships with family as well

as the client's concerns and wishes about how those relationships might change with continued abstinence from substances. For example, a man may hope that abstinence will improve his relationship with his children or worry about its effect on a relationship with a partner who continues to use. Men may have strong feelings about improving their relationships with children, spouses, or significant others, but might be reluctant to discuss those feelings and concerns; the assessment of family history is an opportunity for counselors to introduce these issues.

It is equally important to assess a man's family strengths. A sense of bondedness with significant others, the ability to rely on family for support, expressed concern from family members and their willingness to offer help, the physical proximity of family members, and a family history of resolving crises among family members are all indices of family strengths that can support clients in crisis.

Assessing a history of childhood abuse and neglect

Boys are more likely than girls to experience emotional neglect and to sustain a serious injury as a result of physical abuse (Sedlak and Broadhurst 1996). Although sexual abuse of boys is less common, its effects are lasting. Zielinski (2009) found that a significant proportion of men who have been sexually abused in childhood are negatively affected into adulthood. Men are likely to experience childhood sexual abuse differently than women, and a number of adverse effects from this abuse are uniquely experienced by men. Chapter 3 discusses the impact of childhood abuse and neglect (and other trauma) on men and suggests how to address it in treatment.

TIP 36 (CSAT 2000b) includes recommendations for formal assessment of child abuse and parental neglect. The short form of the

Childhood Trauma Interview (Bernstein et al. 2003) is a structured research interview that evaluates exposure to childhood abuse and parental neglect in adults who abuse substances. The instrument screens for childhood exposure to physical, sexual, and emotional abuse and physical and emotional neglect. TIP 36 includes a listing of standardized instruments for evaluating the psychological consequences of experiencing abuse and parental neglect as a child (CSAT 2000*b*).

Assessing current physical or sexual violence in the client's family

Several validated, structured protocols can screen, assess, and treat individuals who may be involved in ongoing domestic violence. Men with histories of physical or sexual violence typically present with angry defensiveness. The State-Trait Anger Expression Inventory-2, for example, helps identify men who are excessively angry (Spielberger 1999) by measuring experience and expression of anger. (For information on treating anger problems, see Chapter 3 of this TIP.)

Screening substance abuse treatment clients for the experience of domestic violence is important (Chermack et al. 2000; TIP 25, *Substance Abuse Treatment and Domestic Violence* [CSAT 1997*b*]; Easton et al. 2000). Screening measures, such as the Revised Conflict Tactics Scale (Straus et al. 1996), and guidelines, such as those developed by EMERGE (1995), can help determine the extent of abuse (see TIP 25, CSAT 1997*b*, p. 43). Additionally, understanding and applying Prochaska and DiClemente's stages of change model (1984) can help counselors perform a basic evaluation of the client's readiness to address intimate partner violence (Alexander and Morris 2008). The "Safe at Home" instrument for assessing readiness to change intimate partner violence is a 35-item self-report measure that can be administered when domestic violence is sus-

pected or reported (Begun et al. 2008). Counselors can be trained to do basic screening for domestic violence, but assessment services are more complex and require in-depth knowledge and skill (see TIP 25 [CSAT 1997*b*]).

A variety of instruments can help clinicians assess domestic violence risk. These include the Sexual Violence Risk-20 instrument (Boer et al. 1997), the Risk for Sexual Violence Protocol (Hart et al. 2003), the Spousal Assault Risk Assessment Guide (Kropp et al. 1995), and the Historical-Clinical-Risk Management instrument (Webster et al. 1997). Given the sensitivity of these issues and the differing stages of development these testing instruments are in, counselors should seek guidance in their selection and administration from behavioral health professionals who are trained in testing instruments and are knowledgeable about intimate partner violence.

Substance abuse and especially alcohol abuse are associated with increased domestic violence; substance abuse also is associated with increased victimization by domestic partners. Men may be the victims of domestic violence (perpetrated by either male or female partners) as well as the perpetrators. Although the extent of female-on-male domestic violence is debated, data suggest that it occurs more often than most people think (see Chapter 3 for more information and citations). Due to gender role expectations and norms, most men are reluctant to discuss victimization by their partners or even refuse to see violent behavior directed toward them as domestic violence.

For more information on screening and assessing anger and violence, see TIP 25 (CSAT 1997*b*). TIP 25 includes the Revised Conflict Tactics Scale for couples, among other resources. The Family Violence Prevention Fund offers a Practitioner Reference Card (<http://fvpfstore.stores.yahoo.net/prreca.html>) that suggests model questions to ask about

abuse, how to make referrals, and how to document findings.

Assessing Male Sexuality

Sexual assessment involves talking with clients about sensitive topics, including sexual trauma, sexual behavior, and the client’s history of sexual development. For many clients, this area is fraught with anxiety and shame; sensitivity to the client’s level of comfort in discussing these issues is needed, especially during the assessment stage when counselor and client are just beginning to develop a therapeutic alliance (Pridal 2001). Clients should be reassured of the confidentiality of any information they provide. To approach the matter with clients in an open and nonjudgmental way, counselors must explore their own concerns related to sexuality and should always have access to supervision to help them address this issue.

Assessment of a client’s sexuality should address multiple aspects of sexual behavior as well as the client’s *understanding* of that behavior. In terms of sexual orientation, for example, counselors should understand how the client self-identifies (e.g., gay, straight, bisexual) and what types of sexual behavior he engages in and with whom. Determine whether clients understand the importance of taking measures to prevent the sexual transmission of disease and how to use birth control when necessary. Explore the client’s feelings about the relationship of emotional intimacy to sexual activity and the importance of sexual activity in defining his masculinity.

Chapter 4 of TIP 37, *Substance Abuse Treatment for Persons With HIV/AIDS* (CSAT 2000c), includes a section on HIV/AIDS risk assessment that is useful in assessing client risk for various sexually transmitted diseases. It provides a section on sexual risk reduction,

which should play a part in any assessment of men’s sexual behavior. Some clients engage in risky sexual behavior because they do not understand the risks involved (and need to be educated), but others may gain pleasure from pursuing risk; the text box on the next page explains the motivations of this particular group of clients.

The Sexual Sensation Seeking Scale (Kalichman et al. 1994; Kalichman and Rompa 1995) and the Sexual Compulsivity Scale (Kalichman and Rompa 1995) help clients examine sexual risk-taking behaviors. The Sexual Sensation Seeking Scale is an 11-item self-report measure of sensation seeking related to sexual interests, and the Sexual Compulsivity Scale is a 10-item self-report measure of excessive preoccupation with sexual encounters. The reliability and validity of these brief scales when used in research on diverse samples of men has been documented (Kalichman et al. 1994; Kalichman and Rompa 1995). The Sexual Risk Scale is a 9-item self-report scale that measures risk for exposure to sexually transmitted disease based on engagement in specific sexual behaviors in the previous 6 months (Li et al. 2011).

Assessing for Shame

Clinicians and researchers have repeatedly highlighted the role that shame plays in the socialization of men (Pollack 1998b). Because men tend to be sensitive to experiences that provoke feelings of shame, clinicians need to be aware of how this sensitivity can affect treatment beginning in the screening phase. Although shame is not a male-only problem, the specific reasons men feel shame may be different from the reasons women do—and men may manifest their shame differently than women.

Understanding Risk-Taking

Human beings seek stimulation beyond that which satisfies their biological needs. This behavior is often referred to as sensation seeking. On the underlying motivation for high risk behaviors, Zuckerman (1979, 1984, 1994) hypothesized that certain individuals, called sensation seekers, were physiologically predisposed to seek out and engage in a variety of different, highly stimulating, novel behaviors. These included recreational activities (such as parachuting or mountain climbing), occupational activities (such as police work or car racing), increased experimentation with various substances (such as alcohol or marijuana), and increased exploration with numerous sexual partners and sexual practices. Early definitions of sensation-seeking emphasized the performance of actions that entailed physical risks. However, later research showed that other kinds of risk were also involved in this trait, including legal, social, and financial risks.

Burns and Wilde (1995) define risk-taking as any behavior for which there is significant uncertainty regarding potential losses associated with the outcome (e.g., speeding). Losses are undesirable consequences, whether foreseen or not (e.g., a speeding ticket or a car crash). The benefits of taking risks serve as positive reinforcers (e.g., making it to work on time or feeling that one has accomplished something others are afraid to do). When the subjective or perceived benefits of this behavior exceed the losses, the person is motivated to take the risk. However, sensation-seeking need not involve real threats or risks. For example, bungee jumping may seem terrifying and very risky, yet is not especially dangerous given appropriate safety precautions. The risk is deceptive. It is possible to experience the heightened arousal associated with this seemingly risky activity without great risk. Thus, being a sensation seeker does not always signify the taking of actual risks.

Male and female sensation seekers often take risks, but such activity is more pronounced in men. For many men, masculinity involves taking risks. As Thom (2003) notes, “most...leading causes of death among men are the result of gendered behaviours” related to risk-taking (p. 4).

Shame associated with a socially stigmatized behavioral health problem can cause some men to avoid screening and comprehensive assessment or to resist, in a hostile manner, screening and assessment (Fortenberry et al. 2002). Once the screening and assessment process begins, sensitivity to shame may cause men to withhold information about specific thoughts, feelings, and behaviors (MacDonald 1998). Because shame involves an interpersonal dimension, fear of shame will frequently be of concern to men as they begin to develop a helping relationship with a clinician (Retzinger 1998). Moreover, shame can influence compliance with specific aspects of a comprehensive assessment, particularly medical assessment and screening for sexually transmitted diseases (Fortenberry et al. 2002).

To evaluate shame accurately, clinicians must understand the conceptual differences between

shame and other negative emotions, particularly guilt. To evaluate men for sensitivity to shame, observe for it during the initial interview (Tangney and Dearing 2002)—clinicians usually can distinguish accurately between shame and other emotions. According to Retzinger (1998), shame generally is not expressed verbally, but verbal clues can show that a client may be feeling shame. Shame can be overt, with associated feelings projected onto an external source (such as another client); shame can also cause someone to focus on himself and his inferiority, which is known as bypassed shame. Signs of bypassed shame can include rapid speech, thought, or behavior, or comparing self to others. Another common sign of shame in men is anger, often used to hide from the pain of rejection (Retzinger 1998).

Advice to Behavioral Health Clinicians: Identifying and Evaluating Shame

- The best way to evaluate men for shame is to observe for it during the initial interview.
- Signs of bypassed shame include rapid speech, thought, or behavior, or comparisons between self and others. Another common sign of shame among men is anger.
- The Differential Emotions Scale, Experiential Shame Scale, and State Shame and Guilt Scale are brief measures designed specifically to measure current feelings of shame.
- When evaluating shame associated with victimization, questions like “Do you feel ashamed about ____? Can you describe how you feel? Do you feel like that often?” can help quantify frequency and intensity of shame reactions.
- The Internalized Shame Scale documents the extent to which shame as a negative emotion is magnified and internalized as feelings of inferiority, worthlessness, inadequacy, and alienation.
- The timing of the exploration of shame is important; such an assessment may need to wait until a working alliance has been formed between client and counselor.
- Shame can be evaluated through structured interviews and self-report instruments. The Test of Self-Conscious Affect-3 is a measure of how likely someone is to feel shame.

If shame is evident, behavioral health clinicians can use a simple procedure (Andrews et al. 2002) to evaluate shame responses. When evaluating shame associated with victimization, Andrews and fellow researchers simply asked their subjects, “Do you feel ashamed about ____? Can you describe how you feel? Do you feel like that often?” Responses to this short series of questions are then used to quantify frequency and intensity of shame reactions. The timing of this exploration is key and may need to wait until a working alliance exists between client and counselor.

Structured interviews and self-report instruments provide additional means for evaluating shame. Tangney and Dearing (2002) outline conceptual issues relevant to the measurement of shame and review many of the instruments commonly used to measure shame as an emotional state, as well as the tendency to feel shame as a psychological disposition. The Test of Self-Conscious Affect-3 (Tangney and Dearing 2002) is a measure of how likely someone is to feel shame. The Differential Emotions Scale, Experiential Shame Scale, and State Shame and Guilt Scale are brief measures designed specifically to measure current feelings of shame (for reviews, see Tangney and Dearing 2002). Although clini-

cians are unlikely to rely solely on such instruments to gauge the extent and nature of client shame, it is useful to understand the methods researchers use to evaluate shame.

Cook (2000) developed the Internalized Shame Scale to document the extent to which shame as a negative emotion is magnified and internalized as feelings of inferiority, worthlessness, inadequacy, and alienation. The most recent version of the scale includes norms developed from a sample of more than 1,100 men and women drawn from the general population. The reliability and validity of the scale has been documented when used with men who have substance use disorders (Cook 2000; Rybak and Brown 1996). Thompkins and Rando (2003) used it to associate internalized shame with male gender role conflict. For men with substance use disorders, however, Tangney and Dearing (2002) argue that the instrument may blur distinctions among shame as an emotion, the psychological predisposition to experience that emotion, and self-esteem as a stable personality trait representing general appraisal of self across situations.

These instruments have, for the most part, been used in research; norms against which to evaluate the emotional world of men with substance use disorders must be secured from

research reports but should be used cautiously. Each instrument also can be influenced by culture, including cultural and/or gender differences between the counselor and the client. For example, in some cultures, sustained or direct eye contact may be perceived as a sign of disrespect. For some men from certain cultures, it is more difficult to share shame with a woman, whereas others will find it more difficult to

admit shameful feelings to other men. Chapter 3 provides information on how to address shame and stigma in treatment. For more information on issues relating to cultural competence, refer to the planned TIP, *Improving Cultural Competence* (SAMHSA planned c); Georgetown University's National Center for Cultural Competence also offers numerous resources (<http://nccc.georgetown.edu/>).

3 Treatment Issues for Men

IN THIS CHAPTER

- Introduction
- Treating Men for Substance Abuse: General Considerations
- Counselors' Gender: Some Considerations
- Counseling Men Who Have Difficulty Accessing or Expressing Emotions
- Counseling Men Who Feel Excessive Shame
- Counseling Men With Histories of Violence
- Counseling Men About Sexual Issues
- Family Issues
- Spirituality and Religion

Introduction

This chapter describes specific issues facing men that can affect all elements of the treatment process, including the decision to seek treatment in the first place. Behavioral health counselors can anticipate barriers and better engage men in treatment by being aware of factors that influence why men abuse substances, which substances they choose, and the behavioral, social, and situational issues they may confront. The chapter begins by addressing co-occurring disorders—a major issue in the treatment of men—and goes on to examine social, behavioral, family, spiritual, and situational issues.

Treating Men for Substance Abuse: General Considerations

Many treatment approaches useful for men are the same that have been found useful for all clients. As noted in Chapter 1, most clients in substance abuse treatment are male, and most research into treatment methods has used populations that reflect the composition of treatment programs. Small adaptations can be made to improve treatment for men, such as ensuring that waiting rooms have decorations and reading material that appeal to men, and asking about client preferences regarding types of treatment (many men prefer more instrumental approaches, such as cognitive-behavioral therapy) and behavioral health service provider gender (see the discussion on therapist gender later in this chapter). Providers should also recognize the motivations that typically bring men to treatment (such as criminal justice system involvement, referrals from other behavioral health resources, and family or work-related pressures, discussed in Chapter 5) and the possible resentment of

treatment staff that can result. In treatment planning, consider approaches that have been found effective with men or with men who have particular characteristics (such as a high degree of anger)—these, too, are discussed in Chapter 5.

The other considerations of which behavioral health service providers need to be mindful follow from an understanding of the factors that define masculinity and male roles in our society, which are discussed in Chapter 1. Men are expected to be independent, self-sufficient, stoic, and invulnerable. Consequently, they may have trouble identifying or expressing weaknesses or problems within treatment, which may be perceived as a lack of trust or an unwillingness to be open with counselors or fellow clients. Men often have concerns about privacy and need reassurance that treatment will pose no threat to their image or standing. They may also have trouble analyzing their own problems, particularly feelings related to those problems. This too is, in part, a reflection of men's stoicism. Their need to be self-sufficient may result in a false sense of accomplishment or security in their recovery, which may manifest as unwillingness to follow through with continuing care or attend mutual-help meetings.

Men are also expected to be competitive and, at times, aggressive. As a result, male clients may develop combative or competitive relationships with male treatment group members and staff or may appear resistant to others' suggestions. They may resent being told what to do, and so suggestions may need to be reframed as conclusions that are reached collaboratively between client and counselor. Their need to prove themselves may extend into a number of different areas, including sexual accomplishment, physical domination (which can lead to violence), or competitive interac-

tions with other clients (e.g., through the telling of war stories about their substance abuse).

Treatment-Seeking Behaviors in Men

When screening and assessing male clients for substance use disorders, behavioral health clinicians can take a number of steps to alleviate the discomfort men may experience when seeking professional assistance. Of course, establishing rapport and trust with the client from the start is essential. Although time restrictions are a reality, clinicians can make the most of the time they do have, even if only a few minutes. From their first contact with a male client, clinicians can be sensitive to the ways traditional male gender norms may be influencing the screening and assessment process. Certain male clients feel threatened by or uncomfortable with the help-seeking process, so clinicians in behavioral health settings can spend time initially developing rapport and establishing a connection before beginning screening and assessment. In some areas, this can be done by developing kinship: for instance, knowing a bit about where the client grew up, having a common understanding of the client's work, or sharing an interest in a recreational pursuit. When establishing kinship, though, counselors should take care not to transcend confidentiality boundaries or appear too intrusive in questioning.

Although male clients may have some common attitudes and behaviors based on gender role socialization, their personal definitions of masculinity and attitudes toward behavioral health services and interventions (e.g., therapy and assessment) will vary. As much as possible, clinicians need to determine the values, attitudes, and ways of behaving that define masculinity for specific clients and be sensitive to the fact that men who more strongly adhere to traditional male gender role norms might be more anxious than others about the process of

seeking help (Good et al. 2005; Philpot 2001; Pollack and Levant 1998). Because men are generally ambivalent about seeking help for behavioral health problems, it is useful for clinicians to understand the circumstances that prompted a given man's help-seeking behavior. "Why are you here now?" and "For help with what problem?" are useful questions the clinician can ask when beginning the screening and assessment process. Treatment Improvement Protocol (TIP) 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT] 1999b) offers useful techniques for working with clients who are ambivalent about entering treatment.

Many clients are resistant to entering treatment; although traditional concepts of substance abuse treatment emphasize personal responsibility for change, it can be useful for clinicians to accept some responsibility for engaging male clients in the helping process and motivating them for change (Marini 2001; Miller and Rollnick 2002). Clinicians can creatively engage male clients by asking what a

client hopes to change via treatment or what he hopes to gain by beginning treatment.

Men are often embarrassed or reluctant to self-disclose emotions, such as sadness or anxiety, so clinicians should consider acknowledging (e.g., through counselor self-disclosure) fears many men share about relationships, health, abandonment, career, and financial issues. Sometimes, self-disclosure is not warranted; therapists should not reveal personal information if they feel uncomfortable doing so or lack the training to do so properly (Forrest 2010). Clients' reactions to clinician self-disclosure will depend on their expectations. Counselors should try to gauge those expectations, as research suggests that clients who expect self-disclosure will respond by giving more information when their expectations are met (Dixon et al. 2001). Self-disclosure, when done in the best interests of the client, can help move sensitive topics into the open, thus giving clients permission to begin talking about them.

The engagement process can be conceptualized as a series of consecutive steps through

Advice to Behavioral Health Clinicians: Helping Men Get Comfortable With Seeking Professional Assistance

- Establish rapport and trust with the client from the start.
- Male clients may feel threatened by or uncomfortable with the help-seeking process, so consider spending some time initially talking with the client about neutral topics (e.g., his work or hobbies) before beginning screening and assessment.
- Understand, as much as possible, what set of circumstances prompted the help-seeking behavior. "Why are you here now?" and "For help with what problem?" are useful questions to ask when beginning the screening and assessment process.
- Creatively engage a male client in discussions of his life and situation.
- Consider acknowledging common fears related to relationships, health, abandonment, career, and financial issues.
- Conceptualize the engagement process as a series of steps in which the client moves from screening to assessment to treatment planning to active treatment to follow-up care.
- Men are typically socialized to be goal-directed and action-oriented: Try ending each screening or assessment session with a clear plan for what will happen next.
- Something concrete (e.g., a letter documenting attendance, a telephone call to arrange a session with a significant other) may facilitate compliance with the next step.
- It can be helpful to give men something to do to prepare for the next step, which can support their sense of confidence, control, and usefulness.

which the client moves: screening, assessment, treatment planning, active treatment, and lastly, follow-up care (Good and Mintz 1990). Brooks (1998) suggests that, for men, clinicians assertively promote the need for substance abuse treatment and initiate the process one step at a time. The primary goal of each contact is to ensure that the client returns for his next appointment. Even if treatment is clearly indicated, it may be useful to first get the potential client to agree to an initial screening to determine whether further assessment is warranted. If it is, the next step is to get the potential client to agree to an initial assessment; next, to the completion of a comprehensive assessment; and finally, to a course of treatment.

Men are typically socialized to be goal-directed and action-oriented (Pollack 1998*a, b*, 2001), so emphasizing the immediate goal of each step in the screening and assessment process can be helpful, as can ending each screening or assessment session with a clear plan for what comes next. Offering something tangible at the end of an initial contact can also help. Depending on the circumstances that led to the initial screening or assessment session, something concrete (e.g., a letter of attendance, a telephone call to arrange a session with a significant other) can facilitate compliance

with the next step. Giving men something to do to prepare for the next step supports their sense of confidence, control, and usefulness.

Engagement Techniques for Men

Motivational techniques can help behavioral health clinicians engage men in the process of screening and assessment (Miller and Rollnick 2002). Emphasizing the importance of free choice, even when there appears to be none, generally supports men's need for autonomy. For example, even when men have legal mandates to seek treatment or are threatened with the loss of employment or a relationship, the decision to enter treatment can still be presented as voluntary. As much as a man might complain about his lack of choice, he often can still choose separation, legal sanction, or a job search over treatment. Men also can be offered choices about where and how screening and comprehensive assessment proceed; as much as possible, they should be offered choices and allowed to decide how the process will unfold. This process can be as simple as asking the man whether he would like to return next Tuesday or Wednesday or in the morning or afternoon. Emphasizing choices usually facilitates engagement. Similarly, although some treatment models emphasize assertive confrontation of denial, it may be useful, as Miller

Advice to Behavioral Health Clinicians: Treatment Engagement Considerations With Men

- Emphasizing options and the importance of free choice, even when choices are limited, generally supports men's need for a sense of independence and autonomy.
- Confrontation about behavior and right/wrong issues almost always increases resistance. Avoid arguments and use a more subtle, less confrontational manner.
- Reframe coming to treatment as a success and a sign of strength and courage.
- Some men are uncomfortable expressing some or all emotions or have difficulty recognizing and labeling their emotions early in treatment. When discussing emotions, monitor intensity, and don't push clients to experience emotions that may overwhelm them. In some settings, talking while walking can decrease the intensity of direct eye contact and allow clients to dissipate excess energy.
- Some men find it easier to explore and discuss their problems using visual references, such as timelines, node-link maps, and genograms.

and Rollnick suggest, to avoid argument and circumvent resistance in a more subtle, less confrontational manner. For more on how to use Miller and Rollnick's approach to motivate clients with substance use disorders, see TIP 35 (CSAT 1999*b*). TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse* (CSAT 1999*a*), discusses the use of brief strategic and solution-based therapies in substance abuse treatment, which also may be useful in motivating clients to address specific problems.

Directly acknowledging that men often have difficulty seeking assistance can be useful. Reframe comments about failure or weakness by defining help-seeking behavior as a sign of strength and courage. Early in the process, the clinician can highlight ways that adherence to traditional norms about help-seeking behavior may conflict with or undermine other gender norms about being gainfully employed, a good husband, and a good father.

Because men may be particularly uncomfortable with emotional expression or have difficulty identifying and understanding their own emotions early in treatment, the clinician should carefully monitor the emotional intensity of initial interactions, offering men time to compose themselves if needed. It may be useful to defer exploration of feelings until there is less anxiety about the helping process and a better working alliance. Avoiding competitive exchanges, comments, or questions that might provoke shame can likewise be helpful. In some settings, talking while walking can decrease the intensity of direct eye contact and allow clients to dissipate excess energy, which may help make some men more comfortable during initial sessions.

Some men find it easier to look at their problems through a concrete visual representation (Halpern 1997). A variety of visual mapping techniques are available for clinicians to use. Timelines (Suddaby and Landau 1998), node-

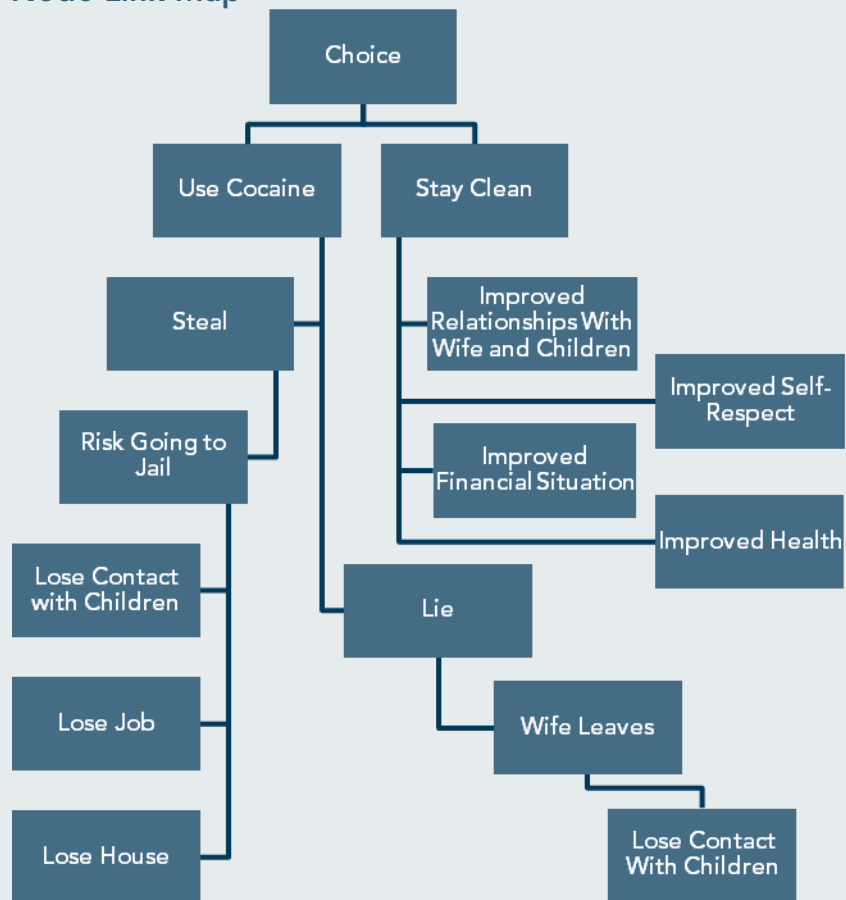
link maps (Czuchry and Dansereau 2003; National Institute on Drug Abuse 1996), and genograms (DeMaria et al. 1999; McGoldrick et al. 2008), among others, can be useful in treatment (Dees and Dansereau 2000). Eco-maps, similar to genograms, are graphic portrayals of personal and family social relationships (Rempel et al. 2007). Node-link maps help clients see, in concrete terms, the consequences of life choices. Exhibit 3-1 provides an example of a node-link map to help a client address a cocaine addiction. For more on genograms, see TIP 39, *Substance Abuse Treatment and Family Therapy* (CSAT 2004*b*).

