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Men's health and psychosocial issues affecting men

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At every age, American men have poorer health and higher risk of mortality than women, and they die 5 years sooner [1]. Although numerous factors such as adverse working conditions contribute to this gender difference, psychosocial issues deserve heightened emphasis. Courtenay [2] contends that it is particularly relevant to address psychological and social factors, given the small predictive power of biological factors in explaining gender differences in morbidity and mortality. Each of the health-damaging emotional states and behaviors highlighted in this article can be traced not to biological differences between the sexes but to the unfortunate effects of gender role socialization for masculinity, especially the lessons that growing boys learn about emotion management.

Emotion and disease have been linked by astute clinicians since Hippocrates, but empirical evidence of the influence of emotion is fairly recent. There now is proof that emotional states directly affect physiology, including the immune system, and they indirectly affect health by precipitating deleterious coping behaviors such as drinking, smoking, and binge eating [3]. Such behaviors provide a way to escape from the self, blunting unpleasant negative emotions [4]. Men do not deal well with emotion. Ineffective emotion management is implicated in each of the four causes of death for which men's death rates are twice as high as women's: accidents, suicide, cirrhosis of the liver, and homicide [1]. Significant reductions in mortality could be achieved if men learned healthier ways to handle their feelings. Emotional behavior is learned, and therefore it is amenable to change. This article explores men's anger and hostility, depression and grieving, and substance misuse and abuse. Prevention and treatment strategies are outlined. Because of space limitations, homicide and other extreme forms of violence are not addressed.

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Anger and hostility

Heart disease is the number one killer of men; therefore, the linkages of anger and hostility to this disease will be addressed first. The pioneering research of cardiologists Friedman and Rosenman revealed a characteristic coronary-prone pattern that they termed Type A, a constellation of hard-driving, impatient, angry behaviors [5]. In a longitudinal study spanning 8 years, men exhibiting this behavior pattern were twice as likely to develop symptoms of coronary heart disease (CHD) [5]. Although subsequent studies failed to support the entire Type A construct, hostility and anger proved to be the critical factors. Hostility and anger are not synonymous, but correlated. Individuals who score high on hostility tests, such as the Cook-Medley questionnaire [6], also tend to score high on unhealthy ways of managing their anger, such as yelling or smashing things. Hostility is an enduring cynical mistrust and antagonism toward other people that fuels frequent outbursts of anger. For example, hostile people are highly reactive to mistakes of coworkers or slow drivers who impede their progress on the interstate. During a typical day, hostile people have more tense, angry, and confrontational interactions with others than nonhostile people do [7].

Studies show that men are more likely than women to exhibit cynical hostility and poorly controlled anger [8], thereby increasing their risk for hypertension, coronary artery calcification and atherosclerosis, angina, ischemic heart disease, myocardial infarction (MI), and premature death [9–13]. Researchers have controlled statistically for other cardiac risk factors, such as smoking and obesity, in the aforementioned studies. Hostility is an independent risk factor for CHD, as demonstrated in a meta-analysis of 45 studies [14]. Hostility also undermines the benefits of angioplasty, doubling the risk of restenosis [15].

What developmental factors contribute to hostility? Houston and Vavak [16] proposed that hostile individuals experience less genuine acceptance from their parents, stricter control, and more punishment. Research on a large sample of college students supported this formulation: The students reported on their parents' child-rearing practices as part of a battery of psychological tests. Although causality cannot be inferred from this cross-sectional study, it is logical to attribute the characteristics of the hostile adults to their childhood experiences. Hostile students were low in self-esteem, excessively angry, and deficient in social support. They drank more alcohol, drove more frequently after drinking, and weighed more than nonhostile study participants [16].

Anger is a normal human emotion with many constructive functions, such as signaling that values or rights are being violated and providing energy to protect boundaries [17]. When does anger become pathogenic? Research shows that it is not the mere arousal of anger but intense, volatile, anger expression that has catastrophic consequences for cardiac health [18]. Both the intensity of anger and its frequency are known to be significant to heart health. In a study of 12,986 black and white men and women, those who were

angered easily were three times more likely to have a heart attack or sudden cardiac death [13]. Men are more likely than women to have frequent and intense anger that is vented in verbal or physical aggression [19,20]. Scholars attribute this difference to gender role socialization [21].