Counselors' Gender: Some Considerations

Like ethnicity, race, religion, and culture, counselor and client gender can play a role in both the counselor's and client's experience of the therapeutic relationship. Gender colors the attitudes, feelings, beliefs, and interactions of both behavioral health counselors and clients. Therefore, it is important for treatment programs working with male clients to consider counselor gender. Both male and female counselors have their advantages, and programs need to consider the specific client as well as a range of other counselor- and program-related factors in assigning the best counselor for any given client. Counselors, too, need to be aware of gender dynamics and how they affect their practice.

Gender bias and stereotyping are among the most important issues that arise in substance treatment contexts with regard to the client's and counselor's gender. Other considerations that must be examined in the context of counseling men with substance abuse issues include the interplay between sexual orientation and gender, client preferences, the availability of male counselors, the appropriateness of raising

Exhibit 3-1: Node-Link Map



the issue of gender with clients, and transference and countertransference issues.

Overcoming Gender Bias and Stereotyping

Like ethnic or racial bias, gender stereotyping is often ingrained in the subconscious by socialization, and even the most well-meaning clinician may be affected by it. Everyone has expectations about how men should behave, and some of these expectations are stereotypes that tend to limit behavioral health clinicians' opportunities to provide the best possible treatment for their male clients.

How can clinicians overcome gender bias so that it does not negatively affect their work with men in substance abuse treatment? It is crucial that both male and female counselors

explore their own biases and assumptions about men. Clinicians should ask themselves, "What is my first thought and immediate reaction to a male client who cries in a session? Do I directly or indirectly praise or encourage male clients who work long hours at the expense of their families? Do I assume that men respond to cognitive-behavioral therapy better than emotionally supportive therapy because men are rational?" Questions like these can help the clinician challenge deeply embedded assumptions and biases about men.

In general, questioning oneself helps overcome stereotypes and gender biases. When a male client walks into a clinician's office, the clinician should be able to adopt a stance of curiosity about his or her own understanding and the client's understanding of what it means for

the client to be a man and how this identity is expressed in relation to his family, colleagues, friends, and the clinician. For example, many American men are raised to be independent and autonomous. Seeking or being mandated to treatment may feel like a weakness and affront to their sense of masculinity; however, such responses may not apply to a particular male client. Clinicians can inquire about such matters by saying, “I imagine that it may be difficult to ask for help because men are socialized to be strong and independent in our culture, but I am curious what it is like for you, specifically, to be here today.” The advice box below summarizes how both male and female counselors can address gender bias and stereotyping when working with male clients.

Raising the issue of gender with clients

Whether or not clients can choose to work with a male or a female counselor, asking about their preference during initial assessment is a way of raising the issue of gender.

Clients can be asked not just about dates of previous treatment if applicable, but also about the gender of their primary counselors in those episodes. Counselors can then use this information to inquire about clients’ past experiences with male and female counselors, what their preferences might be, and why. Exploring past counseling experiences and current preferences with regard to counselor gender is a nonjudgmental, empathetic way to let male clients know that their lived experience and preferences matter, even if it is not possible to match clients with their preferences. Johnson (2001) suggests including questions that address gender socialization and counselor gender preferences on the intake form and/or in the initial conversation with a male client.

Client Transference Related to Counselor Gender

Transference is an unconscious process in which individuals assign attributes from important persons in their past to persons in

Advice to Behavioral Health Clinicians: Addressing Gender Bias and Stereotyping While Working With Male Clients

Female counselors

- Explore your own gender biases and refrain from stereotyping men.
- Be curious and transparent. Make no assumptions about a client’s lived experience based on gender.
- Don’t be afraid to challenge male clients’ psychological defenses and behavior in a nonjudgmental, nonshaming way.
- Take the client’s preference for the gender of his counselor into consideration and match client and counselor when possible.
- Raise the issue of gender in the assessment phase and as a therapeutic issue.
- Explore your own countertransference issues in clinical supervision.

Male counselors

- Explore your own gender biases and refrain from stereotyping men.
- Be curious and transparent. Make no assumptions about a client’s lived experience based on gender.
- Don’t be afraid to be supportive and help male clients touch upon emotional content.
- Take the client’s preference for the gender of the counselor into consideration and match client and counselor when possible.
- Raise the issue of gender in the assessment phase and as a therapeutic issue.
- Explore your own countertransference issues in clinical supervision.

their present lives. In behavioral health counseling, transference generally refers to attributes clients assign to their counselors. Countertransference reactions are the attributes counselors assign (from their histories) to their clients. Transference and countertransference are not inherently good or bad, but both can potentially disrupt the therapeutic process if not recognized and monitored.

One of the most difficult issues to address in any counseling context is the sexualized transference that is likely when a female counselor works with a heterosexual male client or a male counselor works with a gay male client. In therapy, the counselor invites the male client to be open to his feelings, be vulnerable, and engage in a kind of intimacy that may or may not be present in other relationships in that client's life. It is common and normal for the male client to feel emotional and/or sexual attraction for the counselor. Although this is a common occurrence, substance abuse treatment counselors may have received very little training in how to address client transference feelings, particularly sexual feelings. The following clinical scenario offers some options for addressing sexualized transference.

Case example: Hank and Jennifer

Hank is a married 32-year-old African American man with two young children. His drugs of choice were alcohol and marijuana; he entered treatment after his wife threatened to divorce him if he did not stop using. Hank describes his marital relationship as still shaky. He recently completed an intensive outpatient treatment program and was referred to individual counseling as part of his continuing care plan. He was given several counseling options and chose to make an appointment with Jennifer, a 28-year-old White American woman who has worked at the outpatient substance abuse clinic for 2 years. She is a lesbian who has lived with her domestic partner for 5 years.

She is a licensed substance abuse counselor. Jennifer has been seeing Hank on a weekly basis for 3 months when Hank discloses, during a session, that he feels a strong attraction to Jennifer. The following is a brief excerpt of the conversation that ensues.

Jennifer: Hank, I really appreciate the fact that you are risking being so open with me about your feelings toward me. I want you to know that your feelings are normal and a common experience for people who come to counseling. I know this is your first time in individual therapy, so I am wondering how it is for you to hear me say that what you are feeling is normal.

Hank: Well, it's kinda a relief. I thought I was going crazy or that I'm really weird. Especially since, well . . . you know . . . because you're gay. And you know I'm trying to make things right with my wife and I was worried that this meant that I don't love her anymore.

Jennifer: I understand your worry, but I want to reassure you again that it is very common for people to have all kinds of feelings, including sexual attraction, for their counselors. A good thing about these feelings coming up for you with me is that, because we have a professional relationship, there are boundaries that make it safe to talk about those feelings without acting on them.

Hank: Really?

Jennifer: Yes, really. In fact, think about how you have learned that you can talk about your desire to drink and how that helps you not act on your impulse to drink. You can talk about all sorts of feelings with me. I can help you learn how to experience and express those feelings in ways that support your goal to stay abstinent and that make things better with your wife and kids, instead of acting on your impulses in ways that aren't consistent with

your values and what’s important to you in your life.

Hank: I never thought about it that way. That’s a relief.

Jennifer acknowledges Hank’s attraction in a nonjudgmental way, establishes professional boundaries without shaming Hank, and uses his disclosure to reinforce the idea that feelings and impulses do not have to be acted out in negative ways, but can be expressed in ways that support his hopes and values. The key for the counselor is to understand that sexualized transference, which is not necessarily dependent on the gender or sexual identity of the counselor, is a common part of the counseling relationship and to view it as a potentially useful therapeutic opportunity to help the male client lessen the impact of shame in his life while modeling healthful ways of expressing and managing intense feelings.

Countertransference dynamics for men working with men

Scher (2005) states that “countertransference issues are more significant with men working with men than women working with men” (p. 317). He suggests that countertransference issues for male behavioral health clinicians may be more subtle when working with men than when working with women. He states that “when power elements surface, the male therapist goes into competitive mode and does not easily give the competitiveness up; once he does, he begins to feel closer and therefore more vulnerable to the client, which raises homophobic issues and necessitates a pulling back” (p. 317). So the male counselor faces a dilemma when working with male clients. How can he be supportive, model vulnerability, and develop the intimacy required to establish a strong therapeutic alliance without pulling away from the male client due to internalized homophobia? How can he do so

without becoming competitive and dictating treatment goals and plans from the position of the expert who has the objective, rational, right answer?

Certainly, one of the most important things male counselors can do is address countertransference reactions in clinical supervision and consider them in their own practice. As discussed in Chapter 1, strong feelings of shame and inadequacy may arise whenever the male client consciously or subconsciously perceives that he is not living up to socially defined norms of male behavior, such as not asking for help and not being emotionally vulnerable. Male counselors also experience this dilemma when they open up to a clinical supervisor, and their experience of this vulnerability may be used to better understand clients’ feelings. Any strong emotional attraction the male counselor might experience for a male client should also be monitored and addressed in clinical supervision. Due to prescribed masculine gender norms, male counselors might be reluctant to bring up feelings of warmth, love, and emotional attraction for male clients. Clinical supervisors should be nonjudgmental and create a safe relational space for male counselors to bring up any strong reactions they might have to their male clients.

If the male counselor is able to explore, with understanding and self-compassion, his own internalized beliefs about what it means to be a man, he will be in a much better position to help male clients challenge a story of masculinity that might not be their preferred way of being in the world. He will also be able to model a different kind of male behavior simply by being more open emotionally, less competitive and powerful, and working more collaboratively with clients.

Countertransference dynamics for women working with men

Female behavioral health clinicians may have, at one time or another, been ignored or belittled by men in authority; sexually harassed; and/or subjected to domestic violence, child abuse, or childhood sexual abuse. As a result, two of the most potent countertransference issues female counselors may experience in working with men are fear and unresolved anger. A female counselor may subconsciously fear that her male clients will ignore, judge, or belittle her, dominate or take over the therapy, or reject her efforts to help. One of the most difficult experiences women face in our society due to gender role socialization and culturally defined gender norms is a sense of being invisible. If a male client ignores the female counselor's recommendations or belittles the efficacy of the treatment, shame and inadequacy may be activated. A female counselor's subconscious anger may surface in the therapeutic relationship as cynicism, rejection of the client's ideas about what works best for him, or being judgmental. Female counselors may also be sexually attracted to male clients. Such feelings should be normalized and addressed in clinical supervision, where supervisors can address gender differences between themselves and their supervisees to help them understand countertransference toward male clients.

Due to gender socialization, some female counselors tend to defer to the male client's authority and his perception of his situation. Carlson (1981) suggests that "deference to male thinking, again reinforcing the traditional sex role for both, rarely assists the client in considering alternatives to his perception. Instead, it may only help to avoid the real problems and the potential for his growth" (p. 230). This can be a particularly challenging situation for female counselors in predominantly male substance abuse treatment programs. The female counselor must walk the line between

being supportive and accepting and being willing to gently challenge the male client's psychological defenses, such as denial and minimization of the reality that substance abuse is interfering with his life and relationships.

Case example: Clinical team discusses male counselor/male client interaction

This behavioral health team consists of six clinicians (Jim, Larry, Lillian, Jason, Mary, and Kristen) and the clinical supervisor, Ken. The team is part of an intensive outpatient substance abuse treatment program at a major metropolitan hospital, which provides group therapy 5 days a week and individual counseling sessions twice a week. It is a mixed-gender program, but there is one women's and one men's group each week.

Jim brings up a clinical situation in group supervision. He has been assigned as the primary counselor for Kurt, a 45-year old bank executive who was referred to treatment through his company's employee assistance program. Kurt had been involved in derivative trading and a series of high risk mortgages. He had been a heavy drinker most of his adult life; because of the stress of the economic downturn and his bank teetering on the brink of bankruptcy, Kurt has been getting drunk three to four times a week and recently started taking tranquilizers to deal with his anxiety. Jim states that this is Kurt's first experience in counseling or treatment and that he is very resistant to Jim's recommendation to attend Alcoholics Anonymous (AA) meetings as part of his continuing care plan. The following discussion ensues.

Jim: This guy really irritates me. I've been clean and sober for 20 years and he thinks he is such a hot shot executive. Every time I try to suggest something that might help him stay

away from the booze and the pills, he comes at me with some story about how I don't have a clue about what kind of stress he is under and that he knows what works for him . . . after all, he made it all the way up the corporate ladder to where he is today. I want to talk about whether or not we should consider shifting Kurt to another counselor. Maybe Mary or Kristen or Lillian could make more headway with him.

Ken: What makes you think that it might be better for Kurt to work with a woman?

Jim: Well, he seems to be more relaxed in the “Feelings Group” when Kristen is co-leading. And I think he really pushes my buttons. He reminds me of my older brother who was a varsity football player and won all kinds of awards. I hated football and was more interested in playing guitar in a local rock band. My father kept harping on me about how being in a rock band was for sissies. Now that I am talking this through, it seems to me that Kurt probably feels the same kind of shame about not being a real man because he was forced to come to treatment. Asking for help was not something that was real big in my own family.

Ken: Jim, I really appreciate your self-awareness here. It sounds like you are even beginning to feel less irritated and more compassionate toward Kurt.

Jim: Yeah, I guess so . . . but I don't know how to not react so strongly when Kurt gets so defensive.

Ken: Well, I am wondering if you would be interested in briefly role-playing with Kristen. We could get the woman's perspective on how to challenge Kurt's defenses in a nonthreatening, noncompetitive way. What do you think?

Jim: Well, I feel a little embarrassed about being in the spotlight.

Ken: I can imagine. I am wondering if that's some of your own fear about being vulnerable and thinking that because you're a guy, you always have to have all the answers.

Jim: You know me too well. Yeah, let's do it.

Ken sets up a roleplay in which Kristen plays counselor and Jim plays Kurt. Kristen is instructed to challenge Kurt's competitive behavior in a nonjudgmental, nonshaming way by pointing out the behavior and then asking, “What were the different expectations for boys and girls in your family?”

This question begins a conversation about gender roles and expectations for Jim as the client. Inviting Kristen to take on the role of counselor allows all participants to indirectly challenge their own gender stereotypes and biases. By the end of the roleplay, Jim decides that he can continue to work with Kurt, feels a deeper appreciation for Kurt's strategy of competitiveness as a way to hide his shame, and experiences renewed confidence for challenging Kurt's behavior in a nonjudgmental way. He leaves the team meeting feeling reassured that he can ask his female colleagues for help with countertransference.

Advantages of Female Behavioral Health Counselors in All-Male Settings

The reality in most behavioral health clinical settings is that female counselors outnumber male counselors, and this disparity is even more striking when considering that male clients in substance abuse treatment significantly outnumber female clients (Lyme et al. 2008). Even in criminal justice settings, where the client population is typically all male, there are more female counselors than men (Ewing 2001).

Both male and female medical patients talk more and provide more relevant information

to female physicians (Bertakis 2009; Bertakis et al. 2003; Hall and Roter 2002). However, two studies (Farber 2003; Farber and Hall 2002) found that gender did not predict disclosure among therapy patients. A small study (107 patients, 75 percent male) of a Dutch population (Jonker et al. 2000) found that men in substance abuse treatment preferred female counselors (64.5 percent) and that most (58 percent) thought counselor gender played an important role in their treatment. However, when patients were asked to describe ideal characteristics for male and female therapists, those they listed were identical.

Men may be more comfortable with female counselors for any number of reasons: they may feel more comfortable showing their weakness to female therapists, who they believe are less likely to judge them for their failures, real or imagined; they may believe that women are more sensitive and better able to address emotional problems; or they may have had negative experiences with male counselors in the past (Johnson 2001). Some of these perceptions are based on real differences between common male and female counseling styles. Compared with male clinicians, female clinicians typically are more open to discussing relational issues and focusing on underlying process issues during treatment (Miller 1984). This approach may be helpful for some men, who generally tend to have difficulty dealing with their emotions in therapy (Levant 1995; Pollack 1994). Among physicians, women provide more counseling but men are more likely to address substance abuse (Bertakis et al. 2003).

Another benefit to having female behavioral health service providers in facilities serving all-male populations is that they can model healthy male–female relationships for clients.

Teamwork, cofacilitation of counseling, and collaborative working relationships between male and female staff members are of benefit to both the clinical team and clients because they provide positive role models for gender cooperation and communication. If clients see men and women interacting in healthy relationships with clear, nonsexist communication, they are likely to learn how men and women should act together.

Potential Challenges for Female Counselors in All-Male Settings

Female clinicians who work with men do face certain challenges. Each client, whether male or female, brings a set of individual experiences as well as a unique cultural background into the client–counselor relationship that will influence how that client responds to a counselor. For example, some male clients may see the male counselors as the real therapists having the real power in the organization, and may not allow their female counselors the same authority, power, or credibility. Some men have difficulty hearing their female counselors, which likely has to do with differences in how men and women communicate. Also, some men are not used to communicating openly with women.

Behavioral health programs need to be sensitive to the reality that some men who may be antagonistic toward or biased against women in positions of authority may not be able to form a healthy therapeutic alliance with female counselors. Rather than looking for a scapegoat or blaming the client for this, the institution should work with the client to devise a solution that will most benefit him in his recovery from substance abuse. In such cases, it may be best to pair the client with a male counselor.

Advantages of Male Behavioral Health Counselors in All-Male Settings

Men tend to address concrete tasks more readily with male behavioral health counselors, which may work more effectively in a treatment setting that uses task-oriented brief therapy, solution-focused techniques, and motivational interviewing (Lyme et al. 2008); see the “Enhancing Motivation” section in Chapter 5 of this TIP for more information. Some literature supports the theory that men, particularly those from certain cultural backgrounds, disclose more thoroughly to other men. For instance, one study showed that Hispanic/Latino men were more willing to report risk-taking behavior to men than to women, and to older men than to younger men (Wilson et al. 2002).

There are many potential benefits to having all-male group sessions, and a program typically needs male counselors to run these. Some well-known treatment centers, such as the Betty Ford Center and the Hazelden Clinic, will allow only male counselors to work with all-male treatment groups (Powell 2003).

Potential Challenges for Male Behavioral Health Counselors in All-Male Settings

Problems can arise when men alone work as behavioral health clinicians in all-male settings. Male clinicians’ biases and sexism can reinforce negative male communication patterns. Many patients seeking treatment prefer female counselors, so an all-male staff can greatly limit the choices and potential treatment of clients who have such a preference. Male counselors are themselves subject to gender role strain and may have difficulty seeing clients in terms of individual or family pathology or as struggling with cultural issues, such as how to be a husband and father

(Silverstein et al. 2002). Male clinicians and supervisors working with men who are gay need to be aware of their own biases, counter-transference, and level of awareness of gay development and gay culture (Frost 1998).

Recruiting Male Behavioral Health Counselors

The first step for administrators in behavioral health settings assembling a trained, gender-sensitive male treatment staff is to understand their current staff makeup and the pool of providers from which they can expect to draw. The Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) National Treatment Improvement Evaluation Study (Ewing 2001) examined staff members in treatment facilities that received SAMHSA funding. More than 800 counselors responded to the questionnaire. A majority of the counselors in each treatment setting (i.e., methadone, outpatient, short-term residential, long-term residential, and corrections) were women. In a larger study, Mulvey and colleagues (2003) used data from the retrospective study of treatment professionals to gain a profile analysis of the workforce within the substance abuse treatment field. Demographic information from 3,267 participants demonstrated that most treatment professionals were White (84.5 percent) and middle-aged (between 40 and 55 years of age), and slightly more were female (50.5 percent) than male (49.5 percent). Further, it was noted that most professionals remain in the field for a considerable period of time and that approximately 80 percent had earned a bachelor’s or higher education degree. Most professionals were licensed or certified and provided treatment services to clients with racial and ethnic backgrounds different from their own.

It generally has been assumed that most clinical—and especially medical—education addressed men’s issues to the detriment of

women's issues. However, the 2003 SAMHSA Strategic Planning Initiative indicated that coverage of issues specific to men and substance abuse was lacking in most medical education programs (Haack and Adger 2002). As part of the 2003 SAMHSA initiative, training in substance abuse treatment, including men's issues, became a mandatory part of all medical education. This project is a three-way collaboration involving SAMHSA, the Health Resources and Services Administration (HRSA), and the Association for Medical Education and Research in Substance Abuse (AMERSA). SAMHSA and HRSA fund the project, which is administered by AMERSA. The project is known as "Project Mainstream."

All clients, regardless of gender, age, or culture, should have treatment tailored to their needs. Although a specialized credential for clinicians whose patients are mostly or all male may not be necessary, the consensus panel recommends that ongoing training be provided to all clinicians in the substance abuse field concerning the unique issues of both men and women.

The number of female counselors is disproportional to the predominantly male client population seeking substance abuse treatment (Ewing 2001; Mulvey et al. 2003). Clinical centers staffed with both men and women of varying ages are better equipped to treat all clients. Agencies not committed to staff development, training, fair practices, and reasonable reimbursement can have problems in recruiting efforts, regardless of gender issues.

Centers that need more male staff members may have to develop them from the ground up. A variety of distance learning and local certification resources are available, and cultivating talented counselors from among the many individuals in recovery who join the field may be an appropriate avenue for many agencies. For instance, SAMHSA has established 14 regional Addiction Technology

Transfer Centers (ATTCs) along with a national center dedicated to identifying and advancing opportunities for substance abuse treatment, upgrading the skills of practitioners and health professionals, and disseminating the latest science to the treatment community. The ATTC Network Web site offers more information on ATTCs (<http://www.nattc.org>).

Counseling Men Who Have Difficulty Accessing or Expressing Emotions

A significant number of men participating in substance abuse treatment and other behavioral health services have difficulty accessing or expressing emotions (Evren et al. 2008). These deficits can range from a profound absence of any emotion (sometimes referred to as alexithymia or being emotionally frozen) to a more common difficulty in recognizing and expressing specific emotions, such as anger, sadness, or shame. Sometimes, difficulty in handling emotions is a symptom of a mental illness, such as Asperger's disorder, social anxiety disorder, or obsessive-compulsive disorder. Other times, it may result from transient or chronic stress, profound loss, or other environmental factors. For others still, difficulty with emotions may be a personality trait that has been with the individual since early childhood. All of these problems are likely to be exacerbated by substance use as a strategy for coping with unpleasant emotional states; finding new, positive strategies for understanding and expressing emotions is often necessary for a man's recovery from substance abuse (Holahan et al. 2001).

Some of the features of deficits in emotional expression include:

- Difficulty coping with situations in which emotions that the client has disavowed are pervasive (e.g., sadness at a funeral);

tenderness at seeing a grandchild for the first time).

- Being dismissive of certain emotions (“anger is worthless”) or people who express emotions (“scared people are chumps”).
- Channeling a difficult emotion into another emotion (e.g., expressing fear as anger).
- Fearing that emotional expression will result in losing control (“if I start crying, I won’t be able to stop”) or being overwhelmed (“if I feel my shame, I’ll sink into nothingness; I won’t exist anymore”).
- Projecting emotions onto others (e.g., as-signing an emotion that is disavowed in oneself to others).
- Being very uncomfortable when someone expresses an emotion that is difficult to experience (e.g., being uncomfortable in the presence of someone expressing anger).

Case Example: Jack

Jack is a 51-year old electrical engineer and computer software designer who recently completed the intensive phase of outpatient substance abuse treatment and has been referred to an ongoing therapy group for clients in recovery. His primary therapist in the inten-

sive outpatient program felt the group would help Jack get in touch with his feelings. Jack readily acknowledges that he is a logical guy who sees emotions as having little utility, is uncomfortable around others who easily express emotions, and recognizes that his lack of emotionality has been a barrier in relationships. In his initial interview with the group leader, Jack comments that a primary reason for his heavy alcohol consumption (which began in high school) was that he felt more comfortable relating to others after drinking. He also recognizes that he was drawn to his occupation because it allows him to spend large amounts of time working alone and that he becomes uncomfortable in social and work situations when he cannot drink. In treatment, he found emotional expression in an all-male group difficult, and he is very apprehensive about being in a mixed-gender group now. He offered his primary counselor numerous reasons for not attending the outpatient group, but the counselor insisted that the experience would be good for him. He finally agreed to come for 12 visits (3 months). The following advice box gives some tips for Jack’s counselor.

Advice to Behavioral Health Clinicians: Addressing Male Clients Who Have Deficits in Emotional Expression

- Clients who emphasize rationality over emotionality often respond to psychoeducational efforts, which can reduce problems related to feeling and expressing emotions for men (Levant et al. 2009). Learning about feelings is a first step for patients like Jack in addressing emotionally loaded issues.
- Work with these men during group and in individual sessions to apply feeling words to their internal/physical experience.
- Help the client identify emotions that are more comfortable for him (e.g., being scared) and support his efforts to manage the emotions that are more readily available first.
- Intervene and support him if other clients in the group shame or strongly confront his inability to express certain emotions.
- Help the client set goals for his group participation, particularly in terms of learning about emotions and how to express them to others.
- Work with him to develop self-grounding techniques for use when he becomes anxious in the presence of others who are expressing powerful emotions.
- Provide homework assignments to help him express his emotions within a highly structured context (e.g., through expressive writing assignments, which have been found to decrease emotional distress for men with restrictive emotionality [Wong et al. 2006]).

Anger Management

Anger is a common problem for men with substance use disorders and can be exacerbated by the stress of early recovery. Because of men's socialization, anger is one of the only emotions that many men feel comfortable expressing—thus, they often use it to cover up emotions (e.g., fear, grief, sadness) that they feel inhibited about expressing (Lyme et al. 2008).

A high level of anger, particularly trait anger, in men has been associated with substance use disorders and physical aggression (Awalt et al. 1999; Giancola 2002*b*; Tafrate et al. 2002; Tivis et al. 1998). Trait anger refers to an individual's disposition to experience anger in different situations, whereas state anger is the magnitude of the anger felt at a given time. According to a review of the literature, high trait anger is associated with a tendency to experience anger more frequently, more intensely, and for a longer period of time (Parrott and Zeichner 2002). The effects of alcohol on male aggression are most prominent in those who have moderate—as opposed to low—levels of trait anger (Parrott and Zeichner 2002).

Men with anger problems are more prone to relapse to substance use (Kirby et al. 1995; McKay et al. 1995). A few cognitive-behavioral interventions have been shown to be effective in reducing anger in men who abuse substances (Awalt et al. 1997; Reilly and Shopshire 2000). Strategies used in one study to help subjects control their anger included the use of timeout, cognitive restructuring, conflict resolution, and relaxation training (Reilly and Shopshire 2000). Fernandez and

Scott (2009) evaluated a 4-week-long cognitive-behavioral intervention for people in substance abuse treatment that was delivered in gender-specific groups; although the intervention had a high level of attrition (32 of 58 left before completion), it did reduce anger, especially trait anger.

Motivational enhancement therapy or motivational interviewing may be even more effective than cognitive-behavioral approaches in reducing substance use for men with a high level of anger. Researchers analyzing data from the Matching Alcoholism Treatments to Client Heterogeneity Project found that, in general, clients who had high levels of anger did significantly better (in terms of days sober and drinks per drinking day) if they received motivational enhancement therapy rather than 12-Step facilitation or cognitive-behavioral therapy, but that the opposite held true for clients with low levels of anger (Stout et al. 2003). Karno and Longabaugh (2004), looking at the same data, however, concluded that what was more important than the type of treatment received was the level of counselor directiveness; they determined that clients who had high levels of anger did significantly better with counselors who were less directive (as the motivational enhancement counselors were).

SAMHSA has produced an anger management curriculum with an accompanying client workbook that provides a manualized 12-week group treatment for use in substance abuse treatment settings (Reilly and Shopshire 2002). Exhibit 3-2 outlines some techniques used in this anger management intervention.

Exhibit 3-2: Anger Management Counseling Techniques

The main goals of anger management are to stop violence or the threat of violence and to teach clients ways to recognize and control their level of anger. There is no one correct way to conduct anger management counseling, but most interventions involve:

- Breathing and relaxation techniques for managing the physiological components of anger.
- Cognitive restructuring to make clients aware of their self-talk while helping them actively stop and revise their counterproductive thought processes.
- Taking time out by leaving an intense situation for several minutes to cool off.
- Introducing clients to the basics of assertiveness training and conflict resolution.
- Helping clients examine how anger and other emotions were displayed in their families and how the messages they received in the past affect them today.

Given the nature of the topic, anger management counseling should only be conducted by trained clinicians. At the start of the first session, the clinician should explain to the group any policies on safety, confidentiality, homework assignments, absences and cancellations, time outs, and relapses.

SAMHSA curricula on anger management are available in two volumes—a therapy manual and a participant workbook—and can be ordered from the SAMHSA Store (<http://store.samhsa.gov>) or downloaded from SAMHSA’s Knowledge Application Program Web site (<http://kap.samhsa.gov/products/manuals/index.htm>).

Source: Reilly and Shopshire 2002. Adapted from material in the public domain.

Learning To Nurture and To Avoid Violence

Many men with substance use disorders need to learn nurturing skills in their roles as husbands and fathers. Behavioral health counselors can teach and model affirming, caring, nurturing, forgiving, and having patience. Emotional vulnerability is critical if men are to be nurturing, loving, and caring husbands and fathers; it is important in many men’s recovery. For example, the 12 Steps of AA address vulnerability and openness to others. Counselors can suggest that men express vulnerability by engaging in nonstereotypical activities (e.g., creating art, poetry, or music; performing community service) instead of stereotypically competitive male activities like sports and work. Clinicians can also help men identify sports that they enjoy that promote cooperation, bonding, and commitment rather than extreme competition and violence.

For many men, service is another essential part of recovery from substance abuse. Men who participate in mutual-help groups can be en-

couraged to engage in service activities related to those groups, and others can seek service opportunities in their communities or religious institutions, or with national or international groups. Service activities can be matched to men’s interests and skills. For example, men in building trades can work with Habitat for Humanity; men who like to cook can help prepare soup kitchen meals. Counselors should be sensitive to the kinds of service that would be most rewarding and therapeutic for the client and should not assume that all clients will benefit therapeutically from service work.

Learning To Cope With Rejection and Loss

Some male clients may need to learn how to accept being told “no.” Consider this scenario: A man is at a social hour after work and asks a woman at the party out on a date. She is not interested and politely says “no” to him. He feels disappointed and either becomes more aggressive with her or returns to the bar for a pick-me-up to restore his ego. It is important for him to hear “no” not as a rejection of who

he is but as the result of other factors (e.g., the woman's interest in someone else). This insight could avert a relapse trigger for the client. The counselor may need to talk about and model for the client how to treat women with respect: taking "no" as an acceptable answer, giving women the power to accept or decline his invitation without intimidation, and experiencing her decision without it leading to substance use.

A man who is new to recovery may hear family members telling him "No, I won't lend you my car" as an expression of doubt concerning his recovery. He needs to consider that there may be other reasons for not lending him the vehicle and, in any case, it does not reflect who he is today; it may take time for others to see that he has changed. There are many such situations, and men in recovery need to understand that being denied something is not a reflection of their own self-worth.

Providers can introduce men to rituals that will help them deal with negative feelings, such as grief and fear, in a positive manner. Some examples include rituals for expressing grief, being vulnerable in the presence of other men, managing disagreements, and celebrating successes. Men can also observe the value of rituals in 12-Step programs, such as AA and Narcotics Anonymous.

Counseling Men Who Feel Excessive Shame

Stigma and shame are strong obstacles to men's seeking help, and research shows that men in substance abuse treatment often rate their level of shame as high (Simons and Giorgio 2008). Many men with substance use disorders and their families "ignore prevention messages, avoid treatment, [and] endure suffering and risk death daily for the simplest of reasons: They're ashamed" (McMillin 1995, p. 3).

Social stigma tied to substance abuse, co-occurring disorders, other behavioral health problems, failure to meet society's expectations, and other problems can cause intense feelings of shame among men. Shame, in turn, can cause men to avoid needed treatment and can cause their families and friends to deny a man's substance use problem or try to control or cure him (Krugman 1995; McMillin 1995; Pollack and Levant 1998). Shame can also be a major impediment to growth in recovery. It can inhibit a man from looking inward, self-assessing, or experiencing personal deficits, resulting in white-knuckle abstinence and high risk of relapse.

Different men will react differently to shame, and not all men in treatment will experience it (although it is very common). When clinicians are uncertain about a client's degree or sources of shame, they can use an assessment instrument (see Chapter 2), and if the client is resistant to the notion that shame is affecting him, the clinician can share assessment results with him. For some men, shame can be an impetus for behavior change, whereas for others, it may impede change by fueling a desire to escape from the feeling rather than deal with its cause. Others respond to shame with secrecy, anger, denial, and/or hopelessness. Both Lewis (1971) and Scheff (1987) observe that some men externalize—holding others responsible for their actions—to shield themselves from experiencing shame.

A client's cultural orientation may also affect how he responds to shame. Anthropologists have proposed that certain cultures are shame based whereas others are guilt based; for example, for men from many Asian cultures, shame may be an even more significant feeling than for men from European cultures. There are also cultural differences in how individuals are expected to respond to shame. In some cultures, a man may be expected to publicly

demonstrate his shame; in other cultures, a man may be expected to strike out in revenge at whomever caused him to feel shame.

Stigma is different from shame; it results from social attitudes that label certain people, behaviors, or attitudes as disgraceful or socially unacceptable. Crocker and Major (1989) found that people experiencing stigma:

- Frequently experience prejudice and discrimination.
- Feel that their social identity is devalued.
- Are aware that they are being stereotyped or worry that their behavior may be seen as stereotypical.
- Feel unjustly criticized or feel uncertain about the fairness of others' criticism.

Cultural stigma can produce shame in many men with substance use disorders. Men who break gender norms, for example, can be subjected to stigma and experience shame as a result. Eisler (1995) describes gender role stress for men, which can result when a man feels that he has transgressed traditional gender norms. This stress can lead to shame if he perceives that he has violated the norms of a social group or failed to live up to the group's expectations for appropriately masculine behavior.

Substance abuse can lead to behaviors or situations that a man might find shameful or stigmatizing, and many of these relate to a failure to meet prescribed gender roles. Because of substance abuse, a client may have failed to support his family, lost an important job, or experienced detriments to his sexual performance or alterations in his pattern of sexual behavior. Medical conditions, such as HIV/AIDS and certain disabilities (especially physical), are also often stigmatized, as are lack of employment and homelessness; Nonn (2007) notes that men who are homeless or have low socioeconomic status have been “stripped of everything that qualifies a man for

full participation in society” and thus belong to a shamed group (p. 282). Sources of stigma are discussed in greater detail later in this chapter.

Interventions for Shame

In many ways, behavioral health clinicians are already addressing client shame (whether the client is male or female). Mutual-help group and modern substance abuse treatment processes both begin with a fundamental anti-shame message. A major reason for educating clients about the disease model of substance use disorders and their psychological, physiological, and natural histories is to help them overcome the shame they may have experienced in believing their illness to be a personal or moral failing. Clients also benefit from psychoeducation about shame and stigma. In mutual-help groups, the camaraderie of working with others to overcome the effects of substance abuse can be a powerful force for replacing shame with acceptance. Clinicians who are in recovery can also help eliminate the shame of having a substance use disorder by serving as powerful role models for recovering people learning to accept their disorder.

Other interventions for shame are also already in use in most clinical situations. The most important way to help a client who is experiencing significant amounts of shame (see “Case example: Harry”) is to build a strong therapeutic alliance and create an atmosphere of trust in which the client feels comfortable openly exploring the sources of his shame. After building an alliance and exploring sources of shame, clinicians can help clients develop a realistic (i.e., not false) sense of pride, as pride in oneself is a major counter to shame (Krugman 1998). Shame is likely to emerge in many interventions with men; clinicians should thus tailor treatment to avoid further shaming a client (Krugman 1998; Pollack 1998c).

Case Example: Harry

Harry is a 46-year-old man in an intensive outpatient substance abuse treatment program who has had numerous struggles in group and is seen by some counselors as uncooperative. He has resisted attending AA, tends to monopolize the group with long-winded stories of his successes, is defensive when confronted in group, and has not bonded well with other clients. He is also often sarcastic to other clients, but when they return the sarcasm, he either gets angry or withdraws and won't participate in the group process. His behavior tends to alienate him from others, which increases his isolation in the program. In a recent group clinical supervision session, staff members discussed his case and concluded that shame motivates much of Harry's disruptive behavior in group settings and that directly confronting his behavior makes him more defensive. Tips for counseling a client like Harry are given in the following advice box.

Counseling Men With Histories of Violence

Violence and the use/abuse of certain substances (particularly alcohol and stimulants) are associated in numerous studies in many different contexts (Friedman 1998). Although violent behavior is not the sole prerogative of men, research has consistently found that men are more physically aggressive than women (Giancola and Zeichner 1995) and are much

more likely to commit violent acts. For some men, acting in a violent manner may be a way to define their masculinity. Whether this response is simply the result of cultural factors or is due in part to biological differences is a question beyond the scope of this TIP. What is relevant, however, is that behavioral health service providers who work with men must be able to address violent behaviors in a client's past and be prepared for violence in the present (both in and outside the treatment setting). This section addresses men's involvement in violent behaviors; for more information on treating the short- and long-term consequences of exposure to violence, see the trauma section in Chapter 4.

Violence and Criminal Behavior

Some men may engage in criminal behavior as a way of showing adherence to a particular concept of masculine identity (Copes and Hochstetler 2003); others take risks that can make them the victims of violent crime for the same reasons (Thom 2003). Men are more likely than women to be the perpetrators as well as the victims of violent crime. In 2006, men were more likely to be the victims of every type of violent crime except rape, sexual assault, and purse snatching. In that same year, 26.7 per 1,000 men ages 12 and older were victims of violent crimes, whereas 22.7 women per 1,000 were victims of violent crimes (U.S. Department of Justice [DOJ] 2008). More than 60 percent of people treated in emergency rooms in 1994 for injuries resulting from

Advice to Behavioral Health Clinicians: Addressing Male Clients Who Are Disruptive in Group Settings Due to Excessive Shame

- Help the client positively bond with other group members and aid him in finding commonalities with them rather than seeing himself as different.
- Additional individual counseling is less likely to provoke shame and may be efficacious.
- In individual sessions, psychoeducation about shame and its effects can be helpful.
- Involve the client in a 12-Step program where he'll feel safer identifying with others.
- Gently intervene when the client becomes sarcastic with other group members, taking care to confront him in a nonshaming way.

violence were male (Rand 1997). In the case of murder, 77 percent of all victims and 90 percent of all perpetrators were male (Catalano 2004). According to 2006 data, men were more than 3 times as likely to be violent offenders as women. When violent crimes were committed by a single offender, 78.3 percent of offenders were male (DOJ 2008). Throughout North America and Europe, women commit fewer than 1 in 10 assaults (United Nations Economic Commission for Europe 2004). However, men who commit assaults while intoxicated are also more likely than women who do so to become involved in the criminal justice system as a result, although whether or not this reflects an existing bias remains to be determined (Timko et al. 2009).

Violent crime is also strongly linked with alcohol and drug use, with alcohol being the most commonly reported substance in cases of violent crime. In 2006, approximately 27.1 percent of victims of violent crimes reported that the offender was using illicit drugs (either alone or in combination with alcohol) at the time of the offense (DOJ 2008). Reports by violent offenders are similar, with 41 percent of those in jails, 38 percent of those in State prisons, and 20 percent of those in Federal prisons reporting that they were under the influence of alcohol at the time of offense (Greenfeld et al. 1998). People who abuse alcohol (whether determined by self-report or official data) are also more likely to commit property crimes (Andersson et al. 1999). In a Federal Government survey of State prisoners who were expecting a 1999 release, 83.9 percent tested positive for alcohol or drugs when they committed their offense, with 45.3 percent having used drugs at the time of the crime (Hughes et al. 2001).

Certain substances are more likely to be associated with violent behaviors than others, but there is little research on how many substances

affect violent behavior. However, enough data exist to support a link between alcohol use or abuse and being a perpetrator or victim of violence, especially among men (Stuart 2005). For men who are career criminals, substance use can be as important as criminal activity in defining masculinity (Copes and Hochstetler 2003).

Although different theories have been proposed for why men commit violent crimes, it does seem clear that gender roles hinder criminal behavior in women and enable it in men. Substances of abuse, especially alcohol, also seem to aid in removing inhibitions against violent and criminal behavior (Streifel 1997). Researchers postulate that men may expect alcohol to make them more prone to violence while women do not—a theory supported by Kantor and Asdigian (1997), who found that men were more likely than women to believe that alcohol increased irritability and feelings of power over others.

Lisak (2001a) suggests that many men who perpetrate violence are themselves victims of violence, and that it “is therefore imperative to treat this underlying trauma” (p. 286). He notes that this process begins by demonstrating empathy for their pain, which helps these men feel their own past pain; being able to do so and to believe that they are worthy of sympathy is a first step toward empathizing with the pain of others.

To reduce violent behavior in men, many behavioral health service providers have used cognitive-behavioral therapies to help men understand how criminal thinking patterns and irrational beliefs contribute to violent behavior. These approaches, often modeled on the Oakland Men’s Project, typically teach communication skills to help men address problems in a more constructive manner. They are described in more depth in TIP 44,

Substance Abuse Treatment for Adults in the Criminal Justice System (CSAT 2005b).

Anger management is another useful adjunct for men trying to address violent behavior. Several studies show that many men with substance use disorders have high levels of anger (Awalt et al. 1999; Giancola 2002b; Parrott and Zeichner 2002; Reilly and Shopshire 2000; Tafrate et al. 2002). Anger can often lead to aggression and violence and can serve as a precipitant for relapse. Teaching men cognitive-behavioral strategies that help them manage their anger can reduce aggression and violence and possibly improve treatment outcomes (Reilly and Shopshire 2000).

SAMHSA has produced *Anger Management for Substance Abuse and Mental Health Clients: A Cognitive Behavioral Therapy Manual* (Reilly and Shopshire 2002) and the accompanying *Anger Management for Substance Abuse and Mental Health Clients: Participant Workbook* (Reilly et al. 2002), which detail an anger management intervention appropriate for substance abuse treatment settings. Interventions that address criminal thinking and improve communication skills may also prove useful in substance abuse treatment for men who have a history of violent criminal behavior. In particular, these approaches can help men understand how their substance use is related to criminal thinking patterns.

Providers should note that the experience of violence can have a dissociating quality, and remembering past violence (whether one is victim or perpetrator, although typically perpetrators have also been victims of violence) can be a painful and problematic experience. Providers need to be sensitive to the difficulties clients may face in addressing violence in their past. (See the following sections on violence and abuse.)

Domestic Violence and Child Abuse

The relationship between domestic violence and substance abuse is well documented (Caetano et al. 2001; Chase et al. 2003; Chermack et al. 2000; Cohen et al. 2003; Easton et al. 2000; Schumacher et al. 2003; Stuart 2005). The use of certain substances (e.g., alcohol, cocaine, methamphetamine) is associated with increased domestic violence, whereas use of others (e.g., marijuana, opioids) is not (Cohen et al. 2003). Some estimates suggest that up to 60 percent of men seeking treatment for alcohol abuse have perpetrated partner violence (Chermack et al. 2000; O'Farrell et al. 2004; Schumacher et al. 2003). A DOJ survey found that more than half of both prison and jail inmates convicted of a violent crime against a current or former partner had been drinking or using drugs at the time of the offense (Greenfeld et al. 1998).

A survey conducted by the National Committee to Prevent Child Abuse found that up to 80 percent of child abuse cases are associated with the use of alcohol and/or drugs by the perpetrator (McCurdy and Daro 1994). Many individuals who abuse their children were themselves abused in childhood. The rate at which violence is transmitted across generations in the general population has been estimated at 30 to 40 percent (Egeland et al. 1988; Kaufman and Zigler 1993). These probabilities suggest that as many as 4 of every 10 children who observe or experience family violence are at increased risk for becoming involved in a violent relationship in adulthood, either as perpetrator or as victim.

Substance use is also associated with being the victim of domestic abuse for both men and women (Chase et al. 2003; Cohen et al. 2003; Cunradi et al. 2002; Miller et al. 1989; Weinsheimer et al. 2005). Other risk factors for both genders include being young, having

a high number of relationship problems, and having high levels of emotional distress (Chase et al. 2003).

Violence between intimate partners tends to escalate in frequency and severity over time, much like patterns of substance abuse. Thus, identifying and intervening in domestic violence situations as early as possible is paramount. Staff members should understand relevant State and Federal laws regarding domestic violence and their duty to report. More information on the legal issues relating to domestic violence and duty to report can be found in TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT 1997*b*), along with other valuable information on this topic. TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000*b*), discusses child abuse and neglect issues for clients in treatment who have been abused as children and/or have abused their own children.

Relapse can be a particularly high risk time for domestic violence, although it is unclear which event (relapse or domestic violence) precipitates the other. Regardless of causality, both issues need to be addressed. In the midst of a relapse crisis, it can be easy for the counselor to decide to deal with the violence at a later date. Several complications arise, however, as a result. Not addressing the violent behavior may imply that it is not significant or important. It also invites the client to sweep the event under the rug and not address it at a later date. Not addressing the violence may also signal to other family members that the violent behavior should not be brought into the open and discussed. Additional material on addressing domestic violence in counseling is offered later in this section.

When issues like domestic violence or child abuse are discussed, all behavioral health clinicians should be aware of confidentiality laws

and any exceptions to those laws that may apply in specific instances. Providers should also be aware of applicable Federal regulations (notably, the Confidentiality of Alcohol and Drug Abuse Patient Records laws contained in 42 CFR Part 2) and specific State regulations or laws (e.g., “Megan’s Laws”). Appendix B in TIP 25 (CSAT 1997*b*) and Appendix B in TIP 36 (CSAT 2000*b*) provide detailed discussions of these topics. In addition, the SAMHSA (2004) publication, *The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPAA Privacy Rule: Implications for Alcohol and Substance Abuse Programs* discusses these regulations as well as Health Insurance Portability and Accountability Act regulations that affect confidentiality of patient records.

Men as victims of domestic violence

Although women are commonly perceived as the victims of domestic violence, the reality is that men can also be victimized by either male or female partners. In the National Violence Against Women Survey, 15.4 percent of men who lived with male partners and 7.7 percent of men who lived with female partners reported stalking, physical assault, and/or sexual assault by their partners (Tjaden and Thoennes 2000). Other studies, which contextualized domestic violence as family conflict rather than criminal behavior, report higher rates of female-on-male violence, although the types of violence perpetrated and the likelihood of it resulting in injury were inconsistent (George 2003). In a meta-analysis of physical aggression between opposite-sex partners, Archer (2002) found that men were more likely to cause injury to partners but that men still sustained one third of injuries resulting from such acts.

Studies of clients in substance abuse treatment have found high levels of intimate partner violence perpetrated by women against men.

Cohen and colleagues (2003) interviewed 1,016 men and women in treatment for methamphetamine dependence: 26.3 percent of men (compared with 63.2 percent of women) reported that their partners had threatened them, and 26.3 percent of men (compared with 80 percent of women) reported that their partners had been physically violent. In a study of 103 women with alcohol use disorder seeking couples-based outpatient treatment, women were more likely to report having committed serious violence toward their partners (50 percent) than having been victims of such violence (22 percent), although this was not the case in a study of women seeking individually based treatment for alcohol abuse (Chase et al. 2003). It should also be noted that unmarried intimate partners appear to be more likely to commit violent acts toward one another than married partners (Straus 1999).

Because stereotypes of masculinity (see Chapter 1) stress self-sufficiency and strength, men who have been abused by their partners may be even less willing to seek help than women. Additionally, there are fewer resources available for male victims of domestic violence than for female victims. The majority of domestic violence programs are designed for women, and many will not provide assistance to male victims; also, many men who are abused by their partners do not feel that the justice system will support them even if they do report the crime (McNeely et al. 2001). The problem is further complicated by traditional beliefs that men should be the head of the household and men's fear of ridicule for not filling that role; the shame men may feel at disclosing family violence is compounded by the shame of not being able to keep their partners under control (Straus 1999). Often, providers presume that men in treatment should be screened as potential abusers but not as victims of domestic abuse, especially when the man's partner is a woman (CSAT 1997*b*).

Limited data are available on the rates of intimate partner abuse among gay male couples: for example, the National Violence Against Women Survey (Tjaden and Thoennes 2000) found that men with male partners were twice as likely to experience domestic violence as men with female partners. Bartholomew and colleagues (2000) compared factors associated with partner abuse in heterosexual and gay couples, concluding that they were largely the same and that substance use played a significant role in both situations. In a review of 19 studies that examined partner violence in gay and lesbian couples, Burke and Follingstad (1999) only found 3 that gathered data from gay male couples and 1 that extrapolated data on rates of abuse for heterosexual men. Still, these limited studies suggest that men in same-sex relationships are at least as likely to experience violence from their partners as men in opposite-sex relationships.

Treatment and referral for domestic violence

For men who have a history of either perpetrating or being victimized by domestic violence, collaboration with and referrals to domestic violence intervention programs can facilitate their substance abuse treatment. At the same time, behavioral health service providers need to be aware that certain therapeutic interventions (particularly couples or family therapy) can increase the likelihood of further domestic violence and should not be used with clients who have such a history. In some States, standards for domestic violence treatment programs warn against couples counseling as an initial intervention, and some standards regulate what individual treatment improvements need to occur prior to any couples counseling. Interventions designed to reduce domestic violence without addressing substance abuse have proven to be minimally effective (Stuart 2005).

Counselors not specifically trained in treating domestic violence issues should refer clients to counselors qualified to treat these problems, either within their own behavioral health program or elsewhere in the community, and they should share pertinent information with domestic violence staff (as permitted by confidentiality rules) to ensure that both problems are addressed. Providers should not hesitate to leverage the criminal justice system to ensure that male batterers participate in domestic violence treatment.

When a clinician suspects that a man may be being abused by an intimate partner, he or she should address the problem in an individual counseling session emphasizing nonshaming support and education. Options for accessing help and potentially removing himself from the relationship should be discussed. Very few domestic violence programs or shelters exist for male clients, but in certain areas, there are programs to which clinicians can refer a man. The Battered Men Web site posts information on such programs (<http://www.batteredmen.com>).

Because of the close relationship between substance use/abuse and domestic violence, substance abuse treatment in and of itself may help reduce domestic violence for some clients (Stuart 2005). Behavioral couples therapy (also known as behavioral marital therapy) is a substance abuse treatment approach designed specifically to improve relationships while also increasing abstinence. O'Farrell and colleagues (2004) found that this therapy significantly reduced domestic violence (as measured by the Conflict Tactics Scale) and was effective up to 2 years after treatment for men with alcohol use disorder. Again, however, if the potential for a reoccurrence of domestic violence exists, caution should be exercised in implementing couples therapy. More information on this in-

tervention can be found in Chapter 5, as well as in TIP 39 (CSAT 2004b).

Sexual Violence

Sexual violence has long been associated with alcohol consumption. In one study, 75 percent of men who admitted to behavior that met legal definitions of rape acknowledged being under the influence of alcohol when they committed the act (Koss and Dinero 1988). Peugh and Belenko (2001) report that two thirds of incarcerated sex offenders either used substances at the time of their crime or had a history of substance abuse. Alcohol use is more common than illicit drug use among these men. Illicit drug use, however, is more common among offenders who victimize adults than those who target children. The consensus among researchers is that substance use does not cause sexual assault; rather, it contributes to the crime in other ways. Sex offenders also frequently have histories of victimization or co-occurring mental disorders or other behavioral health problems, which further complicate their treatment picture (Peugh and Belenko 2001). (See the sections later in this chapter on male survivors of adult or childhood sexual abuse.)

The vast majority of sex offenders are male. In 2006, 95.4 percent were male, whereas just 2.9 percent were female and 1.8 percent were of unknown gender (DOJ 2008). Among incarcerated sex offenders in 1994, 99.6 percent of an estimated 33,800 convicted rapists were male, as were 98.8 percent of the 54,300 people convicted of sexual assault (Greenfeld 1997).

Several studies have addressed the comorbidity of substance abuse and sexually abusive or violent behavior. Raymond and colleagues (1999) found that 60 percent of a group of 45 pedophiles had a lifetime prevalence of substance use disorders. In a similar sample size of adult sex offenders, McElroy and colleagues

(1999) reported that 83 percent met criteria for a substance use disorder; these men also had high lifetime rates of co-occurring mental issues (e.g., mood and anxiety disorders).

Screening for and addressing patterns of sexual violence among clients in substance abuse treatment is imperative, but treatment of sexual violence requires specialized training, close clinical supervision by someone trained in sexual violence treatment, special programmatic constraints, and often, mandates for treatment from legal and criminal justice resources. Substance abuse counselors should be skilled in screening for sexual violence and knowledgeable of community resources for care. When possible, substance abuse programs should facilitate concurrent care for both substance use and sexual violence.

Violent Behavior in Treatment

A man's violent behavior can interfere with his substance abuse treatment, and conversely, his substance abuse can interfere with interventions aimed at changing his violent behavior (Bennett 1995; CSAT 1997*b*). Clients should be informed upon entering a program what behaviors are acceptable and what consequences result from unacceptable behaviors (e.g., treatment termination, loss of privileges). The nature of a program's response depends on its ability to impose sanctions and its requirements to retain or not retain clients. Anger management techniques (see Chapter 5), which are used by many substance abuse treatment programs, can help reduce violent behavior and can have a number of positive secondary outcomes, such as helping clients reduce impulsive behavior and maintain self-control. Conflict resolution, cognitive restructuring, relaxation exercises, and other such techniques can help clients with their anger and aggressive impulses. Having a client take time out from individual or group therapy sessions if he feels increasing anger is also a use-

ful intervention for deescalating violence. Substance abuse treatment programs are responsible for protecting the health and welfare of all clients and for monitoring potentially violent clients to ensure the safety of other clients in the program. Programs should have policies to guide staff in addressing situations in which one client's violent behavior might affect the welfare of others.

Counseling Men About Sexual Issues

Sexuality and sexual behavior are intimately connected with gender identity for most men (regardless of their sexual orientation). Masculine norms that put a priority on success, self-reliance, and reliability all contribute to men's fear that sexual performance problems reflect negatively on their masculine identities.

Some men are more comfortable discussing sexual issues with a male counselor; others prefer doing so with a female counselor. Both male and female counselors can help male clients feel more comfortable with questions concerning sexual behavior. Male counselors can use self-disclosure and empathy to reduce the client's sense of isolation; female counselors can react positively to the client's disclosure of sexual fears and concerns, thus offering a positive and therapeutic experience.

Substance Use and Sexuality

According to Braun-Harvey's (1997) review of the literature, compulsive sexual behavior is much more common among men than women. Limited research and clinical experience also show that sexual dependency (a term used to refer to a broad range of behaviors involving problems of sexual control and preoccupation that result in psychological distress) is more common among men who abuse substances than those who do not.