What lessons do boys learn about anger and aggression in childhood? Parents are more accepting of anger expression by sons than by daughters [22]. Gender role socialization for masculinity actually encourages boys to engage in aggressive acts when anger is aroused [23]. Boys are given messages by parents, peers, and the media that wrestling, kicking, pushing, shoving, and hitting are appropriate ways to resolve disputes. One study showed that boys as young as age 3 bonded with their fathers while watching male action and horror movies [24]. Physical aggression often is required for boys to earn respect from bullies on the playground [25]. During the years that girls are learning that emotionality is acceptable (except for anger), boys are learning to repress sadness and fear stoically, lest they be viewed as weak or cowardly. Anger and aggression, however, are viewed as manly. They also are being inculcated with Western culture's valuing of male achievement and competition, learning to use externally directed defense mechanisms, such as projection, to handle socially unacceptable feelings [26]. These externally oriented defenses prevent males from experiencing guilt for hurting their competitors [27].

Recent research with a nonclinical community sample of adult men revealed them to be very conflicted about their anger [28]. Although men recognized that anger could be used as a tool to deal with wrongs against the self or others, its potentially overwhelming force was feared. Metaphors used by participants to describe their anger are illustrative: "a runaway horse, fire, flood, eruption, or vortex" [28]. The men expressed great concern about being controlled by angry emotionality versus having and maintaining control. Anger was depicted as an "it," a separate, independent entity that could compel rash actions (eg, throwing a cat toward the wall). Men became angry when they did not have the ability to control or fix things, whether the things were inanimate objects (eg, computers, boats, or cars) or work-related problems (eg, demanding customers or incompetent coworkers). Illogical actions of other people that were out of the men's sphere of personal control (eg, other drivers) provoked considerable ire also.

The study did not support Campbell's claim [29] that aggression feels good to men, because it conveys the reward of power over others. Instead, men who had lost control and engaged in aggressive behavior while angry were ashamed of their behavior and pointed out its irrationality and futility. The study participants decried the social pressure they had received to enact aggressive masculinity. In speaking of boyhood experiences, they denied that becoming a successful fighter made them feel good about themselves. In telling their anger stories, they were nervous and embarrassed. Some expressed concerns about their adequacy as a man, because they felt they did not handle anger according to societal expectations of manliness. An

encouraging finding of the study was the men's perception that they developed more constructive anger with age. As adults, they eschewed physical fights and displayed greater empathy for others. Some attributed changes in anger management to spiritual or religious growth. Because nearly all the men in the study were white and middle-class, findings of the study cannot be generalized to men of other races and social classes and should be replicated with more diverse samples. Nonetheless, the study indicates men's potential for emotional growth and development.

Even men with long-standing hostility and volatile temper respond to treatment programs such as the Recurrent Coronary Prevention Project [30] and the San Francisco Life-Style Heart Trial [31]. They are taught to be less reactive to the diverse frustrations of modern urban life and to turn down the volume when they express anger verbally. Meditation is included in many of these programs also. Compared with patients receiving standard post-MI care, patients receiving hostility control training had significant reductions in hospital days and medical expenses after the training [32]. The impetus of an MI and the possibility of having another serve as powerful motivators for behavior change.

Depression and grief

Depression in men has received far less attention than depression in women, perhaps because only 13% of men experience major depression over the course of their lives [33]. This low percentage is misleading, however. Men's depression undoubtedly is underdiagnosed, because men do not acknowledge it or express it according to the criteria of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) [34]. They may speak of irritability and fatigue instead of sadness and guilt [35]. One large study found that clinicians failed to diagnose depression in nearly two-thirds of men who were depressed [36]. Unlike women, who talk about symptoms and seek treatment, men are prone to mask their depression with drugs and alcohol [37] or escalate compulsive personality characteristics and defensive assertions of autonomy [38]. They may express their unhappiness in reckless or violent acting-out [35].

The National Institute of Mental Health seeks to enlighten the public and alter its negative perception of depressed men through a media campaign called "Real Men, Real Depression," launched in April, 2003 [39]. Clinicians need to be better informed too. In assessing men for the possibility of depressive illness, clinicians should be alert to symptoms such as increased conflict at work or within intimate relationships, blows to self-esteem such as divorce or job loss, and complaints of physical ailments [40]. It is vital to assess depressed patients for suicidal ideation and plans, because men of all ages and races commit suicide at rates from 4 to 15 times that of women of comparable age and race [41].

As with women, men's depression is sometimes a result of unfinished mourning of a loss. For both women and men, the end of a marriage or committed relationship can produce significant and prolonged emotional pain. A man may avoid grieving, however, because it involves acknowledging his vulnerability or dependency on the lost partner [42]. Divorce, especially when it was not the man's choice, can be extremely traumatic, because it signifies rejection and failure. It is fairly common for the partner's announcement of divorce intentions to come as a complete surprise to a man. When a relationship termination is both unwanted and unanticipated, it is even more stressful. Many men have very limited intimate relationships outside marriage and have no one to turn to in their time of grief. They may not know how to reach out and discuss their experience with male friends [43]. They learned as boys not to cry and to "keep a stiff upper lip," at least publicly. One prominent masculinity scholar contends that alexithymia (a condition of having no words for emotions) is so pervasive among men that it can be considered normative [44]. Clearly, alexithymia would present a major impediment to the successful completion of grief work after divorce [43].