Using substances to lower one's inhibitions before and during sex is a widespread practice among youth in the United States, which often carries over into adulthood. As adults, some men might use alcohol to calm anxious feelings they may have about sexual performance (e.g., being able to achieve an erection or please a partner) or as an excuse for certain sexual behaviors that may otherwise be the source of intense guilt or shame. Other men use illicit drugs to control sexual response. For example, some individuals who use methamphetamine believe that it can prolong an erection and provide stamina for longer sessions of sexual activity. Stimulants (such as methamphetamine and cocaine) are also associated with intensified sexual thoughts, feelings, and fantasies (although very large doses can have the opposite effect). Some people use these substances only in sexual situations, while others seek sexual encounters because of the drug's effects.

Research with 464 men and women entering outpatient substance abuse treatment found that 55.3 percent of men who used cocaine as their primary substance of abuse and 85.3 percent of those who used methamphetamine reported that the drug increased their sex drive; by comparison, 11.1 and 55.6 percent of women, respectively, reported the same (Rawson et al. 2002). In the same study, 55.3 percent of men who primarily used cocaine and 76.5 who primarily used methamphetamine reported that the drugs made them obsessed with sex or made their sex drive abnormally high.

Crack cocaine has also been thought of as heightening sexual experiences, and cocaine has been viewed as affecting the sexual arousal areas of the brain (Angrist 1987). Men often report relapse as a result of wanting to experience sexual activity under the influence of the drug (Gottheil et al. 1998), and similar associations are found in those who use methamphetamine (Rawson et al. 2002; Washton

2009). Among gay men, methamphetamine use is also associated with a greater likelihood of engaging in impulsive sexual activity (Halkitis et al. 2009a; Semple et al. 2006). In treatment, counselor and client should engage in a therapeutic dialog regarding the relationship of stimulant use to sexuality; particularly for these clients, management of sexual desire should be incorporated into a relapse prevention program.

3,4-methylenedioxymethamphetamine (MDMA), also known as ecstasy, is another drug used to enhance sexual desire and satisfaction. In a study of 35 healthy individuals who used MDMA for recreational purposes, 20 of whom were men ages 21 to 48, more than 90 percent perceived that their sexual desire and satisfaction were moderately to profoundly increased by MDMA. However, despite its alleged enhancement of sexual desire and satisfaction, MDMA may impair sexual performance: orgasm was delayed but perceived as more intense, while erection was impaired in 40 percent of the men (Zemishlany et al. 2001).

Substance Abuse and the Male Reproductive System

Substances of abuse can have a profound effect on men's reproductive health as well as their sexual functioning. Data are not available on the effects of many illicit drugs on men's reproductive health, but the use of alcohol is prevalent enough to delineate certain facts. Men who drink heavily increase their risk for both impotence and low sperm count. According to the literature, some studies have shown that even moderate alcohol consumption can decrease the production of sperm and alter its physical structure (Burke 1999; Nudell et al. 2002). Impotence may be reversible with the return of abstinence, but it can be persistent when chronic heavy drinking has contributed to neurological, endocrine, or vascular dysfunction (Burke 1999). Alcohol is known to

affect the endocrine system, which regulates growth, reproduction, and other bodily functions. Alcohol use has also been linked to low testosterone, which can intensify levels of depression for men (Booth et al. 1999), and to altered levels of other reproductive hormones (Emanuele and Emanuele 2001).

Not only does chronic alcohol consumption affect a man's ability to impregnate his partner; it also influences his ability to produce healthy children (Emanuele and Emanuele 2001). In Klonoff-Cohen and colleagues' study (2003) of 221 couples with female infertility, increased risk of spontaneous miscarriage and failure to achieve a live birth were both linked with male alcohol use in the month before and during in vitro fertilization (a process in which a woman's eggs are fertilized in an artificial environment and then inserted into her uterus) or gamete intrafallopian transfer (a technique in which eggs and sperm are inserted directly into a woman's fallopian tubes, where fertilization may occur). In another study, male rats, whose reproductive systems are similar to those of human men, were treated with alcohol for 9 weeks prior to breeding. The alcohol significantly decreased the average weight of the resulting fetuses and increased the incidence of undersized offspring (Bielawski et al. 2002).

Other substances can also affect a man's fertility. Some studies have associated cigarette smoking with decreases in male fertility (Curtis et al. 1997; Nudell et al. 2002). Marijuana appears to decrease sperm density, motility, and morphology (Nudell et al. 2002); methadone decreases the amount of sperm ejaculated (GlaxoSmithKline 2005). Many men are not aware and should be informed that marijuana use has also been associated with increased rates of a number of male-specific cancers (e.g., prostate, testicular, penile) as well as a range of other health problems (see review by Pujazon-Zazik and Park 2009). Anabolic ster-

oids, too, affect the male reproductive system in several ways, including producing testicular atrophy. Other substances, such as opioids, cocaine, and amphetamines, may decrease libido when taken in large doses (Nudell et al. 2002).

Sexual Identity

Men trying to come to terms with a gay or bisexual identity often need to focus "on stigma and negative societal attitudes [and] coping mechanisms ranging from denial to nondisclosure" (Taylor 1999, p. 524). In a study on homosexual identification, Weinberg and Williams (1974) found a relationship between gay men's "worrying about exposure and anticipating sanctions" (p. 178) and "being publicly identified as a homosexual" (p. 9). This inhibition is sometimes associated with multiple health and substance use problems for gay men. For example, Cole and colleagues (1996) found that gay men who tested negative for HIV/AIDS and who were closeted had higher rates of cancer and moderately serious infectious diseases than those who were able to be open about their sexuality.

Some men may identify as heterosexual despite engaging in sex with other men. Such behavior may be a temporary or experimental stage, as might occur during adolescence or in the absence of female partners (e.g., in prison). Some men who identify as heterosexual may only have sex with men when under the influence of substances, either because they feel too much shame to do so when abstinent or because the substances impair their judgment; this causes them to feel shame afterward, when no longer under the influence. This can be a significant problem for some men in recovery who feel an added compulsion to use substances to escape feelings of intense shame associated with past sexual behavior or to feel able to express their sexuality.

Becoming comfortable identifying oneself as gay or bisexual is an important part of seeing oneself as part of a larger gay/bisexual community. Being a part of such a community can provide greater access to sources of emotional support that could combat feelings of marginalization due to heterosexism, which can otherwise contribute to distress and mental disorders among gay men (Meyer 1995). These feelings of distress, coupled with a lack of social support or ineffective coping skills, may lead to use of alcohol or drugs. If gay/bisexual men are able to see themselves as part of a larger gay/bisexual community, it may improve their self-esteem and thereby lessen their substance abuse. Some gay men feel considerably more comfortable in programs or treatment groups that are specifically organized to assist gay men, although such options are not available in all areas. Clinicians working with self-identified gay men in other treatment settings should speak with them to determine whether they wish to identify themselves as gay (i.e., be out) in the program.

Sexual orientation is sometimes misperceived as reflecting a person's masculinity, leading to assumptions that all gay or bisexual men are inherently feminine. This belief can result from simple misinformation or can be the product of homophobia. However, what is labeled as effeminate behavior has no real relation to sexual orientation. Gay/bisexual men may be very masculine; heterosexual men may act effeminate. Counselors should educate clients about sexual orientation and the fact that the degree of masculine or feminine behavior a person exhibits is not related to it.

A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals (CSAT 2001) contains more information on substance abuse treatment for gay and bisexual men.

Sexual Performance and Sexual Dysfunction

Fracher and Kimmel (1987) identify the three most common sexual complaints of men seeking therapy—premature ejaculation, inhibited sexual desire, and erectile dysfunction—as issues of sexual performance. Although men often focus on physical symptoms when seeking assistance, Fracher and Kimmel note the importance of the response to the symptom (e.g., anxiety, depression, low self-esteem) that prompts men to seek help and that those responses result from men's failure to perform at the standard dictated by traditional masculine gender roles. To treat sexual dysfunction, they recommend addressing the client's beliefs about masculinity through “exploring and challenging the myths of male sexuality, modeling by the therapist of a different version of masculinity, giving permission to the patient to fail, and self-disclosure by the therapist of the doubts, fears of inadequacy, and other anxieties that all men experience” (p. 92).

Medications for male sexual dysfunction are now widely used. However, a man in recovery may be resistant to such medication—sometimes with good reason—as there have been some reports of abuse of medications like sildenafil (Viagra), especially among gay and bisexual men (Crosby and DiClemente 2004; Smith and Romanelli 2005). Abuse of sildenafil also appears to be more common among men who abuse other substances. Crosby and DiClemente (2004) found that in a sample of men who had sex with men, those who abused cocaine, MDMA, or alkyl nitrate inhalants were 2 to 3 times more likely (depending on the substance) to use nonprescription sildenafil than men who did not use them. Clients considering medication to improve sexual performance should be cautioned about the potential for abuse and other health risks.

Sex and the Internet

Thanks to the Internet, millions of people can now easily access a wealth of information on just about every topic of interest and effortlessly talk with others despite great physical distance. However, this technology also enables people to find an “impersonal, detached sexual outlet” (Schwartz and Southern 2000, p. 128). Those who seek sexual partners and gratification over the Internet are engaged in what is often referred to as cybersex. They may be involved with a variety of partners in different ways. Some participants compulsively search for partners for hours, seeking to create various fantasy scenarios; others spend large sums of money on interactive pornography. Some men believe that cybersex allows them to engage in sexual activity with less anxiety.

Men are significantly more likely than women to engage in online sexual activities. In one large study (n=7,037) men were twice as likely as women to report engaging in online sexual activity to deal with stress (rather than as a distraction or for educational purposes); however, the same study found no significant difference in the number of men (10.5 percent) and women (4.9 percent) who reported a sexual addiction (Cooper et al. 2002). Schwartz and Southern (2000) linked compulsive online sexual activity with male substance abuse in a study of 40 people seeking treatment for problematic cybersex involvement: 73.7 percent of men (but just 42.9 percent of women) reported a substance abuse problem.

The investigation of compulsive online sexual activity is a relatively recent field of study, and screening and treatment approaches are still in development. Cooper and colleagues (2004) found that Internet users who spend more than 11 hours per week engaged in online sexual activity are also likely to score high on measures of sexual compulsivity, and the number of hours spent on such activity may be

used as a simple screening question. Schwartz and Southern (2000) suggest that cognitive-behavioral approaches be used to change behaviors for men with a cybersex addiction. They also suggest additional therapies to treat other problems that may be at the root of such addiction (e.g., depression, trauma, conflicts in relationships, sexual dysfunction, conflict over sexual identity). Some substance abuse treatment programs now also offer treatment for sexual compulsivity and addiction, either as an integrated component of substance abuse treatment or as a separate therapeutic effort.

Sex Trade Workers

Participating in the sex trade is typically not so much a sexual behavior as it is the product of economic necessity and should generally be considered in that light. Poverty may lead adult or adolescent men into prostitution or into exchanging sex for drugs, alcohol, or money.

Involvement in the sex trade (which, for men, typically involves sex with other men) appears to be more common among men who identify as gay or bisexual, but even men who identify as heterosexual may engage in sex with men for money. Prostitution also appears to be much more common among younger men, and a number of clients in treatment settings may have participated in the sex trade as juveniles. In a study of 358 men ages 19 to 35, all of whom identified as gay or bisexual and were HIV negative, 9.8 percent stated that they had engaged in juvenile prostitution (Ratner et al. 2003). Sex trade work also appears to be much more common among gay and bisexual men who inject drugs than among those who do not (Rietmeijer et al. 1998).

Some men choose prostitution primarily as a way to experiment sexually while earning extra money, not as an economic necessity. Cates and Markley (1992) compared a group of 15 young men who stated they were prostitutes

by choice rather than necessity with 15 men from the same cohort who were not prostitutes; those prostituting by choice reported significantly more substance use than those uninvolved in prostitution. Men who had been prostitutes also reported more familial substance abuse.

Rape and Sexual Abuse Among Adult Men

The sexual abuse of adult men is rare. According to DOJ estimates, only 0.2 out of every 1,000 men were victims of sexual abuse in 2003 compared with 1.5 out of every 1,000 women (Catalano 2004). A survey of 2,500 British men found that 2.9 percent had experienced nonconsensual sex as adults, although 5.4 percent reported having had nonconsensual sex as children (Coxell et al. 1999). In samples of self-identified gay and bisexual men, rates of adult and childhood sexual abuse are higher. Ratner and colleagues (2003) sampled 358 HIV-negative men who identified as gay or bisexual; of these, 14 percent reported childhood sexual abuse and 14.2 percent reported nonconsensual sex as adults (defined as being over the age of 14).

What little research exists into sexual assault among incarcerated men suggests that rates in this population are comparable to those found among women in the general population. There is wide variation in prevalence rates across studies because of differences in definitions of sexual assault, methods used to obtain data, and sample sizes. However, all studies imply that sexual assault in prison is significant. The Prison Rape Elimination Act of 2003 (P.L. 108-79) called for a comprehensive study of prison rape to more accurately determine the extent of sexual assault among incarcerated men (Gaes and Goldberg 2004; Thompson et al. 2008). The Just Detention site (<http://www.justdetention.org>) offers a resource guide for survivors of rape during in-

carceration as well as other information of use to survivors and their clinicians.

Because of high rates of HIV/AIDS and other sexually transmitted diseases in the prison population, men who have been raped while incarcerated run a high risk of contracting a sexually transmitted disease (Robertson 2003). Many prison institutions do not test for HIV/AIDS unless an incident report has been filed, but the majority of cases of sexual assault behind bars may go unreported (Gaes and Goldberg 2004; Robertson 2003). In addition to counseling, men in substance abuse treatment who state that they have been sexually assaulted (while incarcerated or not) should receive HIV/AIDS testing and counseling.

Given data on childhood and adult sexual abuse, the number of adult men who have been sexually abused at some point during their lifetimes may be significant, and especially so for men in substance abuse treatment. For example, Ouimette and colleagues (2000) assessed the physical and sexual abuse histories of 24,959 veterans (24,206 of whom were male) who had substance use disorders; 8 percent of the men had experienced sexual abuse during their lifetimes. Lifetime rates of sexual abuse were much higher for women in their study (49.4 percent), but both men and women with sexual abuse histories had similarly poor outcomes as measured 2 years later, even taking into account baseline functioning, co-occurring mental illnesses, and relevant demographic variables (Rosen et al. 2002*a*).

Childhood Sexual Abuse

Rates of child abuse (of all types) are similar between the sexes, but the types of abuses endured differ. According to 2002 data from child protective service agencies across the United States, 48.1 percent of victims ages 17 and under were boys and 51.9 percent were girls (Administration for Children and

Families [ACF] 2004). A more recent report shows that, among children reported to child protective services throughout the United States, 48.2 percent were boys and 51.5 percent were girls; in 0.3 percent of cases, the gender was unknown (U.S. Department of Health and Human Services [HHS], ACF 2009). A large-scale review by Trocmé and colleagues (2001) of child maltreatment investigations in Canada found that 51 percent involved male children and that, among children over age 15, a greater number of investigations were substantiated involving boys (60 percent) than girls (42 percent) (Trocmé et al. 2001).

Girls under age 18 are about three times more likely than boys to experience sexual abuse, but boys are more likely than girls to experience emotional neglect or serious physical injury due to abuse (Sedlak and Broadhurst 1996). Self-reports from college students and general population surveys suggest that 10 to 20 percent of men were physically abused as children (Lisak 2001*b*). Boys are also more likely to die from maltreatment than girls of comparable age (ACF 2004).

Girls are more often sexually abused than boys, but male individuals are more likely to be sexually abused as children than as adults; the age at which a man is most likely to be a victim of sexual assault is 4 years old (Snyder 2000). Estimates as to the prevalence of sexual abuse of boys vary widely (Holmes and Slap 1998), but studies have found that between 8 and 29 percent of adult men have endured childhood sexual abuse (Gorey and Leslie 1997; Putnam 2003; Snyder 2000). Based on 16 cross-sectional studies of sexual abuse of children in North America (adjusted for sample size), Gorey and Leslie (1997) estimate that approximately 8 percent of adult men were childhood victims of sexual abuse.

Despite one fifth to one quarter of juvenile victims (ages 18 and under) of sexual assault

being male, few providers screen for histories of sexual abuse among male clients. In a study of 179 mental health professionals, 82 percent reported that they rarely or never inquired about the sexual abuse histories of men receiving services; many were unaware of the extent of sexual abuse of male children, and most (69.2 percent) felt that they had received insufficient training to inquire about it (Lab et al. 2000). Male victims of childhood sexual abuse may be even less willing to report it than female victims (Holmes and Slap 1998)—especially if the perpetrator is an adult woman and the victim a male adolescent, as both the victim and society have a harder time recognizing such acts as abuse (Mathews 1996).

Sexual abuse in childhood is linked with increased rates of substance use and various other behavioral health problems, including mental illness, suicide attempts and completions, gender role confusion, and involvement in high risk sexual behaviors; it can also increase the likelihood that the individual will sexually abuse others (Dube et al. 2001; Holmes and Slap 1998; Zielinski 2009). Unfortunately, only after becoming involved in the criminal justice system do many adult men receive any assistance with their childhood sexual victimization (Mathews 1996).

A history of childhood sexual abuse can profoundly affect a male client's substance abuse treatment in adulthood. For instance, typical efforts to help men bond with other male clients in treatment may provoke significant anxiety, and the abused client may withdraw, appear angry or threatening to others, or act fearful and hesitant. Sexually charged humor may be misconstrued by such a client; even demonstrations by counselors (or clients) of being interested in or concerned about the client can be seen as similar to the interest shown by a sexual perpetrator. It is often difficult to identify a client with a history of sexual

abuse, so routine physical exams that require a client to disrobe or that involve touching a client's genitalia must be conducted with respect and sensitivity for the man's privacy.

Case example: George

George is a 26-year old client in an inpatient substance abuse treatment program for men with co-occurring disorders. This is his first admission for substance abuse treatment, but he has, since early adolescence, been treated for various mental disorders, including depression, attention deficit hyperactivity disorder, panic disorder, and mixed personality disorder. Prior to entering treatment, he never told anyone that when he was 12, he was repeatedly sexually assaulted by a counselor at a camp for boys without fathers. In late adolescence, he questioned his sexual orientation and tried to resolve this dilemma by refraining from sexual activity. He never dated and allowed no close male friendships. He later described his experience as “feeling like a damaged freak.” In his early teens, he began to abuse marijuana and alcohol.

Twice in his first week in the program, George had panic attacks that he blamed on fears of being trapped. He had nightmares almost every night and had rushes of feeling overwhelmed and ashamed. He appeared frightened and unable to bond with other male clients in the group. He became visibly anxious when asked, in individual appointments, about his sexual and interpersonal history.

In clinical supervision, the counselor described George's symptoms and problems on the unit, expressing concern that George might have a trauma-related disorder. The counselor's supervisor suggested screening George for trauma symptoms, and when the counselor did so, George began to allude to a history of sexual abuse. Subsequent mental health consultation confirmed a posttraumatic stress disorder (PTSD) diagnosis, and integrated treatment of PTSD and substance abuse was undertaken. Efforts were made to ensure that George's treatment did not unintentionally evoke his childhood sexual trauma. He was encouraged to speak with his counselor if his anxiety became intolerable and was given a private bedroom. Without offering details, he described to his primary treatment group that terrible things occurred in his childhood that made it hard to bond with others; he felt great relief in sharing part of his secret with others. Plans were made for George to continue individual treatment for PTSD and relapse prevention after successfully concluding inpatient treatment.

TIP 36 (CSAT 2000*b*) provides information on treating male and female survivors of child abuse and neglect in substance abuse treatment settings. Some basic guidelines are presented in the following text box.

Family Issues

Men fill a number of different relationship roles. They may be employees or employers, and they may be involved with different

Advice to Behavioral Health Clinicians: Addressing Childhood Sexual Trauma in Men

- Screen all male clients in substance abuse treatment for childhood sexual trauma.
- If screening reveals the possibility of childhood sexual trauma, have the client assessed by a clinician competent to diagnose and recommend treatment approaches for trauma.
- In treatment, focus on how the trauma affects the client today, not on the details of the trauma.
- Most clients prefer to work on the effects of their childhood trauma in individual, not group, sessions.
- Childhood sexual trauma may be part of a larger process of abuse and disrespect of the individual in childhood and into adulthood. Do not presume childhood sexual abuse to be an isolated incident.

systems (e.g., the criminal justice system)—both topics are discussed in Chapter 4—but most men have been or currently are members of families (either families of origin or those they have themselves created). Families can affect men’s substance abuse in different ways, but they also can play a powerful role in motivating men to enter and maintain recovery.

Parenting Responsibilities

Parenting can be a stressful activity for both men and women. Some fathers who abuse substances may believe their substance use actually helps them cope with stress associated with parenting, enhancing their ability to function as fathers. However, substance use is likely to increase child abuse and neglect and create a much more chaotic environment for children in the home (Ammerman et al. 1999; Reid et al. 1999). Paternal substance abuse has also been associated with negative outcomes for children, including children’s own abuse of substances later in life (McMahon et al. 2005; Schuckit and Smith 2001); antisocial traits and higher rates of depression, anxiety, and mania (Finn et al. 1997); lower intelligence quotient (IQ) and school achievement scores (Moss et al. 1995*b*); and increased aggression (Moss et al. 1995*a*).

Father–child relationships within families affected by paternal substance abuse are not categorically problematic (Eiden et al. 2002), and there is some evidence that, even in the midst of chronic substance abuse, positive father–child relationships may still help promote positive child development (Brook et al. 2002*a, b*). Still, it is best that fathers contribute to the well-being of children when they are in a position to maintain close, responsive relationships with them, to provide emotional support and practical assistance to their children’s mothers, and to contribute economically to the family’s welfare, all of which are extremely difficult to do when abusing substances.

The importance of child custody for women and the value of programs that treat women with their children have been recognized for some time (CSAT 2004*b*), but clinicians and researchers still tend to minimize the roles played in the lives of their children by men who abuse substances (McMahon and Rounsaville 2002). Losing custody of their children can affect men’s substance use; some men enter treatment due to their concern for their children (McMahon and Rounsaville 2002), and men who have children are more likely to complete treatment (Rabinowitz and Marjefsky 1998). Conversely, lack of contact with one’s children is correlated with increased substance misuse among men (Grill et al. 2001).

Although empirical data on how parenting responsibilities affect the treatment seeking and retention of men are not readily available, studies suggest that family can play an important role in motivating a man to enter treatment. For example, Steinberg and colleagues (1997) found that 53.3 percent of their sample (105 men in a couples-based outpatient program for alcohol abuse) said they were motivated by their spouse or family to enter treatment. In analyzing data from the Drug Abuse Treatment Outcome Study, Grella and Joshi (1999) found that opposition to substance use and support for treatment from family members had an effect on men’s entry into treatment that it did not have on women’s entry. The authors also reported that despite not being as concerned with child custody issues as women, a significant number of men reported concern that entering treatment might affect custody of their children (15.7 of men compared with 30.5 percent of women) and that they might lose custody of their children because of their substance abuse (4.2 percent of men versus 16.9 percent of women).

The consensus panel believes that fatherhood and the desire to be a good father can serve to

motivate a man to enter and remain in treatment as well as potentially hinder treatment entry. For example, concerns about working to provide financial support for children may prevent some men from seeking treatment in a timely manner, particularly if treatment requires absence from work. Similarly, internal or external pressure to return to work as soon as possible so that they can provide for their children may cause some men to leave treatment prematurely. Some fathers, particularly single custodial fathers, may avoid seeking treatment or leave treatment if they believe it could interfere with their ability to effectively parent their children. Also, men living with their children may be less likely to commit themselves to an extended period of inpatient, residential, or maintenance treatment. Men involved in family court proceedings might believe involvement in treatment could be used against them in hearings concerning child custody or visitation rights. For these reasons, among others, it is important for fathers to have some contact with their children during treatment, even if only through supervised visitation. Sensitivity to a father's visitation schedule helps him maintain contact with

his children and ensures that custody exchanges proceed smoothly and both mother and father cooperate with the terms of the agreement.

Counseling fathers in substance abuse treatment

When entering treatment, men sometimes discover that they lack basic parenting skills—a problem they did not recognize when they were using. Substance abuse programs that treat male clients should consider adding a component that teaches parenting skills, as many men with children will express an interest in such an option if offered. Although formal evaluation data are scarce regarding parenting programs for men in treatment, criminal justice system providers believe they are helpful for both the men and their children; men are interested in such programs and view them favorably (Jeffries et al. 2001).

Given the complex, multidimensional nature of their problems, fathers who abuse substances may need a great deal of support and assistance from their counselors to be able to provide for and have close, healthy relationships with their

Advice to Behavioral Health Clinicians: Parenting Issues

Programs specifically designed to teach men parenting skills are almost universally absent in substance abuse treatment settings. Parental interventions for men with substance use disorders must systematically address the motivational, cognitive, behavioral, and interpersonal aspects of parenting from the perspective of men:

- Why men should work to become better parents.
- The benefits clients can receive by becoming better parents.
- Family-of-origin issues that may interfere with effective fathering.
- Legal barriers to greater involvement with children.
- Problem-solving with mothers who typically control access to children.
- Building better communication skills with children.
- Developing specific parenting skills appropriate for use with children of a specific age.
- Relating to children who are grown.

Cogent issues that can emerge for fathers with substance use disorders include:

- Excessive guilt about being an ineffective parent.
- Family secrets about substance use and HIV/AIDS status.
- Relating to children when both parents are addicted.
- Lack of role models for effective parenting.

children. Unfortunately, formal resources for clinicians interested in helping men become more effective parents are somewhat limited. There are generic parenting interventions, such as Focus on Families (Catalano et al. 2002) developed for use with both men and women with substance use disorders, as well as gender-specific approaches to parenting for mothers with substance use disorders that may be adapted to address the specific needs of men with substance dependence (e.g., see Luthar and Suchman 1999, 2000).

Although educating fathers about parenting is important, the consensus panel recommends that behavioral health clinicians move beyond education and develop a more comprehensive parenting intervention that acknowledges the complex nature of parent–child relationships and the special needs of fathers. Because the parenting problems of men with substance use disorders range broadly from decisions to voluntarily terminate parental rights to new responsibilities to care for children as single custodial fathers, flexible treatment approaches are necessary. In their work with fathers en-

rolled in methadone maintenance, McMahon and Giannini (2002) found that parental interventions for men with substance use disorders must systematically address the motivational, cognitive, behavioral, and interpersonal aspects of parenting from the perspective of men, including:

- Why men should work to become better parents.
- The benefits clients can receive by becoming better parents.
- Family-of-origin issues that may interfere with effective fathering.
- Legal barriers to greater involvement with children.
- Problem-solving with mothers who typically control access to children.
- Building better communication skills with children.
- Developing parenting skills appropriate for use with children of a specific age.
- Relating to children who are grown.

When working with fathers who have substance use disorders, behavioral health clinicians should be particularly aware of the

Family Issues: Helpful Resources for Behavioral Health Service Providers

Programs specifically designed to teach men parenting skills are almost universally absent in substance abuse treatment settings. Parental interventions for men with substance use disorders must systematically address the motivational, cognitive, behavioral, and interpersonal aspects of parenting from the perspective of men:

- SAMHSA's toolkit, *Supportive Education for Children of Addicted Parents* (<http://store.samhsa.gov/>), provides materials to help substance abuse programs initiate educational support programs for children of clients in substance abuse treatment. The programs teach youth skills, such as problem-solving, coping, social competence, autonomy, and sense of purpose. Although the material is oriented toward Native American communities, it can easily be adapted for use with non-Native groups.
- The Center for Substance Abuse Prevention's guide, *Helping Children and Adolescents in Families Affected by Substance Use* (<http://www.nacoa.net/pdfs/guide%20for%20health.pdf>), presents information and tools to help healthcare practitioners ask questions and intervene with patients and families experiencing substance-related difficulties.
- SAMHSA's National Center on Substance Abuse and Child Welfare has produced a toolkit (<http://www.ncsacw.samhsa.gov/training/toolkit/>) that provides child welfare workers with learning opportunities and baseline knowledge relating to substance use and mental disorders and interventions while motivating and facilitating cross-systems work. The toolkit also addresses cultural awareness and offers ways to facilitate cultural competence in child welfare practice.

possibility of treating men who have excessive guilt about being an ineffective parent, have family secrets about substance use and HIV/AIDS status, have children with a woman who abuses substances, and/or who are overwhelmed with sole custody.

Although both fathers and children stand to benefit from improvement in father–child relationships, clinicians may encounter situations in which it is not practical, feasible, or safe to promote a client’s greater involvement in his child’s life. Geographic distance, children’s refusal to see their fathers, obstructive mothers, and angry members of the extended family may complicate men’s efforts to improve their relationships with their children. Ongoing substance use, past or present domestic violence, allegations of child abuse, and ongoing involvement in criminal activity may raise ethical questions about promoting involvement that may prove harmful to children or partners, particularly as ongoing research begins to better define those circumstances (Jaffe et al. 2003). Similarly, when men have systematically abused or neglected children for a long period of time, clinicians may need to help them negotiate difficult decisions about petitions for extended placement of children, voluntary termination of parental rights, and/or adoption by others interested in functioning as parents.

Reproductive Responsibility

Most interventions focusing on male sexuality emphasize the prevention of sexually transmitted diseases—if discussed at all, issues of unwanted paternity seem to be of secondary concern. However, what little information exists about patterns of family formation among men with substance use disorders suggests that, as a group, they may have more children with more partners than do other men, have their first child earlier in the lifecycle, and father the majority of their children before the

onset of their substance use disorders (McMahon 2003; McMahon et al. 2005). Substance abuse treatment programs are an ideal setting in which to raise and discuss issues about male sexuality, unwanted paternity, and reproductive responsibility.

Legal Issues Affecting Families

Child support

Fathers with substance abuse problems are twice as likely to fail to pay child support as those without such problems (Garfinkel et al. 1998). The Child Support Enforcement Program links Federal, State, and local authorities to ensure that orders for child support are followed. A father’s wages may be garnished to pay for back child support, and drivers’ and professional licenses can be revoked, passports denied, and financial institution deposits seized (ACF 2002). All of this may add to the stress of a father who is in substance abuse treatment and unable to meet child support payments.

Family court involvement

Men seeking substance abuse treatment may need support and assistance in navigating the child welfare and family court systems. As stereotypes involving substance abuse collide with traditional ideas about family life, men involved in family court proceedings may experience bias that labels them as entirely negative influences to be excluded from the family (McMahon and Giannini 2003). Stereotypes of men who abuse substances may reinforce traditional ideas about gender and family such that these men, more so than others, are quickly but inappropriately dismissed as indifferent, uninvolved, irresponsible, and irrelevant (McMahon and Giannini 2003; Parke and Brott 1999).

When fathers with substance use disorders are involved in family court proceedings, the courts use clinical evaluations to inform their

decisions. As McMahon and Giannini (2003) note, comprehensive, integrated evaluations of fathers who abuse substances should:

- Characterize the nature of the substance use.
- Document the presence of other behavioral health problems.
- Highlight capacity for effective parenting.
- Document compromise of parenting.
- Characterize treatment needs.
- Offer comment about the adequacy of whatever treatment might be occurring.

Professionals working with fathers who have substance use disorders should support, as much as possible, the self-defined goals of their clients and should, with proper authorization, give family courts information about ongoing treatment to use in making decisions.

Clinicians providing ongoing substance abuse treatment to fathers may have to educate court personnel about their ethical obligation to advance the interests of their clients and their need to remain, as much as possible, a neutral party in family court proceedings. Treating clinicians should not offer opinions about visitation, custody, termination of parental rights, or similar matters if they are to continue their clinical intervention with a given client, regardless of legal outcome.

Support From Partners, Family, and Friends

The personal relationships of men who abuse substances can either help bring about change in their lives or contribute to the problem. Associating with friends with whom one used substances is a common trigger for relapse. Vaillant and Hiller-Sturmhofel found that warm and cohesive environments and close relationships were more common among men who did not develop alcohol use disorders than among those who did (1996). Various studies also indicate that men who have wives

and/or children tend to use substances less frequently and in smaller amounts than those without such ties (Blazer and Wu 2009*b*; HHS, SAMHSA, Office of Applied Studies 2008*a*, 2009*b*; Kuntsche et al. 2009). Having friends who drink heavily and/or use drugs is strongly associated with such behavior for men (Weisner et al. 2003), and not having such friends is associated with better recovery outcomes (Christakis and Fowler 2008; Flynn et al. 2003; Laudet et al. 2006). Clinicians who understand the power of family and other personal relationships in men's lives can actively address these issues through couples and/or family treatment or through building other social supports (such as mutual-help group support, discussed in Chapter 5) to help men struggling with substance use minimize their likelihood of resuming substance-related behavior.

Having a partner or family member who supports treatment for substance abuse is likely to improve its outcome. When men are not in relationships (or have no children), they are less likely to complete treatment (Rabinowitz and Marjefsky 1998). Counselors can help clients improve marital and family relationships through psychoeducational programs, relationally oriented group counseling, and couples counseling that emphasizes supporting treatment and recovery efforts, managing interpersonal struggles and crises, and building relational strengths, such as marital communication and parenting skills.

Although partner and family support is certainly important, behavioral health clinicians should not overlook the influence a man's friends have on treatment outcomes. Including men's friends in some aspect of the treatment process can be of great value if they are supportive and not abusing substances themselves. Unfortunately, deteriorating or absent friendships can be a barrier to successful substance

abuse treatment. Although men 55 to 65 years of age who abuse alcohol were found to experience more support from their spouses, they received less support from their “children, extended family members, and friends” (Brennan et al. 1993, p. 781). These men also reported more chronic stress in their lives, in part because of the state of their relationships with friends (Brennan et al. 1993).

Spirituality and Religion

Most clients in substance abuse treatment usually have some religious and/or spiritual beliefs, based on research in medical settings (Koenig 2001*b*) and among the general population (Public Broadcasting Service 2002; Robinson 2003). Spiritual and religious activity should generally be encouraged; research has repeatedly confirmed that people who participate in spiritual/religious activities are less likely to abuse substances (Koenig 2001*b*). Also, religious practices and beliefs (at least those from established religions) seem to affect physical health by improving coping, reducing emotional distress, improving attitude and mood, increasing social support, and reducing problem behaviors (Koenig 2001*a*).

Due to the influence of 12-Step groups like Alcoholics Anonymous, spiritual beliefs play an important role in many substance abuse treatment programs. Many clients find that spiritual and/or religious beliefs (the difference

is defined in the text box below) play an important role in their recovery, so counselors should be prepared to discuss these beliefs with clients if they so choose.

Counselors in behavioral health settings can use a male client’s religious or spiritual beliefs to motivate change and, sometimes, to counter the negative effects of certain cultural beliefs about masculinity and alcohol use. For example, a client who believes that not drinking will jeopardize his masculinity and status among his peers may be better able to reconcile his decision to maintain abstinence as a culturally appropriate one if it is supported by a priest or clergyman. Faith can also help recovering clients as they reenter their communities; support from a church, synagogue, mosque, or other faith-based institution can improve their chances of recovery and reduce the odds of relapse (CSAT 1999*b*).

Although substances (such as wine or peyote) may be used in some religious rituals, all major religions have made adaptations for individuals with substance use disorders, enabling them to participate in the religion without partaking of those substances.

Behavioral health services providers should become familiar with their clients’ spiritual beliefs, practices, and experiences just as they learn about their occupations, families, habits, and mental health. (See Chapter 2 for information on assessing clients’ spiritual/religious

Defining the Difference Between Religion and Spirituality

It is useful to distinguish between spirituality and religion, as some men seeking treatment view themselves as spiritual but not necessarily religious. Religion is organized, with each religion having its own “theology, doctrine, creeds, catechisms, and liturgical practices, all of which are intended to enhance each member’s spirituality” (Chappel 2003, p. 970). Spirituality, on the other hand, is a personal matter involving the individual’s search for meaning, and it does not require an affiliation with any religion. People can have spiritual experiences or develop their own spirituality regardless of the presence or absence of any religious connection (Chappel 2003). In recovery from substance abuse, focusing on spirituality rather than religion can help some people accept the need for a higher power or a power greater than themselves (which could be other people, nature, a spiritual being, or a deity) when they might otherwise be resistant toward organized religion (Hazelden Foundation 2003).

beliefs.) In a therapeutic relationship of mutual respect and tolerance, differences between counselor and client in spiritual beliefs need not become problematic. A clinician can serve as an orchestrator of resources when it comes to a client's religious or spiritual beliefs (Koenig 2001*b*). Just as the clinician or other appropriate staff person can help clients get the physical services they need (e.g., housing,

medical care), they can also help clients meet their spiritual needs by arranging visits with spiritual advisors or clergy, as well as by providing access to religious services during treatment upon client request. Clinicians must be able to refer clients to spiritual advisors from many different faiths (reflecting the population with which the clinician works).

4 Working With Specific Populations of Men in Behavioral Health Settings

IN THIS CHAPTER

- Introduction
- Men With Co Occurring Disorders
- Men With Physical Health Problems
- Men From Different Age Groups
- Gay and Bisexual Men
- Men With Employment or Career Related Issues
- Men With Systems Related Needs
- Men From Diverse Cultural and Geographic Groups
- Conclusion

Introduction

The patterns of substance abuse and the treatment needs of adult men (ages 18 and older) are diverse, as are their conceptions of masculinity. Men in need of treatment come from all walks of life; this chapter outlines some of the patterns of substance use and abuse for specific populations of men, noting areas in which men differ from women. Clinical examples and tips are offered to guide behavioral health clinicians in treating men from these diverse populations.

Men With Co-Occurring Disorders

Many men in treatment for a substance use disorder have a co-occurring mental disorder. In the general population, men are less likely to have serious mental illness than women (Epstein et al. 2004), but a larger percentage (56 percent) of adults in substance abuse treatment with co-occurring mental disorders are men, just as more adults in substance abuse treatment overall are men (Office of Applied Studies [OAS] 2004a). Among adults with serious mental illness, men are more likely than women to have used illicit substances in the past year (Epstein et al. 2004; Substance Abuse and Mental Health Services Administration [SAMHSA], OAS 2007a).

Men with co-occurring disorders are more likely than women with co-occurring disorders to use more than one illicit substance and are more likely to report daily use of illicit substances (SAMHSA, OAS 2007a). Data from 2003 show that, as a group, men with

co-occurring disorders are more likely to have dropped out of high school than their female counterparts (17 percent of women versus 28 percent of men), less likely to have health insurance (77 percent of women versus 67 percent of men), and less likely to have received treatment for substance abuse or a mental disorder in the past year (55.4 percent of women versus 41 percent of men) (OAS 2004*b*).

As noted in Chapter 1, men are more reluctant to seek professional assistance for health-related problems, including substance abuse and mental illness, than women (Addis and Mahalik 2003; Grella et al. 2009*a*). Therefore, although people with co-occurring disorders are more likely to seek mental health services than those with just a substance use or mental disorder (Wu et al. 1999), a large number of men with co-occurring disorders still seek no treatment for either disorder. Masculine gender norms can cause men to feel greater shame than women in seeking help for mental illness (Addis and Mahalik 2003). The “Counseling Men Who Feel Excessive Shame” section in Chapter 3 of this Treatment Improvement Protocol (TIP) addresses shame related to the failure to meet masculine gender expectations and offers advice on addressing shame.

Even men already in substance abuse treatment may be reluctant to seek assistance with

co-occurring mental disorders, so programs that work with male clients need to be especially proactive in screening and assessing such disorders (see Chapter 3) and assisting these clients in getting the help they need. Conducting a thorough medical and mental health assessment at admission can minimize the risk of these disorders going untreated, even if the program itself cannot provide that treatment. Screening and assessment for mental illness must also be ongoing; clients with one type of disorder are at increased risk of later developing disorders of another type. Moreover, the symptoms of a substance use disorder can mask co-occurring mental disorder symptoms at any point in treatment. Treatment Improvement Protocol (TIP) 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (Center for Substance Abuse Treatment [CSAT] 2005*c*), details the screening, assessment, and treatment of co-occurring disorders in male and female clients and offers information on various co-occurring mental disorders (some of which are discussed later in this TIP). Chapter 5 of TIP 42 presents strategies for treating people with co-occurring disorders.

When screening for co-occurring disorders (see advice box below), clinicians may find that many men are uncomfortable discussing the emotional aspects of mental illness and will focus more on tangible symptoms, such as

Advice to Behavioral Health Clinicians: Screening and Assessment for Co-Occurring Disorders in Men

- Some men, even if already in substance abuse treatment, are reluctant to seek help with co-occurring mental disorders. Programs treating male clients must proactively screen and assess such disorders.
- Thorough medical and mental health assessment at admission can minimize the risk of these disorders going untreated.
- Ongoing screening and assessment for mental illness is necessary; clients with one type of disorder are at increased risk of developing subsequent disorders of different types.
- Men tend to emphasize the behavioral, rather than the emotional, symptoms of mental disorders.
- Symptoms that are common during early recovery from substance abuse (e.g., agitation, sadness, feeling overwhelmed) can mask symptoms of mental illness. Counselors should not assume that these symptoms will fade with abstinence.

difficulties in sleeping, changes in appetite, physical complaints, decreased interest in sex). For this reason, male clients with co-occurring disorders may be less interested in psychotherapy than female clients. Male clients may also present with more behavioral problems than women (e.g., fighting, lack of compliance with medication regimen).

Anxiety Disorders

In general, men are less likely to have anxiety disorders than women (American Psychiatric Association [APA] 2000; Grant et al. 2009; Kessler 1998). The only exceptions are social phobia and obsessive-compulsive disorder (OCD), as some research has found that rates for those do not vary significantly between genders (Bekker and van Mens-Verhulst 2007; Grant et al. 2009).

However, rates of anxiety disorders among men with substance use disorders vary from those found in the general population. For example, OCD appears to be much more common among persons with substance use disorders (see discussion later in this chapter). Rates also vary according to treatment setting and primary substance of abuse. Even within a specific type of setting, rates vary greatly according to the assessment instruments used and other factors. For example, a study of men who were incarcerated and receiving substance abuse treatment found that 17.8 percent had met criteria for an anxiety disorder at some point during their lives (Zlotnick et al. 2008), whereas another study of men entering the prison system found that 74.6 percent met criteria for a current substance use disorder and 36.4 percent met criteria for a current anxiety disorder (Gunter et al. 2008). Other research comparing rates of anxiety disorders among individuals with different substance use disorders has found significantly higher rates in those with cocaine use disorders (Conway et al. 2006; McRae et al. 2007).

One significant issue for men with co-occurring anxiety and substance use disorders is the use of alcohol and/or drugs to cope with anxiety symptoms (sometimes called self-medication). Robinson and colleagues (2009) evaluated data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), which surveyed over 43,000 adult men and women and inquired about alcohol and/or drug use to reduce symptoms associated with specific anxiety disorders. They found that the frequency of this behavior varied depending on the type of anxiety disorder a person had; 35.6 percent of men and women with generalized anxiety disorder (GAD) reported self-medicating, but only 7.9 percent of those with social phobia did so. Men with anxiety disorders were significantly more likely to report such behavior than were women with anxiety disorders.

For men with co-occurring anxiety and substance use disorders, substance abuse may be a means of coping, but as the substance use disorder progresses, it actually worsens anxiety disorder symptoms. Substance abuse treatment is complicated by subsequent patient resistance toward giving up a drug that he feels is necessary for his emotional survival, by anxiety arising from emotionally intense treatment, and, in some cases, by deficits in social skills important in substance abuse recovery. Because of masculine social norms, men may feel greater pressure to deny anxiety or to use avoidance coping methods (such as self-medication) to address it. This behavior can be a persistent problem that endangers recovery for men with anxiety disorders, and it serves as an added impetus for counselors to address anxiety in treatment.

The following sections examine anxiety-related mental health issues commonly seen among men in substance abuse treatment, including posttraumatic stress disorder (PTSD),

social phobia, OCD, GAD, and combat stress reaction (CSR).

Posttraumatic stress disorder

In the general population, men are exposed to trauma more often than women, although women experience higher rates of PTSD (Breslau 2002; Kessler et al. 1995). Between 5 and 6 percent of men have had PTSD sometime in their lives (Breslau et al. 1998; Kessler et al. 1995). However, in certain male populations exposed to greater amounts of trauma, rates of PTSD are likely to be higher. Studies have found rates of trauma exposure between 42 and 95 percent in men seeking treatment for substance use disorders (Farley et al. 2004) and equally high rates in populations of men with serious mental illness (Goodman et al. 2001) and men who are homeless with co-occurring disorders (Christensen et al. 2004). Men involved in the criminal justice system (Swartz and Lurigio 1999) and men who are combat veterans (Kulka et al. 1990) are 2 to 3 times more likely to experience PTSD than men in the general population.

Prior trauma exposure may also contribute to the development of PTSD following a subsequent trauma. Smith and colleagues (2008) report that individuals who had been the victim of an assault prior to being deployed in Operation Iraqi Freedom (OIF) were twice as likely to develop new-onset PTSD during or after deployment than were service members with no history of assault. Kessler and colleagues (1995) found that men with PTSD are more likely to have a co-occurring substance use disorder (51.9 percent) than men without PTSD (34.5 percent) and are also more likely to have a co-occurring substance use disorder than women with PTSD (27.9 versus 26.9 percent, respectively). These data suggest that men in substance abuse treatment are at particularly high risk for having both PTSD and a substance use disorder.

Men and women are typically exposed to different types of trauma and appear to be affected differently by traumatic events. The most common traumas for men are exposure to combat; being physically assaulted, shot, or stabbed; and witnessing killings or serious injuries. Women, however, are most often exposed to sexual assault and rape (Breslau 2002; Kessler et al. 1995). Men are also more likely than women to be victims of violent crime (Catalano 2004). In a sample of men with substance use disorders (both in and out of treatment), 45 percent had witnessed a killing or injury, 33 percent had been physically assaulted, 16 percent had been threatened, and 16 percent had experienced a sudden injury or accident; women were 14 times more likely to have been raped than men but 3 times less likely to have been physically assaulted (Cottler et al. 2001).

Among men, rape and combat are the two types of trauma most likely to lead to PTSD. In a general population sample of men, rape (a relatively rare event for adult men) resulted in PTSD approximately 65 percent of the time; combat exposure resulted in PTSD 38.8 percent of the time (Kessler et al. 1995).

Men are expected to be tough, so their trauma histories may not be explored in treatment as often as those of women, nor are they as likely to self-identify as trauma survivors. The problem is complicated by men's greater tendency to externalize their experiences of trauma; thus, men are more likely than women to react to their own traumatization by victimizing others. Men are also more likely to report symptoms of increased alcohol use and irritability as a result of traumatic experiences (Green 2003).

Case example: Tim

Tim is a 30-year-old veteran of OIF. While on active duty, he was exposed to several life-threatening events, including being in a convoy vehicle that hit an improvised explosive

device (IED) on the roadside. The passenger in the vehicle's front seat was killed, and Tim was thrown from the back, resulting in abrasions and bruises across his body, a broken arm and kneecap, and wounds from shrapnel. At the time of this traumatic event, Tim was screened for trauma symptoms but was approved to return to combat; as soon as his wounds healed, he returned to his unit for another 7 months of active duty.

Following his discharge from the Army, Tim entered college and majored in criminal justice. Although he had exhibited some trauma symptoms prior to starting college (sleep disturbances, nightmares, anxiety when he saw objects on the side of the road), the symptoms were not disabling until he began an internship at a local prison. Within the first month of the internship, Tim began experiencing disabling PTSD symptoms that were exacerbated by the noises, sights, and smells in the prison. The yelling among inmates and the clanging of metal doors were particularly stressful. He began smoking marijuana after work and on weekends to quell his symptoms, and he tested positive for marijuana on a routine drug screen. He was referred to the prison's employee assistance program, which referred him to a substance abuse treatment program for evaluation.

The substance abuse program staff identified Tim's co-occurring PTSD and substance abuse and enrolled him in a 2-month assessment group for his substance use. To address his PTSD symptoms, the program also arranged regularly scheduled appointments at the local U.S. Department of Veterans Affairs (VA) clinic with a behavioral health counselor who had been trained in PTSD treatment.

The planned TIP, *Trauma-Informed Care in Behavioral Health Services* (SAMHSA planned), provides more information on trauma and PTSD among men and women with substance use disorders and on treating trauma concurrently with substance use disorders. It offers more detail regarding all trauma-related subjects touched on in the following sections of this chapter.

Treating men for PTSD

Many interventions to address both PTSD and substance use disorders, even if developed for both male and female clients, have been evaluated primarily with women or with men who have experienced combat-related trauma. Behavioral health clinicians may need to consider how to adapt these interventions for other populations. In some cases, models created specifically for women have been adapted for men; one such example is the Men's Trauma Recovery and Empowerment Model (M-TREM). This model appears promising in its ability to engage male clients and improve their coping skills, and it is a useful example of how trauma treatment can be adapted for a male population (personal communication with R. D. Fallot, June 10, 2005). However, research on M-TREM's effectiveness is ongoing; no recent study reports are available to provide empirical evidence of its potential success.

The developers who adapted TREM for male clients formulated eight basic assumptions about how trauma treatment for men should differ from that provided to women. These assumptions are shown, along with the developers' responses to them, in Exhibit 4-1.

Exhibit 4-1: Assumptions and Adaptations Used in M-TREM

Assumption	Response
Men and women understand and respond differently to traumatic experiences.	The TREM model emphasizes empowerment for women; M-TREM focuses on emotions and relationships (areas in which men have difficulties).
Male trauma survivors must either disconnect from male gender role expectations to feel the fear, vulnerability, and powerlessness associated with trauma, or else disconnect from those feelings to retain their sense of masculine identity.	M-TREM focuses on exploring the relationship between trauma experiences and masculine gender role expectations.
Many male survivors develop all-or-nothing responses, especially emotional responses (e.g., rage or timidity), or ways of being in relationships (e.g., dependence or emotional distance).	M-TREM teaches men a wide range of options for expressing emotions and being in relationships.
In spite of the appearance of independence that results from trying to fill masculine roles, men with trauma histories feel cut off from their families, communities, and selves.	M-TREM uses reconnecting skills of emotional, cognitive, and behavioral self-recognition and teaches relational mutuality to improve men’s understanding of how to be in relationships.
Men who were traumatized early in life lost the opportunity to develop important skills necessary for adulthood.	M-TREM uses a psychoeducational and skills-oriented approach to treatment for trauma.
Men with trauma histories have skills and strengths that can help them in recovery.	M-TREM uses a strengths-based approach.
As with women, men’s dysfunctional responses to trauma (or its symptoms) may have begun as useful coping strategies.	M-TREM helps clients reframe problematic behaviors as attempts to cope with trauma.
Any attempt to cope with trauma is likely to have advantages and disadvantages.	M-TREM helps clients look at the costs and benefits of their coping strategies in an objective fashion and reframe problems so they can choose the best coping strategies.

Source: FalLOT et al. 2001. Adapted with permission.

Other researchers and behavioral health clinicians have suggested ways in which treatment for men with PTSD may need to differ from that provided for women with the disorder. For example, Lisak (2001b) notes that the ideology of masculinity limits the resources available to men to respond to trauma. Therefore, any treatment for men with trauma must address how men internalize masculine ideology concurrently with their trauma histories. Otherwise, the legacies of masculine socialization can impede the process of healing from trauma

by keeping men from connecting with the painful feelings that result from it.

Ruzek (2003) describes several interventions for treating veterans with co-occurring PTSD and substance use disorders; most of this population is male, and the research Ruzek draws upon is primarily with male clients. Specifically, he notes that members of this population often have anger control problems that need to be addressed in the context of their trauma treatment.

The Seeking Safety model for treating co-occurring trauma and substance use disorders effectively reduced PTSD symptoms and substance use in a small ($n=5$) study of men with co-occurring substance use disorders and PTSD (Najavits et al. 2005).

Emotionally directed, cognitively oriented counseling can help men connect with their feelings and the feelings and experiences of others (Hardy 2004). Treatment for trauma and trauma-related disorders typically involves the active processing of painful feelings that expose the individual as vulnerable—an exploration that runs counter to the masculine norms of our culture, thus making this process potentially more difficult with male clients than with female clients. Because of this added impediment, behavioral health clinicians treating men with trauma histories must explore with them the social processes of masculinization and the ways in which masculine norms hinder recovery from trauma (Lisak 2001*b*). Treatment for men with histories of trauma, whether or not they have PTSD, is discussed later in this chapter. Specific information on treating men exposed to combat trauma is presented in the following section.

Combat stress reaction

CSR is an acute anxiety reaction similar to an acute stress disorder but only occurring among combatants (and noncombatants exposed to combat events) in an armed combat situation. Although the the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR; APA 2000) does not list CSR as a diagnosis, CSR (also called combat trauma) affects a significant number of male veterans. Substance use and mental disorders are strongly associated with trauma from combat exposure (Hoge et al. 2006; Ruzek 2003).

Common causes of CSR often relate to direct attacks, as with insurgent small arms fire or

IEDs, and can also result from being near combat, handling the bodies of wounded or dead individuals, being repeatedly exposed to events with a high risk of death or injury, or making frequent on-the-spot decisions under ambiguous conditions—especially when the result is death or injury to others.

CSR can be transient and nondebilitating, or it can result in major psychological disorganization. Normally, with support and treatment, symptoms diminish in a relatively brief period of time (1 to 2 months). If symptoms persist beyond that time, the person may be diagnosed with PTSD. Typical CSR symptoms include hypervigilance, sleeplessness, irritability, anger, and difficulty concentrating. More severe symptoms may include freezing up, feelings of impending doom, significant but unreasonable guilt, unpredictable responses in ordinary situations, and impaired memory.

Significant strides have been made in recent years in addressing CSR in combat zones. Military personnel are briefed prior to entering a war theater about stressors and coping strategies. Personnel with combat stress symptoms are more rapidly and efficiently identified, and onsite treatment in the combat zone has been remarkably improved. Most treatment for service members is provided in their assigned camp by members of combat stress control teams composed of behavioral health professionals who use brief and targeted individual, group, and psychoeducational methods. If service members do not respond to these services, they are evacuated from the combat zone whenever possible to access more specialized resources. A more detailed description of this process is described in the planned TIP, *Trauma-Informed Care in Behavioral Health Services* (SAMHSA planned *g*). Reintegration efforts for veterans returning to the United States have been significantly enhanced as well. Programs for families, ongoing medical

care, and civilian life have been developed and implemented throughout all service branches.

Behavioral health clinicians should know that veterans are eligible for a variety of services offered by regional VA centers, including readjustment counseling, referral for benefits assistance, marital and family counseling, substance abuse information and treatment referral, job counseling and vocational assistance referral, and sexual trauma counseling and treatment referral. The *Iraq War Clinician Guide* (National Center for PTSD and Walter Reed Army Medical Center 2004) is a treatment reference for mental health issues among veterans of OIF. This document is available for free on VA's National Center for PTSD Web site (http://www.ptsd.va.gov/professional/manuals/manual-pdf/iwgcg/iraq_clinician_guide_v2.pdf). Military OneSource also offers veterans and their families useful resources relating to mental health and substance abuse issues (<http://www.militaryonesource.mil>; 1-800-342-9647).

Social phobia

Social phobia, also called social anxiety disorder, is one of the most common anxiety disorders. It affects women more than men, with a lifetime occurrence of 15.5 percent for women and 11.1 percent for men (APA 2000; Kessler 1998). It entails a "marked and persistent fear of social or performance situations in which embarrassment may occur" (APA 2000, p. 450). Men with social phobia seek treatment more often than women, which is opposite the norm for most mental disorders (Weinstock 1999). Men may be more likely to seek treatment for this disorder because it has a greater impact on them due to the gender role expectation that they be more proactive in social relations.

Men are particularly susceptible to using alcohol to combat the symptoms of social phobia. Some men describe how they drink to be able

to leave the house, interact with others, or work in front of others (e.g., when making presentations). Men with social phobia may use alcohol at work when confronted with stressors that involve interpersonal interaction. They may drink heavily at unavoidable social events and then experience the negative effects of heavy use. Social phobia also makes it difficult for men to enter substance abuse treatment, where they fear being overwhelmed with anxiety. They may be especially fearful of group sessions or 12-Step participation and will feign illness or other crises to avoid attending. It can be easy for counselors to equate this behavior with clients being resistant or less motivated.

Many clients with social phobia have anticipatory anxiety: imagining a worst case scenario about an upcoming event at which they might be the center of attention, interrogated by others, or exposed as a fraud; they then react emotionally as if that event has occurred. Anticipatory anxiety emotionally validates that the upcoming event is, indeed, dangerous and needs to be avoided. Some people cope with anticipatory anxiety by using drugs or alcohol to quell their symptoms.

Screen clients with social phobia symptoms (see DSM-IV-TR for symptoms; APA 2000) for the disorder and refer, if necessary, to qualified behavioral health professionals who specialize in the treatment of anxiety disorders for assessment and discussion of treatment options, including counseling (especially cognitive-behavioral therapy) and medication. Along with confronting limiting beliefs and perceptions, counseling should build skills in social interaction, anxiety self-monitoring, and positive coping options for use during anxiety-producing social situations.

Obsessive-compulsive disorder

Although not highly prevalent in the general population, OCD almost always co-occurs

with other mental disorders and often with substance use disorders (Mancebo et al. 2009; Pinto et al. 2006). A study of people in treatment for OCD found that 27 percent of the sample met criteria for a lifetime diagnosis of a substance use disorder; men were more likely than women to have a co-occurring substance use disorder.

For a man with OCD and a co-occurring substance use disorder, the substance use disorder may have originated in an attempt to cope with overwhelming and disabling anxiety. However, as substance use progresses, it actually worsens anxiety symptoms. Substance abuse treatment can be complicated by men's resistance to giving up a drug that they believe necessary to their emotional survival, by anxiety that arises from the emotional intensity of treatment, and sometimes, by deficits in social skills important for recovery from substance abuse. As with other anxiety disorders, a licensed behavioral health service provider with specific training in the treatment of anxiety disorders should diagnose and treat OCD, which should be treated concurrently with the substance use disorder. In addition to counseling, treatment may include medication.

Generalized anxiety disorder

GAD is sometimes associated with substance use disorders. In cases of GAD, the origins of the substance use disorder may lie in attempts to cope with overwhelming and disabling anxiety. However, as substance use progresses, it actually worsens anxiety symptoms. Substance abuse treatment can be complicated by men's resistance to giving up a drug that they believe necessary to their emotional survival, by anxiety that arises from the emotional intensity of treatment, and sometimes, by deficits in social skills important for recovery from substance abuse. As with other anxiety disorders, a licensed behavioral health service provider who specializes in the treatment of anxiety disor-

ders should conduct diagnosis and treatment; the anxiety disorder needs to be treated concurrently with the substance use disorder.

Mood Disorders

In general, women are more likely to experience mood (i.e., affective) disorders than men (APA 2000; Kessler et al. 1994), although the reasons for this difference are unclear. The same factors that protect men against certain disorders may contribute to increased rates of other disorders or problems, such as an increased rate of death by suicide among men (see the "Suicidality" section starting on p. 81). Furthermore, affective disorders may be more common in men than is generally believed, due to underdiagnosis or misdiagnosis (Levin and Sanacora 2007). Mood disorders can present with a wide range of symptomatology. Some of the more common mood disorders seen in substance abuse clients include dysthymia, a chronic depressed mood that extends over years; major depressive disorder, which manifests as recurring, significantly disabling depressive episodes; bipolar disorder, which can manifest as recurrent, interspersed manic and depressive episodes; and cyclothymia, which comprises cyclical manic and depressive episodes that do not meet criteria for bipolar disorder or substance-induced mood disorder. For more information on assessment and treatment of these disorders, see TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (CSAT 2008b).

Dysthymia and major depressive disorder

According to a number of studies, women are from 1.5 to 3 times as likely as men to have a depressive disorder, and this finding holds true in many settings around the world (Chui et al. 2009; Kessler 2000a; Levin and Sanacora 2007). However, approximately 12.7 percent of all men will experience an episode of major

The Nature of Depressive Symptoms

The term “depressive symptoms” is generally applied to a state of sadness, depressed mood, the blues, or related feelings and behaviors that do not meet diagnostic criteria for a DSM-IV-TR (APA 2000) mood disorder. People with such symptoms may experience considerable emotional pain and significantly impaired functioning in some areas.

Symptoms of depression exist on a continuum ranging from sadness and other depressive symptoms occurring at appropriate times and for short periods, during which the individual successfully uses coping strategies, to clinical (or major) depression as described in the DSM-IV-TR (APA 2000). The line between depressive symptoms and full-blown depressive disorders is a question of degree. Having depressive symptoms differs from having a major depressive disorder in terms of the number or severity, but not the *type*, of symptoms experienced by a client. Only behavioral health professionals credentialed to diagnose mental illness can determine whether a client has a serious disorder, such as major depression, dysthymia, bipolar disorder, or substance-induced mood disorder. Counselors who suspect that a client has a depressive illness should refer him to a behavioral health professional for assessment, diagnosis, and treatment.

Depressive symptoms may become more or less intense over time due to the client’s physiology, stressful events in the client’s life, or the client’s stopping or starting substance use. For example, someone who drinks heavily may have intense depressive symptoms that seemingly meet criteria for depressive illness but lessen dramatically in the weeks after initial abstinence from alcohol. Similarly, someone with major depression or dysthymia who has taken antidepressant medication for several weeks may show few or no currently debilitating depressive symptoms. Conversely, a client may demonstrate only mild depressive symptoms at intake but may be headed toward a significant depressive episode.

As with substance abuse, although a person may be in remission from his depressive symptoms, the depressive disorder may remain. Treatment must address prevention of and early intervention in recurrences, especially during early recovery from substance use disorders. Many depressive disorders cycle and recur. If a client has a history of a mood disorder, he and his counselor should be on the lookout for a recurrence of symptoms.

Source: CSAT 2008b, page 5. Adapted from material in the public domain.

depression at least once during their lives (Kessler et al. 1994).

Different explanations have been proposed for the large difference in rates of depression between genders. Depression seems to manifest differently in men than in women. This may contribute to the higher incidence of substance use disorders and antisocial personality disorder (ASPD) in men than women (National Institute of Mental Health [NIMH] 2003; Pollack 1998c; Real 1997). Others have suggested that the apparent difference may exist because men are less likely to seek help for depression, present with different symptoms of depression than women, and may be diag-

nosed by behavioral health clinicians and diagnostic instruments that are influenced by gender bias. Men tend to be underdiagnosed with depression, whereas women are overdiagnosed (Levin and Sanacora 2007). However, conclusive evidence supporting a single explanation is still lacking (Winkler et al. 2004).

The fact that men are less often diagnosed with depression than women may also result from cultural factors that define permissible masculine behavior—so that the same gender roles that shield men from their emotions in other areas may keep them from showing symptoms of depression, alter their symptoms, or make them less likely to report symptoms.

Studies also show that rates of depression are nearly the same among some subgroups of men and women, such as the elderly (Bebbington et al. 2003) or certain cultural/ethnic groups (e.g., the Amish, Hassidic Jews), in which men are less likely than men in the general population to have substance use disorders, ASPD, or other problems that may be manifestations of underlying issues that also cause depression (Cochran 2001).

A study of patients at a German hospital found gender differences in the presentation of symptoms, but not the severity, of depression—with men who were depressed more likely to show emotional rigidity, blunted affect, and decreased libido (Winkler et al. 2004). Men who are depressed may be more likely to focus on somatic or physical complaints than women, and depression in men may manifest in interpersonal difficulties and conflicts. Notably, men with depression are more likely to have a substance use disorder than women who are depressed (Cochran 2001; Pollack 1998c).

Depressed mood, whether attributable to a specific disorder or not, can significantly affect substance abuse treatment and recovery. For example, among a group of men who had relapsed during the 12 months following treatment, the most reported reason for relapse—reported by 26.9 percent of participants—was depressed mood (Strowig 2000). Such feelings as boredom and anger can cause relapse to substance use and may also result from underlying depression. TIP 48 (CSAT 2008b) discusses how to address subclinical depressive symptoms (for men and women) in substance abuse treatment settings.

Treatment for depressive disorders can be concurrent with substance abuse treatment. It usually includes a combination of counseling and antidepressant medication, which only behavioral health clinicians specifically trained

in the treatment of mood disorders should provide.

Bipolar disorder

Men and women appear to be affected differently by bipolar disorder. The disorder has an earlier age of onset in men than in women; men with the disorder also seem to have more frequent manic episodes and require a greater number of weeks of hospitalization for these episodes than women with the disorder, whereas women have more depressive episodes than men (Arnold 2003). Men with bipolar disorder appear more likely than women with the disorder to have a co-occurring substance use disorder, according to a number of studies reviewed by Arnold (2003); see also Albanese and colleagues (2006).

Many clients in substance abuse recovery who have been diagnosed with bipolar disorder describe trying to regulate their manic and depressive cycles with substances. For instance, in a manic episode, clients may use alcohol or sedatives to sleep and/or stimulant drugs to increase the high of the episode (i.e., emotional expansiveness and sense of well-being). In a depressive cycle, clients may use alcohol (even though it is a depressive drug) to dull the pain of their depression and/or stimulants to counteract the effects of the depression.

Manic symptoms can often be confused with symptoms of substance abuse, making diagnosis simply by observation difficult. Generally, bipolar disorder has to be diagnosed by a thorough examination of the client's mental health history, which should be conducted by a licensed behavioral health professional trained in making such diagnoses. Treatment for the substance use and bipolar disorders needs to be integrated or at least concurrent, as symptoms for one can trigger onset or relapse of the other. In addition to counseling, psychotropic medication is usually prescribed to regulate the bipolar disorder; the use of medication to

regulate the illness must be considered in the client's total treatment plan.

Schizophrenia

Across cultures, the onset of schizophrenia begins earlier in men than women (Moriarty et al. 2001; Nasser et al. 2002). The DSM-IV-TR (APA 2000) notes that the age of onset of schizophrenia is typically between 18 and 25 years of age for men and between 25 and the mid-30s for women. Some research suggests gender differences in the course and presentation of schizophrenia as well. In diagnosing schizophrenia, clinicians look for positive symptoms (i.e., an excess or distortion of normal function) and negative symptoms (i.e., a decrease in or loss of normal functions). Men appear to have more severe negative symptoms (e.g., emotional withdrawal, lack of spontaneity, blunted affect) and less severe positive symptoms (e.g., hallucinations, delusions) than women with schizophrenia (Moriarty et al. 2001). Men with the disorder also seem to have higher rates of co-occurring substance use disorders than women with schizophrenia (Fowler et al. 1998). One large-scale study of 1,027 veterans with schizophrenia (97 percent male) found that more than half had a history of substance abuse (Bailey et al. 1997).

Men with schizophrenia typically have poorer treatment outcomes than women (Moriarty et al. 2001), and they do not always respond as well as women to medications or to family involvement in treatment. Haas and colleagues (1990) found that an inpatient psychoeducational intervention for clients' families was associated with improved symptoms and functioning in women but with worsened symptoms and functioning in men. The effectiveness of family involvement depends on how the family is involved. In reviewing three studies, Ayuso-Guiterrez and del Rio Vega (1997) found significantly reduced relapse

rates for clients with schizophrenia whose families received psychoeducational or behavioral interventions. Women with schizophrenia may respond better to certain medications than men (Goldstein et al. 2002), but this may be due to better medication compliance in women (Nasser et al. 2002).

Some symptoms of schizophrenia may be masked by drug use, which can cause the schizophrenic illness to be overlooked—particularly among young men in whom the illness is just emerging. Symptoms, such as blunted affect and other negative symptoms, poor interpersonal relationships, and poor self-care, may be seen as by-products of drug use, with the expectation that these symptoms will improve with abstinence. However, with schizophrenic illness, only temporary remission is typically seen, and the symptoms may even appear more pronounced with drug abstinence. Careful mental health evaluation is required for differential diagnosis and treatment planning.

Pathological Gambling

Pathological gambling is an impulse-control disorder characterized by “persistent and recurrent” gambling “that disrupts personal, family, or vocational pursuits” (APA 2000, p. 671). Two thirds of individuals with this disorder are men, in whom it typically begins at an earlier age (early adolescence) than in women (APA 2000). Men are more likely than women to be in treatment for pathological gambling or to attend Gamblers Anonymous (Ladd and Petry 2002; LairRobinson 1997). In fact, the DSM-IV-TR estimates that 96 to 98 percent of people in treatment for this disorder are men (APA 2000). Men who gamble pathologically are significantly more likely than men in the general population to have a co-occurring substance use disorder (Kessler et al. 2008; Scherrer et al. 2007).

Pathological gambling is more common among people with substance use disorders than among those who do not have such disorders. One study of 113 patients admitted to a gambling treatment program found that 66.4 percent had a lifetime incidence of a substance use disorder (Kausch 2003). Other researchers have found equally high or higher levels of co-occurring substance use and pathological gambling disorders, and problem gamblers who have alcohol use disorders may also have more severe gambling problems than those who do not abuse alcohol (Stewart and Kushner 2003). In a study of gambling treatment program admissions, gamblers with substance abuse treatment histories had more severe gambling problems than other participants, including greater number of years with a problem and greater number of days spent gambling in the month prior to treatment entry (Ladd and Petry 2003). Other risk factors for pathological gambling include lower socioeconomic status (SES), gambling at casinos, and participating in a greater number of different games of chance (Welte et al. 2004). Appendix D of TIP 42 (CSAT 2005c) addresses pathological gambling in clients with co-occurring substance use disorders.

Eating Disorders

Because of the relative rarity of eating disorders among men, many clinicians may not expect to see or may not recognize eating disorders in their male clients. However, studies show prevalence rates of bulimia in men from 0.1 percent to 2.1 percent (Makino et al. 2004). Two studies that administered the Eating Attitudes Test-26 found that 4 and 10 percent of the men in their respective samples had abnormal eating attitudes (Makino et al. 2004). General population studies have not measured the prevalence among men of anorexia nervosa (the other specifically diagnosable eating disorder). However, a study of 135

men with diagnosable eating disorders who were treated at a Boston hospital found 22 percent to be anorexic and 46 percent to be bulimic; 32 percent had an unspecified eating disorder (Carlat et al. 1997).

A study by Carlat and colleagues (1997) found that 37 percent of men with eating disorders had a co-occurring diagnosis of substance abuse or dependence. A large percentage of the men sampled were gay or bisexual: 27 percent of the total and 42 percent of the men with bulimia. Eating disorders are often related to poor body image (Shelton and Liljequist 2002), which is also associated with increased alcohol use and physical and verbal aggressiveness. Given these data, clinicians should expect to see men in treatment for substance use disorders who also have eating disorders, and they should be prepared to screen for these disorders and refer clients for treatment when warranted. TIP 42 (CSAT 2005c) explores the treatment of clients who have co-occurring substance use and eating disorders.

Even men who do not meet criteria for an eating disorder may develop disordered eating practices (e.g., binge eating, eating to regulate mood) in early recovery, and men in later recovery may feel distress about weight gain that occurs after they stop using substances (Cowan and Devine 2008).

Personality Disorders

The DSM-IV-TR (APA 2000) describes 10 different personality disorders, some of which seem to affect women more than men (i.e., borderline personality disorder, dependent personality disorder), some of which seem to affect the genders about equally (i.e., histrionic personality disorder, avoidant personality disorder), and some of which appear to affect men more than women (i.e., paranoid personality disorder, schizoid personality disorder, schizotypal personality disorder, ASPD,

Exhibit 4-2: Rates of Co-Occurring Personality Disorders Among Men With a Substance Use Disorder

Co occurring disorder	Men with a drug use disorder, %	Men with alcohol use disorder, %
Antisocial	8.5	3.5
Avoidant	5.7	2.4
Dependent	17.1	4.4
Histrionic	7.2	4.3
Paranoid	5.4	3.1

narcissistic personality disorder, obsessive compulsive personality disorder [OCPD]). The greatest gender differences are in ASPD, which affects at least three times as many men as women in the general population; OCPD, which affects twice as many men as women; and borderline personality disorder, which affects about three times as many women as men (APA 2000).

Recent epidemiologic research paints a somewhat different picture of the prevalence of personality disorders. NESARC, which surveyed over 43,000 adult men and women, found that OCPD was the most common personality disorder (affecting 7.9 percent of the population) and was about equally common for men and women. The survey excluded borderline, schizotypal, and narcissistic personality disorders because of the greater number of questions needed to assess for those disorders (Grant et al. 2005).

Grant and colleagues (2004b) reviewed NESARC data and found that avoidant, dependent, and paranoid personality disorders were significantly more common among women than men, but that men were more likely to have ASPD. They investigated the rates of co-occurring personality and substance use disorders and found that co-occurring personality disorders were much

more common among people with drug use disorders (47.7 percent) than among people who had alcohol use disorder (28.6 percent). Exhibit 4-2 depicts rates of co-occurring personality disorders among men with substance use disorders (Grant et al. 2004b).

Antisocial personality disorder

The National Comorbidity Study found that 5.8 percent of men (compared with 1.2 percent of women) had sufficient symptoms to warrant a diagnosis of ASPD at some point during their lifetimes (Kessler et al. 1994). NESARC found similar rates of 5.5 percent for men and 1.9 percent for women (Grant et al. 2004b). In a study by Klonsky and colleagues (2002), ASPD was associated with both self-endorsement of masculine attributes and peer reports of masculine attributes among a sample of male and female college students. In large-scale studies, 80 percent of ASPD cases in the general population are men; this may relate to impulsive aggression, which characterizes ASPD, being a trait more common to men than women (Paris 2004). Most ASPD symptoms are described in terms of male behavior, so women may be underdiagnosed if they have ASPD symptoms less likely to appear in diagnostic criteria, such as stealing from an employer or engaging in prostitution.

Studies of people in substance abuse treatment (Compton et al. 2000) and people with substance use disorders who are not in treatment (Falck et al. 2004) have found much higher rates of ASPD for both men and women. Moreover, rates of ASPD in treatment settings tend to be closer between genders than rates found in the general population (Millery and Kleinman 2001), and some researchers have even found slightly higher rates among women in treatment than among their male counterparts (Galen et al. 2000). NESARC's survey of the noninstitutionalized population showed

a stronger association between ASPD and substance use disorders in women than in men; however, this may be, in part, because men are overrepresented in criminal justice populations left out of the sample (Grant et al. 2004*b*).

Assessment of possible ASPD in substance abuse treatment clients can be confounding. Many clients have exhibited antisocial behavior during their drug use that does not justify an ASPD diagnosis. People may display antisocial symptoms in one context, such as prison, but not another. Diagnosis for ASPD is generally based on the client's history as well as his current behavior. Forrest (1994) describes some of the difficulties of and alternative approaches to differential diagnosis in his book, *Chemical Dependency and Antisocial Personality Disorder*.

Treatment of men with ASPD in substance abuse treatment settings can be difficult. In fact, certain elements of usual substance abuse treatment can make people with ASPD anxious and prone to act out in treatment. Often, substance abuse treatment emphasizes emotional sharing, personal disclosure, honesty, and confronting shame—all of which may feel provocative and overwhelming to men with ASPD. Clients who are antisocial may manipulate staff members and other clients, violate or flout program rules, be intentionally deceptive, shame or abuse others, attempt to control the treatment environment and, as a last resort, leave treatment early. As a result, people with ASPD may require special treatment that provides a safe and contained environment in which to manage their anxiety. In early treatment, counselors may need to emphasize controlling negative behavior and compliance with rules while downplaying emotional expression and interpersonal sharing, and they should establish clear consequences for violating program rules (though these might seem draconian in other treatment settings). Treatment programs for co-occurring ASPD and

substance abuse are often found in prison settings, but many clients who could benefit from such programs are not in prison. A community alternative is the establishment of long-term residential therapeutic communities (TCs), although not all TCs are appropriate for people with ASPD.

Suicidality

A variety of mental and substance use disorders can increase a man's risk for committing suicide; therefore, although it is not a disorder *per se*, suicidality must be addressed. Women are three times more likely to *attempt* suicide than men, but men are more than four times as likely to die from suicide (NIMH 2001). In fact, researchers have found this to be true across cultures, with a few notable exceptions, such as mainland China (Arsenault-Lapierre et al. 2004). The highest rate of completed suicide among any demographic group occurs in White American men ages 65 and older (U.S. Public Health Service 1999). Higher rates of suicide completion among men may result, in part, from the deadlier methods men typically choose for suicide. For example, 79 percent of all suicides using firearms are committed by White men, and firearms are involved in most (58 percent) completed suicides (Antai-Otong 2003). Additionally, men tend to perform fewer suicidal acts but exhibit a higher intent to die (Nock and Kessler 2006).

Substance use and abuse are major risk factors for suicide; men with substance use disorders have high rates of death by suicide (Wilcox et al. 2004). Approximately 30 to 40 percent of suicide attempts and completed suicides involve acute alcohol intoxication (Cherpitel et al. 2004). Substance-related problems appear to be more often associated with suicide in men than in women, suggesting an even greater need to screen for suicidality among men in treatment (Arsenault-Lapierre et al. 2004).

Co-occurring mental disorders increase the likelihood of suicide even more than substance abuse alone: depression, schizophrenia, bipolar disorder, and personality disorders all increase the chances that someone will both attempt and complete suicide (Arsenault-Lapierre et al. 2004; Blumenthal 1988). Other factors, such as certain physical ailments (e.g., epilepsy, cancer, Huntington’s chorea) and a family history of suicide, also appear to increase the likelihood of suicide (Blumenthal 1988).

Rates of death by suicide vary by race and ethnicity. Exhibit 4-3 depicts age-adjusted rates of suicide per 100,000 individuals in the year 2006 according to the Centers for Disease Control and Prevention’s (CDC’s) National Center for Injury Prevention and Control (NCIPC; 2009).

Appendix D of TIP 42 (CSAT 2005c) recommends that all substance abuse treatment clients receive at least a basic screening for suicidality and notes a particularly high risk among clients who have relapsed to substance use after an extended period of abstinence. TIP 42 (Chapter 8 and Appendix D) also lists key questions for evaluating suicide risk and provides other information on this topic.

TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT 2009a), provides more data on suicide by men and women with substance use disorders as well as information on and case studies relating

to addressing this issue in substance abuse treatment. TIP 50 proposes that counselors use a four-step screening and intervention process with clients who may be suicidal: (1) Gather information, (2) Access supervision, (3) Take responsible action, and (4) Extend the action. These steps, known by the acronym GATE, are described in the text box on the next page.

Men With Physical Health Problems

Men with substance use disorders are at increased risk for a wide range of medical conditions either caused or exacerbated by their substance use, including various cancers, cardiovascular and pulmonary conditions, neurological problems, gastrointestinal disorders, endocrine syndromes, and hepatic disorders (Mannelli and Pae 2007; Ries et al. 2009; Saitz 2009). They are also at increased risk for infectious diseases, including viral hepatitis (see TIP 53, *Addressing Viral Hepatitis in People With Substance Use Disorders* [SAMHSA 2011a]) and HIV/AIDS (see the “Men With HIV/AIDS” section on p. 84 of this TIP; see also TIP 37, *Substance Abuse Treatment for Persons With HIV/AIDS* [CSAT 2000c]). Some such illnesses (e.g., liver cirrhosis) may result directly from the substances used, whereas others (e.g., HIV/AIDS) may result from the method of drug administration or the lifestyle that accompanies substance abuse.

Exhibit 4-3: Age-Adjusted Rates of Suicide per 100,000 Individuals in 2006 by Race/Ethnicity

	White	Latino	African American	Asian American/ Pacific Islander	Native American
Men	19.62	8.87	9.40	8.07	18.28
Women	5.06	1.84	1.39	3.46	5.08

Source: NCIPC 2009.

An Overview of GATE

G: Gather information. There are two steps to gathering information: (1) screening and spotting warning signs and (2) asking follow-up questions. Screening consists of asking brief, uniform questions at intake to determine if further questions about suicide risk are necessary. Spotting warning signs consists of identifying telltale signs of potential risk. Counselors should ask follow-up questions when clients respond “yes” to one or more screening questions or whenever they notice a warning sign. Asking follow-up questions elicits as much information as possible so that counselors and their supervisors and/or treatment teams can develop a good plan of action. Counselors should provide as much information as possible to other providers upon referring their clients to them.

A: Access supervision and/or consultation. Counselors should never attempt to manage suicide risk alone in clients, even if they have substantial specialized training and education. With suicidal clients, two or three heads are almost always better than one. Therefore, counselors should speak with a supervisor, an experienced consultant who has been vetted by their agency, and/or their multidisciplinary treatment team when working with a suicidal client. It is a collective responsibility, not the counselor’s alone, to formulate a preliminary impression of the seriousness of risk and to determine the action(s) that will be taken. Accessing supervision or consultation provides invaluable input that promotes the client’s safety, gives counselors needed support, and reduces personal liability.

T: Take responsible action(s). A counselor’s action(s) should be responsible and make good sense in light of the seriousness of a client’s suicide risk. Some of the potential actions (which cover a range of intensity and immediacy) that counselors and their supervisors or teams may take include:

- Gather more information from the client to develop an accurate clinical picture and treatment plan.
- Gather additional information from other sources (e.g., spouse, other providers).
- Arrange a referral:
 - To a clinician for further assessment of suicide risk.
 - To a counselor for behavioral health counseling.
 - To a provider for medication management.
 - To an emergency provider (e.g., hospital emergency department) for acute risk assessment.
 - To a mental health mobile crisis team that can provide outreach to a client at his or her home (or shelter) and make a timely assessment.
 - To a more intensive substance abuse treatment setting.
- Restrict access to means of suicide.
- Temporarily increase the frequency of care, including more telephone check-ins.
- Temporarily increase the level of care (e.g., refer to day treatment).
- Involve a case manager (e.g., to coordinate care, to check on the client occasionally).
- Involve the primary healthcare provider.
- Encourage the client to attend (or increase attendance) at 12-Step meetings.
- Enlist family members or significant others (selectively, depending on their health, closeness to the client, and motivation) in observing signs of a return of suicide risk.
- Observe the client for signs of a return of risk.

Upon a return to acute suicidality, create a safety card with the client. TIP 50 (CSAT 2009a, p. 21), describes this process.

E: Extend the action(s). Too often, suicide risk is dealt with once, in acute fashion, and then forgotten. As with substance abuse, vulnerable clients may relapse into suicidality. Thus, counselors need to continue to observe and check in with clients to identify any possible return of risk. Another common problem is referring a suicidal client but failing to coordinate or follow up with the provider. Suicide risk management requires a team approach, and a client’s substance abuse counselor is an essential part of this team. A counselor should document all actions taken to create a medical and legal account of the client’s care: what information was obtained, what actions were taken and when, and how follow-up on the client’s substance abuse treatment and suicidal thoughts and behaviors was conducted. This record can be useful for supervisors, consultants, the counselor’s team, and other providers.

Source: CSAT 2009a, pp. 14–15. Adapted from material in the public domain.

The consensus panel recommends that all clients entering substance abuse treatment programs have a thorough physical examination with appropriate laboratory studies. Programs should also provide medical services or link to such services; doing so can improve recovery outcomes for clients (Friedmann et al. 2003, 2009). Integrated medical care results in better abstinence outcomes than independent but linked services (Weisner et al. 2001), and onsite services result in better use of medical care than offsite services (Friedmann et al. 2001).

Men With HIV/AIDS

The HIV/AIDS epidemic is not uniform in distribution; prevalence varies considerably across the country, not only from region to region, but also within regions, States, and even communities. However, men have consistently been more affected by HIV/AIDS than women. CDC's *HIV/AIDS Surveillance Report* estimates that, in 2007, men ages 13 and older made up 74 percent of current HIV/AIDS cases and 73 percent of cases diagnosed in that year (CDC 2009). Between 2003 and 2006, the number of HIV/AIDS cases increased approximately 5 percent for men but decreased 6 percent for women.

Encouraging men at risk for HIV/AIDS infection to obtain counseling and testing is a priority. In men, HIV/AIDS is most often transmitted by men having sex with other men, but injection drug use is the second most common transmission method among men (CDC 2009). Men who have sex with men may also engage in substance abuse and are more likely to have unprotected sex if under the influence (Purcell et al. 2001). About 17 percent of men ages 13 and older who had HIV/AIDS in 2006 may have acquired the disease by injecting drugs (CDC 2008b).

Men with HIV/AIDS can have great difficulty accessing services. The added complication

of a substance use disorder can create even more troublesome barriers to seeking treatment. Societal attitudes toward men with HIV/AIDS in particular areas of the country, such as certain rural communities, can contribute to even larger gaps in service for this population (Heckman et al. 1998; Shernoff 1996). For more information on HIV/AIDS and substance abuse treatment for men who are HIV positive, see TIP 37 (CSAT 2000c).

Stigma can make men reticent about discussing their HIV/AIDS status with counselors. Clinicians who know that a client is HIV positive should speak privately with him about whether he wishes to identify as such to other group members. Counselors should caution clients of the possible negative effects of disclosure even in a treatment setting and help them carefully consider pros and cons.

Men With Physical Disabilities

Men with disabilities may experience more prejudice than other men because their disabilities keep them from meeting cultural expectations about male bodies and behavior. This causes gender role stress and makes it difficult for some men with disabilities to fulfill certain socially defined gender roles. Men are socialized from an early age to be active, independent, tough, self-confident, athletic, and self-reliant—but having a disability can limit a man's ability to satisfy some or all of these roles (Marini 2001). Society typically views people with disabilities as helpless, incapable, and inferior (Lyons 1991). Ironically, for many men with severe disabilities, their substance use, even though problematic, may represent one of the last masculine behaviors remaining available to them. TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998e), provides information on substance abuse treatment for people with physical disabilities.

Traumatic Brain Injury

Men are at higher risk for violence in our society, and therefore, they are also at higher risk for traumatic brain injury (TBI). TBI results from a sudden blow to the skull due to collision (causing a concussion), sudden penetration of the skull, blast pressure waves, or the head being thrust out of position. The injury may damage a specific part of the brain or diffuse throughout the brain tissue.

TBI symptoms can be subtle and thus go unrecognized in many people; moreover, the symptoms are often similar to those caused by other problems, resulting in misdiagnosis. TBI symptoms may last only a few days or weeks, or they may be permanent. Even mild TBI can produce long-lasting cognitive and behavioral effects that significantly impair substance abuse recovery. For instance, a person's ability to accept and integrate information in treatment may be compromised by TBI. The injury may also cause the person to act impulsively without being able to explain why. TBI symptoms can include:

- Motor, sensory, and emotional effects.
- Dizziness, lightheadedness, or vertigo.
- Fatigue or lethargy.
- Gait disorders.
- Headaches and other pain symptoms.
- Nausea.
- Difficulty regulating emotions.
- Sleep disturbances.
- Weakness.
- Cognitive problems.
- Executive function problems affecting one's ability to organize thoughts and plans, follow through on intentions, do abstract reasoning, solve problems, make judgments, or read.
- Impaired attention and concentration.
- Language and communication impairments.
- Reduced cognitive speed and endurance.
- Reduced multitasking ability.
- Worsened memory.
- Impulsive, disruptive, or inappropriate behavior.
- Aggression and irritability.
- Apathy or lack of spontaneity.
- Personality changes.
- Anxiety.
- Lack of self-awareness (including lack of awareness of cognitive deficits).
- Sensory impairments (e.g., blurred vision, sensitivity to light, ringing ears, itching).

Treatment should be adapted to meet the specific needs of clients with TBI:

- Modify psychoeducational and cognitive-behavioral counseling approaches to be sure that clients with TBI are able to incorporate the information.
- Adapt treatment to accommodate the shorter attention span of clients with TBI.
- Help clients develop and implement coping strategies to manage everyday functioning, such as making lists, managing stress, and asking for the support of others.
- Note that inappropriate affective responses (e.g., anger disproportional to stimulus) may be symptoms of TBI.
- Educate the client about TBI, its symptoms, and its effects.
- Work with families to assist clients in their recovery from both TBI and substance use disorders.

These resources provide more information on recognizing and treating clients with TBI:

- TIP 29, available at the SAMHSA Store (<http://store.samhsa.gov>)
- National Institute of Neurological Disorders and Stroke (<http://www.ninds.nih.gov/disorders/tbi/tbi.htm>)
- Brain Injury Association of America (<http://www.biausa.org>)
- Brainline.org (<http://www.brainline.org>)
- NCIPC's Traumatic Brain Injury Web site (<http://www.cdc.gov/TraumaticBrainInjury/index.html>)
- Defense and Veterans Brain Injury Center (<http://www.dvbic.org>)
- The National Institute of Neurological Disorders and Strokes' Traumatic Brain Injury Information Web site (<http://www.ninds.nih.gov/disorders/tbi/tbi.htm>)
- *Anger Management for Substance Abuse and Mental Health Clients: A Cognitive Behavioral Therapy Manual* (also available in Spanish), available at the SAMHSA Store (<http://store.samhsa.gov>)
- *Anger Management for Substance Abuse and Mental Health Clients: Participant Workbook* (also available in Spanish), available at the SAMHSA Store (<http://store.samhsa.gov>)

Source: CSAT, 2010b. Adapted from material in the public domain.

Men From Different Age Groups

Young men often feel great pressure to show their masculinity. As men grow older, their beliefs about masculinity and the social expectations for masculine behavior change. Similarly, men's substance use/abuse often changes over the course of their lives. Age, therefore, can be a significant factor in determining substance abuse patterns and appropriate treatment for substance abuse.

Specific Needs of Younger Men Entering Treatment

Young adult men, typically defined as men ages 18 to 24 (Park et al. 2006), have issues related to masculinity and substance abuse that distinguish them from men in other age groups. Drug and tobacco use, binge drinking, and recent illicit drug use are most common in this age group and are more common for men in this age group than for women (Park et al. 2006). In this age group, men are three times more likely than women to die, and high rates of death by automobile crashes, homicide, and suicide account for much of the difference (Park et al. 2006; Pollack 2010). Among young men in certain cultural/ethnic groups (notably Native American and African American men), rates of violent death are considerably higher. Frequent or binge alcohol use and frequent drug use have been associated, in diverse samples of young men, with increased risk for being the victims of violence; these behaviors appear to increase young men's likelihood of being perpetrators of violence as well (Cooper et al. 2000; Friedman et al. 1996; Richardson and Budd 2003).

For both younger and older adults, binge drinking has been associated with significant alcohol-related problems, and men (15 percent) are more likely than women (4.7 per-

cent) to binge drink (Blazer and Wo 2009a). In one study, younger men were five times as likely to be involved in fighting or violent crime and seven times as likely to break or damage something as their counterparts who drank less frequently and did not binge drink (Richardson and Budd 2003).

High rates of substance use/abuse and violence may reflect the fact that young men are often less secure about their masculinity than older men and therefore may feel a greater need to engage in behaviors that supposedly prove their masculinity to others. Take, for example, the elevated death rate by automobile collision among men in this age group. This results largely from the fact that young men are the least likely of men in any age group to use seatbelts and the most likely of men in any age group to be in a crash in which at least one driver is alcohol impaired (Park et al. 2006). Young men also engage in a variety of other high risk behaviors. For example, young men who inject drugs are more likely to engage in practices that put them at high risk for contracting HIV (Rondinelli et al. 2009).

Heavy drinking and illicit drug use can be seen as high risk behaviors that young men engage in, in part, to demonstrate their masculinity. Research by Peralta (2007) found that most undergraduate students (both male and female) agreed that drinking was generally perceived as an activity that expressed masculinity. More White American (76 percent) than African American (53 percent) students held this belief, suggesting that cultural background influences attitudes about masculinity and drinking. Students interviewed for the study spoke of the beliefs that being able to hold your liquor was a sign of masculinity and that bouts of heavy drinking were rites of passage for men (but not women).

Other types of substance use may also be perceived, in certain cultural contexts, as ways of

expressing masculinity. Brown (2010) evaluated methamphetamine use among young Native American and White American men in Appalachia and found that use of the drug was linked with a strong masculine identity, but admitting that one had a problem with the drug (e.g., by entering treatment) was considered a sign of weakness. In other contexts, success in the drug trade is also considered an expression of a strong masculine identity (Bourgois 2003).

Young men may have some unique substance abuse treatment needs, although these vary according to cultural and sociodemographic factors. For example, young men who have made a living from the drug trade or other criminal activity may need vocational training and help finding a job, whereas college students in recovery value alcohol-free housing (i.e., dorms) and social activities (Bell et al. 2009).

Young men often enter treatment under coercion (by family, the criminal justice system, schools, and/or employers), and thus more effort may be needed to help them move from an early stage of readiness for change (precontemplation) toward embracing and accepting abstinence. The largest single source of treatment referrals for individuals (both male and female) in this age group is the criminal justice system, which accounted for 52 percent of first-time admissions and 46 percent of return admissions in 2006; the percentages for men alone are likely higher (SAMHSA, OAS 2008a). In comparing young adults to those ages 26 to 45 in a largely (85 percent) male, probation-referred treatment population, Sinha and colleagues (2003) found that young adults were significantly more likely to be in precontemplation but significantly less likely to be in contemplation, determination, or maintenance stages than adults ages 26 to 45. Young adult male clients may also be more resistant to involvement in mutual-help

groups, especially when groups specifically for younger people are unavailable. Transference-related issues can arise for younger clients who have older counselors. Some transference may be positive and useful for treatment, but much may be negative, causing clients to rebel against the advice and support of older counselors.

Data on substance abuse treatment programs specifically geared toward young adult men are limited, but various program models have been tried with this population (including gender-specific programming), particularly in criminal justice settings. Research into TCs (see Chapter 5) shows that young adult men are less likely than other clients to be involved with or integrated into the TC (Chan et al. 2004), perhaps because they have a greater need to rebel against the high degree of structure offered by TCs. Even so, this should not disqualify the TC approach, which has been found useful for young men (more so than older men) in prison settings (Messina et al. 2006).

Data suggest that adults who begin using substances at a younger age are more likely to be classified as substance dependent when they get older than those who start using substances later in life. Some boys start using alcohol or tobacco in the fifth or sixth grade or even earlier (SAMHSA 2005; Vega et al. 1993). Boys may start to use substances at an especially early age because of factors in their school environments, such as availability of drugs on or near the school campus (National Institute on Drug Abuse 1999), or because of substance abuse in their homes.

Specific Needs of Older Men Entering Treatment

Men 55 years of age and older often decrease or end their alcohol and drug use, and their rates of substance use disorders decline as well. A number of factors contribute to these changes, including early mortality among

individuals who drink heavily and/or use illicit drugs, negative effects of substances on medical problems, additional medical problems caused by substance use, decreased desire to use, potential financial strain, and less participation in social events and activities focused on substance use (Menninger 2002). However, other factors, such as loneliness and depression, may cause some older adults to increase their drinking (Capraro 2000; Strowig 2000). Some of these factors may affect men and women differently. For example, older men seem less concerned than older women about the effects of alcohol on their health (Satre and Knight 2001), which may help explain why older age is associated with greater decreases in alcohol consumption for women than for men (Satre and Areán 2005).

In SAMHSA's 2007 National Survey of Drug Use and Health (NSDUH), a survey of the general U.S. population ages 12 and older, 2.6 percent of men ages 65 and older met criteria for a past-year alcohol use disorder (U.S. Department of Health and Human Services [HHS], SAMHSA, OAS 2008a). Other studies have found higher rates (see review in Satre and Areán 2005). Also in the 2007 NSDUH, a greater percentage of men than of women over the age of 65 reported drinking more than the amount recommended by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), which is no more than one drink per day for older men (NIAAA 2005). Among those ages 65 and older who reported drinking at least one drink in the prior month, 48.7 percent of men reported more than one drink per day compared with 28.7 percent of women; 17.7 percent of men reported more than two drinks per day (HHS, SAMHSA, OAS 2008a). Although rates of alcohol abuse/dependence declined with age for both men and women, the extent of that decline was greater for women than for men. In the 2007 NSDUH, men ages 65 and older

were 37.5 times more likely to not have a past-year alcohol problem than to have one; women in the same age group were 249 times more likely (HHS, SAMHSA, OAS 2008a).

Data from SAMHSA's 2005 and 2006 NSDUH surveys (Blazer and Wu 2009a) show that men ages 65 and older were more likely to engage in binge drinking if they had higher incomes; were separated, widowed, or divorced; smoked; and/or used illicit drugs. As with younger men, men ages 65 and older were significantly more likely to binge drink (14 percent) than were women (3 percent). Research with older adults who have completed treatment also shows that older men have greater difficulty than older women maintaining abstinence after substance abuse treatment (Satre et al. 2004a; Satre et al. 2004b).

Although published data on the abuse of substances other than alcohol by adults older than 55 is limited, many researchers have raised concern about the misuse and abuse of prescription drugs by this population (Blazer and Wu 2009b; Simoni-Wastila and Yang 2006). Some studies describe prescription drug abuse as less common among older men than older women (Simoni-Wastila and Yang 2006); others conclude the inverse specifically for pain medication (Blazer and Wu 2009b). For more information, see SAMHSA's *Get Connected! Linking Older Adults With Medication, Alcohol, and Mental Health Resources* toolkit (2003). Also see TIP 26, *Substance Abuse Among Older Adults* (CSAT 1998d), which recommends that substance abuse treatment programs for both male and female older adults:

- Make use of age-specific groups that are supportive and nonconfrontational and work to build or rebuild the client's self-esteem.
- Focus on coping with depression, loneliness, and loss.
- Help older clients rebuild social support networks.

- Have pacing and content that reflect the needs of older people.
- Use staff members interested and experienced in working with older people.
- Integrate/link to medical services, older adult services, and other services used by older adults.

Gay and Bisexual Men

Gay and bisexual men generally have higher rates of substance use and substance use disorders than heterosexual men, although some research indicates that the rates are becoming more similar between these groups (Cochran et al. 2000). NESARC data showed that men who self-identified as gay were 4.4 times as likely as heterosexual men to have used marijuana in the past year, 3.5 times as likely to have used other drugs, 2.9 times as likely to have past-year alcohol dependence, and 4.2 times as likely to have past-year dependence on a drug other than marijuana (McCabe et al. 2009). Odds ratios for bisexual men, compared with heterosexual men, were even greater. Cochran and colleagues (2006) found that men with male partners were significantly more likely than men with female partners to report lifetime illicit drug use (72.8 percent and 54.6 percent, respectively) and were 2.4 times as likely to meet criteria for problematic drug use.

Gay and bisexual men entering substance abuse treatment, compared with heterosexual men, report more frequent use of their primary substance of abuse and are more likely to primarily abuse methamphetamine, to have had prior hospitalization for mental health issues, to be homeless, and to report being victims of domestic abuse; they are less likely to primarily abuse alcohol or marijuana or to have current legal problems (Cochran and Cauce 2006). However, gay and bisexual men are significantly more likely than heterosexual

men to seek treatment for substance use and/or mental disorders (Grella et al. 2009a).

Much of the disparity in alcohol and drug consumption rates between gay/bisexual and heterosexual men may be connected to the fact that, within gay culture, clubs, bars, and parties at which alcohol and drugs are consumed continue to be important and widely used social outlets (CSAT 2001; Weidel et al. 2008). *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (CSAT 2001) provides more information on substance abuse treatment for gay and bisexual men. It recommends that clinicians be sensitive to gay cultural norms, prejudices against gay men, and social expectations related to gay culture that may affect substance use.

The sexual orientation of both client and counselor can complicate the issue of gender bias in the therapeutic relationship. For example, a gay male substance abuse client may expect that a straight male counselor, due to his own socialization and bias, will be judgmental and potentially shaming. As a result, gay men in substance abuse treatment settings may be more cautious about coming out and discussing issues related to relational/social aspects of their substance abuse experiences or their primary relationships. As with gender considerations, the sexual orientation of the client and counselor should be considered when assigning counselors to substance abuse treatment clients. Gay male clients may feel more comfortable working with a woman or a gay male counselor. If a gay client is matched with a gay counselor, the issue of sexualized transference will most likely need to be addressed. It is not always possible to match clients and counselors with regard to sexual orientation, so counselors need to explore and challenge their own sexual orientation biases and beliefs to work

effectively with gay men in substance abuse treatment settings.

Men With Employment or Career-Related Issues

Employment-related issues (e.g., type of job, lack of employment) can strongly affect men's substance use/abuse, and men with substance use disorders are at greater risk for unemployment. The link between SES and substance abuse is more complex (see text box below).

For men who are employed, their type of profession may affect the pattern and extent of their substance use. For example, research has shown a relationship between drinking and having positions that are typically male dominated. Men who work in “precision production, craft, and repair jobs, and those who [a]re operators, fabricators, and laborers” have higher rates of alcohol use and dependence (OAS 2002, p. 3), and those in physically risky positions (e.g., maintaining heavy machinery, operating light machinery, working with hazardous chemicals) are more likely to use substances than those in less risky positions (Lehman and Bennett 2002).

In some professions, use of certain substances (usually alcohol) is considered normal behav-

ior and not using is seen as anomalous among men. In treatment, this can be an issue for men who must decide whether to return to a job or type of employment that may, in some ways, promote drinking or drug use. It may be difficult for a man to return to such a work setting, but it can be equally as difficult for him to leave a career that has helped define who he is. Counselors may find it useful to discuss work-related concerns with clients and to use role-playing and other methods to help them develop strategies for avoiding substance use at work or in other settings where they may feel pressure to use.

Whether a client has a job or not, employment and work-related issues should be addressed in treatment. Ask male clients about positive and negative aspects of work in their lives and talk with them about their work-related goals. Doing so may help them see how substance abuse has affected their work and how recovery can positively influence their careers and offer other means for fulfillment (Lyme et al. 2008).

Some men with jobs do not have insurance or sick leave to use for treatment, or they are unwilling to seek treatment for fear of risking their employment. In SAMHSA's 2007 NSDUH, men who needed substance abuse treatment were more than 16 times as likely as

Socioeconomic Status and Men's Substance Abuse

Research on men's economic class and its relation to substance abuse usually focuses on men with lower SES. This may be because men of lower SES are overrepresented in substance abuse treatment populations, particularly those receiving public funds. However, data supporting the claim that men of lower SES are more likely to abuse substances are inconsistent at best. The relationship of substance use and abuse to SES appears to depend, in part, on the type of substance involved. For example, surveys consistently show that men living below the poverty line are more likely to smoke cigarettes than those with higher incomes (CDC 2004), and research has associated past-year marijuana use with lower incomes and unemployment (Robertson and Donnermeyer 1998). People of lower SES are also more likely to have drinking-related problems (Crum 2003) despite greater consumption of alcohol being associated with higher socioeconomic status (Casswell et al. 2003; van Oers et al. 1999). SES apparently interacts with other factors (e.g., age, gender, acculturation) to influence alcohol consumption. Changes in income or status may also affect substance use and abuse; men who unexpectedly or unwillingly move from a higher to a lower SES can experience anxiety and depression, which are associated with substance use and abuse (Hemmingson et al. 1999; Timms 1998).

women who needed treatment to express concern that entering treatment would affect their jobs (HHS, SAMHSA, OAS 2008a).

Men Who Are Unemployed

Men without jobs have a surplus of time—and sometimes, too few constructive activities with which to fill it. Men, who are traditionally expected to be the breadwinners in American society, often experience lowered self-esteem as a result of unemployment, which can lead to despair and hopelessness. Men who have lost a job often increase their alcohol consumption (Dooley and Prause 1998). When a man loses his job, is demoted, or loses social status in some other way, the resulting anxiety may lead him to use problematic coping techniques, such as substance use (Liu 2002).

Men who are unemployed are more likely to be currently using a substance than those with full-time jobs, and people with substance use disorders are more likely to be unemployed than the general population (Platt 1995). According to 2003 data, 18.2 percent of unemployed adults were currently using illicit drugs compared with 10.7 percent of those employed part time and 7.9 percent of those employed full time. Current alcohol use was slightly greater among people with jobs, but heavy use (five or more drinks on five or more occasions in the past month) was greater among those without jobs (OAS 2004b).

Men entering substance abuse treatment are more likely to be unemployed than employed. Data from 2006 showed that 68 percent of men admitted to substance abuse treatment programs that received State agency funds were unemployed or not in the labor force (HHS, SAMHSA, OAS 2008a). Unlike men with jobs, who are sometimes willing to seek substance abuse treatment to keep their positions, men who are unemployed may lack im-

portant help-seeking resources like employee assistance programs and health insurance.

Employment has been correlated with successful treatment outcomes (Platt 1995). A study by Arndt and colleagues (2004) found a positive association between abstinence and full-time employment for men after treatment. For more information on the relationship between employment and treatment success, as well as integrating vocational training into substance abuse treatment programs, see TIP 38, *Integrating Substance Abuse Treatment and Vocational Services* (CSAT 2000a).

Men Who Are Veterans

In 2006, veterans accounted for over 66,000 admissions (4.9 percent of total admissions) to substance abuse treatment programs tracked by SAMHSA's Treatment Episode Data Set (TEDS); most (91.4 percent) were men. The most common source of referral for male veterans, as it is with all men, is the criminal justice system, accounting for 36.7 percent of admissions (HHS, SAMHSA, OAS 2008a).

Estimated rates of substance abuse are similar for veterans and nonveterans, but male veterans receiving treatment are more likely than male nonveterans to report alcohol as the primary substance of abuse (59 percent and 40.4 percent, respectively; HHS, SAMHSA, OAS 2008a). Veterans treated in VA facilities (see advice box on the next page) have significantly more problems than patients in non-VA facilities with employment, education, legal issues, and co-occurring mental and medical disorders (Veterans Health Administration 1996). Furthermore, VA programs serve a large number of veterans who are homeless, many of whom have co-occurring substance abuse and mental disorders (Kasprow et al. 1999). About 50 percent of VA substance abuse treatment program clients also have one or more co-occurring mental disorders (Tracy et al. 2004).

Advice to Behavioral Health Clinicians: Accessing VA Services

To be eligible for treatment in the VA system, veterans must have served in the U.S. Armed Forces and received an honorable military discharge or general discharge under honorable conditions, subject to minimum duty requirements. VA substance abuse treatment facilities provide inpatient, residential, and outpatient services. A variety of VA programs exist to help veterans who are homeless obtain health care, vocational rehabilitation, job training, and transitional or permanent housing.

Veterans can be referred to VA services by any treatment provider and can register for services via the member services office at their local VA facility. They must bring a copy of their discharge papers and may be charged a copay if their annual gross income exceeds a given amount (exceptions being any veteran who served in Vietnam or has a service-connected disability). To reach veterans in rural or remote areas, the VA has community-based outpatient clinics linked to major VA medical centers.

For more information on how to access VA services, find local VA resources, and so forth, visit VA's "New to VA" Web site (<http://www1.va.gov/opa/newtova.asp>). Real Warriors also offers numerous resources for veterans (<http://www.realwarriors.net/veterans/treatment/substanceabuse.php>; 1-866-966-1020), including opportunities to speak over the phone or chat live on the Web with a trained health resource consultant at the Defense Centers of Excellence Outreach Center.

An analysis of data from the National Survey of Homeless Assistance Providers and Clients found that, for clients who are homeless, being male increased the odds of having an alcohol problem by nearly 3 times, whereas being a veteran increased the odds by 1.3 times (Dietz 2007). Being male and/or a veteran similarly affected the odds of having a drug problem.

Men With Systems-Related Needs

Men enter treatment with multiple needs, as their substance abuse has likely affected every aspect of their lives. Often, a man's behavior involves him with a system (e.g., the criminal justice system) that may require his treatment providers to interact with that system. In other cases, other systems may be required to provide for a man's specific needs (e.g., housing). Some such systems (medical services, VA services, and vocational rehabilitation) have already been covered in this TIP; two more that involve many men in treatment (housing and homelessness services and the criminal justice system) are discussed in the following sections.

Men Who Are Homeless

It is difficult to ascertain the total number of men who are homeless in the United States; nevertheless, the National Survey of Homeless Assistance Providers and Clients (the largest survey of its kind) found that 61 percent of adults who were homeless and sought services in 1999 were men living alone. Another 24 percent were men living with another person. Of men in the survey who were homeless, 33 percent were veterans (Burt et al. 1999).

Men also make up a large percentage of adults who are homeless and seek treatment for substance abuse. In SAMHSA's 2006 TEDS study, men comprised 75.6 percent of individuals who were homeless and entered substance abuse treatment programs that received funding through State agencies (HHS, SAMHSA, OAS 2008*b*). Substance use disorders are especially common among men who are chronically homeless; according to one study, they occur in 84 percent of men compared with 58 percent of women (North et al. 2004).

Burt and colleagues' (1999) review of data from programs that provide homelessness services

found that 73 percent of clients were male. Out of the total client population, 66 percent reported at least one alcohol, drug, or mental problem in the month prior to their interview, 74 percent reported such a problem in the past year, and 86 percent reported a problem at some time during their lives. Alcohol was the most commonly abused substance; 38 percent of clients reported alcohol problems in the past month, 46 percent reported such problems in the past year, and 62 percent reported problems with alcohol during their lifetime. In terms of other substances of abuse, 26 percent of clients reported a drug problem during the past month, 38 percent during the past year, and 58 percent during their lifetimes.

In a large survey, 46 percent of men who were homeless reported alcohol problems, whereas only 22 percent of women who were homeless did; men were also 50 percent more likely to report a problem related to illicit drugs (Burt et al. 1999). Men who are homeless are more likely than other men to have various concurrent problems ranging from high levels of shame and low self-esteem to HIV/AIDS and co-occurring disorders.

A number of specific treatment interventions are considered promising for clients who are homeless, including modified TCs, intensive outpatient programs, contingency management approaches, motivational enhancement techniques (e.g., motivational interviewing), the provision of transitional and supportive housing for individuals who were formerly homeless, and intensive case management (Begun 2004; Zerger 2002). Treatment retention is a particular problem for providers working with men who are homeless (see advice box below). For more on substance abuse treatment for clients who are homeless, see TIP 55, *Behavioral Health Services for People Who Are Homeless* (SAMHSA 2013).

Researchers have noted the potential benefits of gender-specific treatment for women who are homeless and have substance use disorders (Zerger 2002). However, despite the fact that men who are homeless outnumber women who are homeless in treatment 4 to 1, little research has been done to determine the best interventions for this specific population. Kraybill and Zerger (2003) reviewed six substance abuse treatment programs for clients who are homeless that they recognized as

Advice to Behavioral Health Clinicians: Increasing Retention Among Clients Who Are Homeless

Traditional substance abuse treatment models are often ineffective for individuals who are homeless. Dropout rates of two thirds or more are seen in this population; thus, engagement and retention are areas that any program working with men who are homeless must address.

Based on the experiences of eight NIAAA grantees providing treatment to men and women who were homeless (six of which served a primarily male client base), Orwin and colleagues (2001) suggested the following ways to increase retention:

- Eliminate/decrease waiting periods.
- Strengthen the orientation process (involving a longer and more intensive orientation period).
- Increase the level of client involvement with case managers.
- Make the program more accessible.
- Improve the program environment (e.g., make it more welcoming).
- Respond to the specific needs of the population (e.g., provide gender-specific services for men and women, respond to client feedback).
- Increase opportunities for recreational and educational activities.
- Put more effort into relapse prevention.

providing effective services; one of these, Casa Los Arboles (a component program of Albuquerque Health Care for the Homeless), provides services specifically to men. This 6- to 9-month intensive inpatient program uses staff members recovering from substance abuse, intensive case management, and a slow process of transition to independent living for clients. In the orientation phase, which lasts 45 days, clients cannot leave the premises on their own—this and other privileges are introduced slowly. Overall, the program is much more rule-bound than the equivalent program for women at Albuquerque Health Care for the Homeless.

Men Involved in the Criminal Justice System

Men who require treatment for substance use disorders may hesitate to seek services out of fear that acknowledging and seeking help for problems with substances may complicate their legal difficulties; they may fear that their insurance providers will consequently refuse to pay for treatment or that they will be turned over to legal authorities. Other men may be reluctant to acknowledge a history of arrest and incarceration and may fear that this information will be revealed if they enroll in a treatment program. Thus, many men may resist needed care. Behavioral health counselors should not offer legal advice, but they can help clients recognize when to seek professional legal counsel and can refer them appropriately.

Men are more likely than women to be involved in the criminal justice system, and this is reflected in referrals to substance abuse treatment from this system. In 2006, referrals from the criminal justice system accounted for 41.7 percent of all men entering substance abuse treatment programs that received public funds (compared with 30 percent of all women entering treatment), making it the largest single source of referral for men entering substance abuse treatment (HHS, SAMHSA,

OAS 2008a). In addition to the many substance abuse treatment programs available for men who are incarcerated, 28 percent of all programs in 2006 offered services for criminal justice clients other than those convicted of driving under the influence (SAMHSA, OAS 2007a). TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System* (CSAT 2005b), provides more information on treatment options available for men in the criminal justice system. TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* (CSAT 1998b), offers information on working with clients who are making the transition from criminal justice institutions to the community.

Men involved in the criminal justice system may be affected differently than women by certain factors. For example, a large study of men and women treated in prison-based TCs found that men who were employed prior to incarceration were significantly less likely to return to custody in the 2 years after treatment than those who were unemployed, which was not the case for women (Messina et al. 2006). However, men who were employed were also less likely to enter continuing care, suggesting that although having a history of employment helped men avoid returning to custody (possibly because it enabled further employment), employment may have also made them less interested in or less able to participate in further treatment following incarceration.

Men in correctional settings and men on probation or parole often have unique needs in substance abuse treatment. For instance, men in prison may have different ways of thinking about and judging specific behaviors than men on the outside. These cognitive distortions are not necessarily distortions in the context of prison life, but rather are useful for managing day-to-day prison life. Criminogenic patterns can influence a man's values, beliefs, attitudes,

and emotion management; therefore, the patterns need to be identified and addressed in treatment. Adaptations that can help a man survive in prison may be maladaptive in the community or in substance abuse treatment program settings. Persons entering substance abuse treatment after incarceration may benefit from training to build skills for coping and operating successfully in the free world. Treatment for men who have been imprisoned should also address recidivism and relapse.

Men currently involved with the criminal justice system as well as those who leave it to enter substance abuse treatment may be reluctant to divulge information, resistant to expressing vulnerable emotions (e.g., sadness, fear), or hesitant to interact in group treatment. Behavioral health counselors should try not to interpret these behaviors as resistance, denial, uncooperativeness, or unwillingness to participate in recovery. To do so may actually increase the negative, protective behavior.

Serious, pervasive mental illnesses occur more often among men who have been incarcerated than those who have not (Center for Mental Health Services National GAINS Center for Systemic Change for Justice-Involved Persons with Mental Illness 2007). Men with mental illnesses are further traumatized in prison, and although their resulting adaptations may help them survive there, they can also make substance abuse treatment even more difficult. The GAINS Center offers specific suggestions and treatment options for people from the criminal justice system who have concurrent mental illness and a substance use disorder; for more information, visit the Center's Web site (<http://gains.prainc.com/>).

Men From Diverse Cultural and Geographic Groups

Rates and patterns of substance use/abuse vary among men according to cultural group. Researchers generally investigate cultural differences using broad racial/ethnic categories; those categories are thus used here. However, each broad category encapsulates a diverse set of cultures, and intragroup differences may be greater than intergroup differences in many cases. Behavioral health service providers are encouraged to investigate the specific cultures of their clients and discuss those cultures with their clients.

SAMHSA's NSDUH showed that among men in 2007, American Indians/Alaska Natives had the highest rates of past-year substance use disorders (17.6 percent) of any single group, and Asians had the lowest rates (7 percent). The same survey showed past-year rates of substance use disorders of 13.0 percent for non-Hispanic White men, 12.1 percent for African American men, and 12.2 percent for Hispanic/Latino men (HHS, SAMHSA, OAS 2008a).

SAMHSA's TEDS surveys individuals when they enter treatment and thus excludes the many men who need but do not receive treatment. Exhibit 4-4 presents data on substance preferences for men entering treatment by ethnic or racial group. Percentages are derived from State and jurisdiction reports of treatment admissions to programs that received public funds (directly or indirectly) in the year 2005. With the exception of alcohol plus another substance, only the primary substance of abuse is indicated (SAMHSA, OAS 2008b). These data indicate, to some extent, how culture affects patterns of substance use/abuse.

Exhibit 4-4: Primary Substance of Abuse According to Cultural/Ethnic Group Among Men Admitted for Treatment

Substance	White	African American	Latino (Mexican origin)	Latino (Puerto Rican origin)	American Indian or Alaska Native	Asian or Pacific Islander
Alcohol only	27.7	13.1	31.3	10.5	39.8	22.1
Alcohol plus other substance	19.5	21.2	11.9	16.5	23.9	13.3
Heroin	11.5	13.5	12.6	47.7	3.6	7.1
Other opioids	4.5	0.5	0.5	0.8	1.8	2.3
Smoked cocaine	5.4	20.4	3.4	5.3	2.3	5
Other cocaine	3.2	4.7	4.0	4.7	1.6	1.9
Marijuana or hashish	15.1	22.8	18	12	12.9	20.2
Methamphetamines	8.9	0.9	17.1	0.6	7.2	25.5
Tranquilizers	0.4	0.1	0.1	0.3	0.2	0.2
Sedatives	0.2	0.1	0.1	0.1	0.1	0.1
Hallucinogens	0.3	0.1	*	*	0.1	0.2
Phencyclidine	0.1	0.4	0.2	0.2	0.1	0.2
Inhalants	0.2	*	0.1	*	0.2	0.1
Other/none specified	5.2	2.1	0.5	1.4	6.3	1.9

*Less than 0.05 percent.

Source: SAMHSA, OAS 2008.

Information about substance use by diverse cultural groups of men is given in the following sections, as is information on specific substances and the populations that use them. Because of the gender rather than cultural focus of this TIP, this discussion of cultural issues is limited. More information can be found in the planned TIP, *Improving Cultural Competence* (SAMHSA planned c), which explores cultural and ethnic differences in substance abuse and discusses various culturally and ethnically based treatment issues.

African Americans

Within-group diversity

The term African American is a broad denotation for an ethnocultural group of considerable diversity. The history and experience of African Americans has varied in different parts of the United States, and the experience of African American people in this country varies even more when considering the culture and history of more recent immigrants. Today,

African American culture embodies elements of Caribbean, Canadian, Latin American, European, and African cultures. Intragroup diversity among people of African descent is further influenced by numerous factors, in-

cluding their country or region of origin; their upbringing; the extent to which their families conserve and perpetuate Afrocentric values, rituals, and beliefs; regional mores and customs; gender socialization; and age. The terms African American and Black are used synonymously at times, but some recent Black immigrants may not consider themselves African Americans, assuming that the term applies only to people of African descent born in the United States.

African American men's concept of masculinity may differ depending on their specific cultural background as well as their geographic location and SES, among other factors. For example, a study by Levant and colleagues (1998) found that African American men in the South endorsed significantly more traditional masculine roles than did African Americans from Northeast/Mid-Atlantic regions (the latter groups' concept of masculinity more closely resembled that of White Americans).

Admission/substance use statistics

African American men made up 15.5 percent of all substance abuse treatment admissions to programs receiving funds through States in 2005 (SAMHSA, OAS 2008a). According to SAMHSA's NSDUH, in 2006, the rate of past-month illicit drug use for African American men (ages 12 and older) was 13.8 percent; their past-year rate of heavy drinking was 13.4 percent (HHS, SAMHSA, OAS 2007). Rates of crack cocaine use are higher for African American men than rates of methamphetamine, inhalant, or prescription drug abuse (HHS, SAMHSA, OAS 2008a).

Although young African American men are less likely to use drugs than young White American men, older African American men are more likely to do so—this is sometimes referred to as the crossover effect (French et al. 2002; Watt 2008). A particularly powerful influence on increased drug use in this popula-

tion is that African American men ages 35 and older are more likely to be offered drugs than are men in that age range from other racial/ethnic groups (Watt 2008).

American Indians and Alaska Natives

Within-group diversity

The terms American Indian and Alaska Native refer to the indigenous peoples of North America, who collectively are often called Native Americans. There are 562 federally recognized American Indian and Alaska Native Tribes (SAMHSA, planned a), but there are also numerous Tribes recognized only by States and still others unrecognized by any government entity. Each represents a distinct culture; although similarities exist among certain Tribes, there are also significant differences.

More information on substance abuse treatment for this population is presented in the planned TIP, *Behavioral Health Services for American Indians and Alaska Natives* (SAMHSA planned a).

Admission/substance use statistics

American Indians and Alaska Natives comprise about 1 percent of the population of the United States (McKinnon 2003). However, in 2000, they constituted approximately 1.4 percent of individuals in substance abuse treatment programs receiving funds through the States (SAMHSA, OAS 2008b). Substance use patterns vary significantly among Native American Tribes, but within specific Tribes, American Indian and Alaska Native men usually have significantly higher rates of substance use disorders than women from the same Tribe. Rates of injuries, suicide, and homicide are disproportionately high among American Indian men, who are significantly less likely than American Indian women to receive medical services (Rhoades 2003).

NSDUH data from 2007 show that American Indians/Alaska Natives report the heaviest use of alcohol, tobacco, and many illicit drugs of any racial group (SAMHSA 2008). Rates of use are especially high for American Indian and Alaska Native men (HHS, SAMHSA, OAS 2007). American Indian men as a group have higher rates of binge drinking than the general population, but they also have higher rates of abstaining completely from alcohol than the general population (May and Gossage 2001; OAS 2007*b*). Drinking starts at an earlier age among American Indian men than their female counterparts (17 years versus 18.1 years, respectively), and American Indian men as a group have a tendency to drink more frequently and in larger quantities than American Indian women (May and Gossage 2001).

Asians, Hawaiian Natives, and Other Pacific Islanders

Within-group diversity

Asian Americans comprise over 30 diverse ethnic groups (e.g., Chinese, Filipino, Asian Indian) who speak different languages, have different levels of acculturation, and may have different immigration statuses and levels of income. This complexity is increased by key variables, such as reasons for migration, degree of acculturation, English proficiency, family composition and intactness, education, and adherence to traditions or religious beliefs.

Although they come from distinct cultures, Native Hawaiians and other Pacific Islanders are often grouped together with Asian Americans in surveys and other research. They are a relatively small group; data from the U.S. Census 2000 show that 0.3 percent of the population reported some Native Hawaiian or other Pacific Islander ancestry (Grieco 2001), and accurate information concerning patterns of substance use and abuse is thus difficult to come by. Chang and Subramaniam (2008) dis-

cuss how Asian American cultural beliefs about appropriate masculine behavior influence such factors as male help-seeking and concepts of health.

Admission/substance use statistics

Asian Americans generally use alcohol and illicit substances less frequently than other Americans, although there are variations among subgroups. Asian Americans rank lowest of all racial or ethnic groups in terms of past-year illicit drug use. According to 2007 data, Asian Americans ages 12 and older were also less likely than members of other racial groups to report current alcohol use (35.2 percent) or recent binge drinking (12.6 percent). Asian Americans had a relatively low rate (4.3 percent) of past-year alcohol use disorders in 2007 (SAMHSA 2008); in 2005, they comprised 1 percent of admissions to substance abuse treatment programs receiving State agency funds (SAMHSA, OAS 2008*b*). Among those who did enter treatment, methamphetamine and marijuana abuse rates were high.

Research suggests considerable variations in substance use/abuse patterns among men from diverse Asian American populations. For example, the National Latino and Asian American Study, the largest national study to assess substance use disorders among Asian Americans from diverse cultural backgrounds, found that Filipino American men were 2.38 times as likely to have a lifetime substance use disorder as Chinese American men (Takeuchi et al. 2007). Other research indicates significant differences in substance use and abuse patterns according to specific Asian cultural group, as well as differences related to such factors as geographic location and acculturation.

The use of alcohol and other substances is more common among Native Hawaiians than members of other ethnic and racial groups living in Hawaii. In an adult household survey of Hawaiian residents conducted in 1998, about

36.7 percent of Native Hawaiian men reported heavy drinking and 15 percent met diagnostic criteria for either alcohol abuse or dependence (Gatrell et al. 2000).

White Americans

Within-group diversity

White Americans (also referred to as Caucasians), like other large cultural groups, are heterogeneous in historical, social, economic, and personal features, with many subgroups and subtleties. Many have been in the United States for three or more generations, but others are recent immigrants (Giordano and McGoldrick 2005). Many White Americans have European cultural roots, but growing numbers come from Middle Eastern or North African cultures. For many White Americans, such characteristics as gender, sexual orientation, socioeconomic status, geographic location, occupation, religion, and so forth may be more important than race in defining their sense of cultural identity.

Admission/substance use statistics

Recent data show that White Americans are the racial group most likely to report current (i.e., past-month) use of alcohol. Overall, White Americans report more illicit substance use and abuse than do most other major racial/ethnic groups, but rates of use and abuse of specific substances vary (SAMHSA 2008). White men made up 39 percent of all substance abuse treatment admissions in 2005, the largest subset in the treatment population (SAMHSA, OAS 2008*b*).

Alcohol seems to be the primary substance of abuse among White Americans, but differences in its use do exist among the subpopulations in this community. For example, O'Dwyer (2001) reviewed a study that found that 51 percent of Irish-born men admitted to various psychiatric hospitals in New York had

alcohol-related diagnoses, whereas only 4 percent of Italian-born men had similar diagnoses during the same period. Researchers identify two basic drinking patterns in European cultures: a Northern/Eastern European pattern (more common in the United States) in which alcohol is consumed only on weekends or during celebrations but often in large quantities on those occasions, and a Southern Europe pattern in which alcohol is consumed daily or almost daily but in smaller quantities and almost always with food (Room et al. 2003).

White American men, on average, begin drinking and develop alcohol use disorders at a younger age than men from other racial/ethnic groups (HHS, SAMHSA, OAS 2008*a*; Reardon and Buka 2002). However, certain White American groups, (e.g., those of Middle Eastern descent) may drink very little if at all (Arfken et al. 2007).

Hispanic/Latino Americans

Within-group diversity

Hispanic and Latino are terms used to refer to cultures that originated, at least in part, in Spain or Portugal, and most often indicate people from Western Hemisphere cultures that have been influenced by Spanish or Portuguese colonization. The term Hispanic technically refers to people from the Spanish-speaking countries of North, Central, and South America and the Caribbean. However, the term Latino refers to people from Latin America, whether they are from a Spanish or Portuguese-speaking country. Unlike other groups described here, Hispanic/Latino is an ethnic, not a racial, category. Latinos may belong to any race and may include more than 30 national and cultural subgroups (Padilla and Salgado de Snyder 1992; Rodriguez-Andrew 1998). Latino Americans are currently the fastest-growing ethnic group in the United States (Ramirez and de la Cruz 2003; U.S. Census Bureau 2004).

Admission/substance use statistics

SAMHSA's TEDS recognizes within-group diversity among Hispanics/Latinos by reporting admissions for diverse groups of Hispanic or Latino descent—the largest of these being Mexican and Puerto Rican. In the 2005 TEDS survey, Mexican American men made up 4.1 percent of treatment admissions; Puerto Rican men made up 3.2 percent of treatment admissions (SAMHSA, OAS 2008*b*).

Data about drinking and drug use behaviors among various Hispanic/Latino groups, outside of those that enter treatment, do not always present a clear picture (Nielsen 2000). However, there seem to be significant variations in substance use patterns and disorders among diverse groups of Latinos (Alegria et al. 2008; HHS, SAMHSA, OAS 2000). Studies have consistently found that more acculturated Hispanics/Latinos drink more frequently and in larger quantities than less acculturated individuals (Alegria et al. 2008; Zemore 2005).

Hispanic/Latino men are considered to be at high risk for alcohol abuse and dependence (Colon 1998; Corbett et al. 1991) and substance abuse (Vega et al. 1998). Among individuals entering substance abuse treatment, rates of heroin use are high for Puerto Rican men, as are rates of methamphetamine use for Mexican American men (Singer 1999).

Geographic Regions

Geographic region can significantly affect the availability of substances, attitudes toward substance use, and cultural patterns of use for men. Each population has its own set of challenges that can contribute to the magnitude of substance use problems in that region. For example, men in rural settings may have less access to substance abuse prevention and treatment programs than men in urban settings but also less access to some illicit substances. Lo and Stephens (2002) compared

arrestees' perceived needs for substance-specific treatment in rural and urban settings. The investigators did not discuss gender other than to note that male detainees dependent on cocaine were less likely to express a need for treatment than female detainees dependent on cocaine. Nonetheless, they make some pertinent conclusions about urban/rural differences. As a general rule, urban arrestees were more likely to perceive a need for treatment and to exhibit increased motivation for treatment, whereas rural residents exhibited decreased motivation for treatment. More educated rural arrestees were less likely to be receptive to alcohol treatment than those who were less educated, whereas the converse was true in urban areas. The authors speculate that uneducated, unemployed rural residents stood the least to lose by entering treatment.

Conclusion

Behavioral health programs and providers should consider the variety of factors that influence the significant disparity in substance use disorder rates between men and women in the United States. These factors range from greater opportunity to use substances to increased social pressure and possibly to a greater genetic disposition to use substances. In addition, men's reasons for substance use differ from those of women and include rites of passage and a greater need to medicate feelings and emotions that they have difficulty expressing. The factors at work differ not only between genders, but also among men from diverse cultural and ethnic groups; providers need to consider these various and complex factors as they undertake the screening and assessment approaches outlined in Chapter 2.

5 Treatment Modalities and Settings

IN THIS CHAPTER

- Introduction
- Detoxification
- Treatment Modalities
- Treatment Strategies
- Treatment Settings
- Mutual Help Groups
- Community Influences
- Helping Men Live With the Residual Effects of Substance Abuse

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 2000a, 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] 2008a). Detoxification, especially from substances like alcohol and barbiturates, is a serious undertaking that can pose a significant health risk. Therefore, on entering a detoxification pro-

gram, 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] 2006a).

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 2009a). 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 2008b). 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 2004b).

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 func-

tioning, 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 1999b), 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; Isenhardt 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 (Isenhardt 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 preven-

tion 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 ena-

bles 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 2005b]). 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 2005c], 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; Isenhardt 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 (2008a) 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 (Isenhardt 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 1998a; 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 2005c).

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. 2004a; 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.

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Appendix B—Glossary

Acculturation—the socialization process through which people in minority groups adopt certain elements from the majority culture.

Assessment—a comprehensive evaluation of a client’s in-depth status and needs.

Chromosome—a microscopic, rodlike structure in the cell’s nucleus that carries genetic material.

Co-occurring disorders—co-occurring substance use (abuse or dependence) and mental disorders. In the context of this TIP, clients said to have co-occurring disorders have one or more mental disorders as well as one or more disorders relating to the use of alcohol and/or drugs.

Countertransference—the feelings, reactions, biases, and images from the past that the clinician may project onto the client.

Culture—the conceptual system that structures the way we view the world. Culture incorporates a particular set of beliefs, norms, and values that influence our ideas about the nature of relationships, the way we live our lives, and the way we organize our world.

Cyber—a prefix relating to computers or computer networks.

Employee assistance programs—programs that provide professional consultation services for employees who are experiencing personal issues that might be negatively affecting their work performance.

Ethnicity—shared values and beliefs, social identity, mutual belongingness, and standards of behavior that define a group of people.

Gender—category to which an individual is assigned, by self or others, on the basis of sex.

Gender identity—the subjective, continuous, and persistent sense of oneself as male or female.

Gender role conflict—a psychological state in which a person’s beliefs about himself or herself or his or her behaviors conflict with socialized gender roles, resulting in negative consequences. Gender conflict occurs when rigid, sexist, or restrictive gender roles result in personal restrictions, devaluation, or violation of others or self.

Gender role stress—may arise from excessive commitment to and reliance on certain culturally approved masculine or feminine schemes that limit the range of coping strategies a person is able

to use 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 have not appeared successful or tough enough in situations requiring masculine appearances of strength and invincibility.

Gene—a specific sequence of DNA that encodes for a specific trait, characteristic, or protein in an organism.

Genetic transmission—inherited characteristics passed from parents to children.

Heterosexism—an attitude or belief that heterosexual behavior is the norm.

Intersystemic—occurring between systems.

Intrasystemic—occurring within systems.

Maladaptive—marked by faulty or inadequate adaptation.

Male—of, relating to, or designating the sex that has organs to produce spermatozoa for fertilizing ova.

Mandate—a command, order, or direction—written or oral—which courts are authorized to give and people are bound to obey.

Marginalization—removal of someone's importance and power.

Masculine role socialization—the process whereby men learn how they (as men) are expected to act, feel, and think. As part of this learning process, they experience negative consequences (e.g., public humiliation, anger from peers) when they fail to meet those expectations.

Masculine—relating to or marked by the characteristics of the male sex or gender.

Masculinity ideologies—a body of socially constructed ideas and beliefs about what it means to be a man. The ideologies attempt to measure the degree to which an individual endorses these cultural norms regarding the male gender role.

Nonrelational sex—the tendency to experience sex primarily as lust without any requirements for relational intimacy or emotional attachment.

Posttraumatic stress disorder (PTSD)—an illness whose essential feature is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury or other threat to one's physical integrity; it can also result from witnessing an event that involves death, injury, or a threat to the physical integrity of another person or learning about the unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close friend or relative.

Psychoactive—possessing the ability to alter mood, feelings, behavior, cognitive processes, or mental states; usually applied to pharmacologic agents.

Psychotherapy—treatment of emotional, behavioral, personality, and mental disorders based primarily on verbal or nonverbal communication and interventions with the patient, in contrast to treatments that use chemical and physical measures.

Race—a social construct to describe people with shared physical characteristics.

Racism—an attitude or belief that people with certain characteristics are better than others.

Religion—any specific system of belief about one or more deities, often involving rituals, a code of ethics, and a philosophy of life.

Screening—a process to determine whether a client warrants further evaluation for a particular diagnosis (e.g., substance use disorders, mental disorders, HIV/AIDS). A screening process can be designed so that it can be conducted with little additional training by counselors. Positive screenings are followed by comprehensive **assessments**.

Sex—the biological differences between women and men.

Sociocultural—of or involving both social and cultural factors.

Spirituality—the state or quality of being dedicated to a deity, a religion, or spiritual things or values, especially as contrasted with material or temporal ones.

Stigma—a negative association attached to some activity or condition; a cause of shame or embarrassment.

Substance—can refer to a drug of abuse, a medication, or a toxin.

Substance abuse—a maladaptive pattern of substance use manifested through recurrent and significant adverse consequences related to the repeated use of substances. Sometimes used interchangeably with the term **substance dependence**.

Substance dependence—a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by a need for increasing amounts of the substance to achieve intoxication, markedly diminished effect of the substance with continued use, the need to continue to take the substance in order to avoid withdrawal symptoms, and other serious behavioral effects, occurring at any time in the same 12-month period.

Substance use disorders—a class of substance-related disorders that includes both **substance abuse** and **substance dependence**.

Transference—the feelings, reactions, biases, and images from the past that the client may project onto the clinician.

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CSAT TIPs and Publications Based on TIPs

What Is a TIP?

Treatment Improvement Protocols (TIPs) are the products of a systematic and innovative process that brings together clinicians, researchers, program managers, policymakers, and other Federal and non-Federal experts to reach consensus on state-of-the-art treatment practices. TIPs are developed under CSAT's Knowledge Application Program to improve the treatment capabilities of the Nation's alcohol and drug abuse treatment service system.

What Is a Quick Guide?

A Quick Guide clearly and concisely presents the primary information from a TIP in a pocket-sized booklet. Each Quick Guide is divided into sections to help readers quickly locate relevant material. Some contain glossaries of terms or lists of resources. Page numbers from the original TIP are referenced so providers can refer back to the source document for more information.

What Are KAP Keys?

Also based on TIPs, KAP Keys are handy, durable tools. Keys may include assessment or screening instruments, checklists, and summaries of treatment phases. Printed on coated paper, each KAP Keys set is fastened together with a key ring and can be kept within a treatment provider's reach and consulted frequently. The Keys allow you, the busy clinician or program administrator, to locate information easily and to use this information to enhance treatment services.

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<i>Replaced by TIP 43</i> | TIP 9 Assessment and Treatment of Patients With
Coexisting Mental Illness and Alcohol and
Other Drug Abuse— <i>Replaced by TIP 42</i> |
| TIP 2 Pregnant, Substance-Using Women— <i>Replaced
by TIP 51</i> | TIP 10 Assessment and Treatment of Cocaine-
Abusing Methadone-Maintained Patients—
<i>Replaced by TIP 43</i> |
| TIP 3 Screening and Assessment of Alcohol- and
Other Drug-Abusing Adolescents— <i>Replaced
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for Alcohol and Other Drug Abuse and
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| TIP 5 Improving Treatment for Drug-Exposed
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Quick Guide for Clinicians QGCT13
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KAP Keys for Clinicians KAPT13 |
| TIP 6 Screening for Infectious Diseases Among
Substance Abusers— <i>Archived</i> | TIP 14 Developing State Outcomes Monitoring
Systems for Alcohol and Other Drug Abuse
Treatment— <i>BKD162</i> |
| TIP 7 Screening and Assessment for Alcohol and
Other Drug Abuse Among Adults in the
Criminal Justice System— <i>Replaced by TIP 44</i> | |
| TIP 8 Intensive Outpatient Treatment for Alcohol
and Other Drug Abuse— <i>Replaced by TIPs 46
and 47</i> | |

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