Death of a spouse, while it does not have divorce's connotations of rejection and failure, is known to be one of life's most severe stressors. Like divorce, it leaves a man bereft of his principal support system. Although Quigley and Schatz [45] did not find gender differences in men's and women's responses to death of a spouse, their study finding is contrary to the bulk of previous research and the perceptions of most bereavement counselors. Widowed and divorced men are known to be at higher risk for psychological problems and suicide [46], and the risk is probably even greater if the men do not have close friends, church affiliations, or other social ties to the community. Longitudinal research by Eng et al on 28,000 men showed that socially isolated men are more likely to die from accidents and suicide and have increased risk of fatal CHD and death from noncardiovascular causes [47]. Because the Eng study was conducted on health professionals, its findings cannot be generalized to populations of lower educational attainment and socioeconomic status (SES). The researchers suspect, however, that lack of social ties may have even more profound effect on men with lower SES.

Given the research, connecting grieving divorced men and widowers to bereavement counselors and support groups may be life-saving. A competent grief counselor always will inquire about suicidal ideation [48]. The counselor also will assess the degree of completion of the four tasks of mourning: accepting the reality of the loss, experiencing the pain, adjusting to life without the lost person, and ultimately investing emotional energy in a new relationship [48]. Worden has provided clinicians with an excellent set of guidelines for assisting patients to complete these tasks [48].

When the patient is assessed to have depressive illness, both counseling and medication are efficacious. Therapies that capitalize on patients' pre-existing strengths work better than those that focus on deficits [33]. The therapist can

capitalize on a man's reasoning ability to gently challenge the irrational cognitions that characterize depressive illness. A biochemical explanation of depression may mitigate men's shame for perceived weakness and promote receptiveness to taking antidepressant medication. Given the solidly proven effectiveness of antidepressants, it is unfortunate that men are less likely to receive prescriptions for them [49]. As is the case with female patients, men who are taking an antidepressant drug must be cautioned not to stop taking it prematurely, a common problem. Relapse is more likely when medication is stopped too soon. The bigger problem, of course, is getting men into treatment in the first place.

Substance misuse and abuse

Epidemiological studies consistently show that men report higher levels of substance misuse and abuse than women [50]. The type of chemical chosen has to do with the feelings the man is trying to assuage [51]. Sedatives appeal more to the man who is anxious or rageful, while stimulants attract the man who is depressed or shy. The most striking emotional pattern in opiate addicts is lifelong difficulty managing anger; with the drug, they feel normal and relaxed [52]. Alcohol is the drug of choice for millions of men. Alcohol abuse is five times more prevalent in men than in women [34], and 39% of men have some degree of psychological dependence on alcohol during their lives [53]. Illicit drug use is also higher in men (7.7%) than in women (5%) [35]. In addition, men have more psychosocial problems associated with alcohol or drug use [54].

Drinking is an integral part of becoming a man in America. Not surprisingly, US men are twice as likely as women to engage in heavy episodic drinking (consuming more than five alcoholic drinks) [1]. Heavy episodic drinking has been termed the biggest public health problem on American college campuses, because it is the leading cause of death among undergraduate students [55]. Male students, especially those in fraternities, have higher rates of this heavy drinking behavior than do females [56,57]. Although men drink for many reasons, including purely social motives, the association of alcohol use and manliness is clear in the following description: "the hard drinking, two-fisted, pioneering frontiersman;...the ruggedness of the guy who can hold his liquor like a man; and the notion that you can't trust a man who won't drink" [58].

It stands to reason, given the widespread social approval for men's drinking, that men rely on alcohol to cope with stressors more so than women do; research by Park and Levenson [59] supports this line of reasoning. Alcohol may be seen as a ready remedy for depressed and hostile moods [60,61]. Many men observed their fathers drinking to alleviate emotional discomfort. Researchers note that the lower rate of depression in men is almost perfectly balanced by higher rates of addiction and antisocial behavior

[35]. Not surprisingly, adherence to stereotypical masculinity ideology is associated with reluctance to admit dependency on alcohol and enter treatment [62].

Because college is the setting for the initiation of many men's drinking careers, preventive efforts and interventions on campus deserve greater emphasis [59]. Studies suggest that students who begin drinking in college to cope may not mature out of their heavy drinking patterns, continuing to drink excessively after graduation [63]. Students who are drinking to cope need training in stress management and adaptive coping skills. Langner proposes teaching mindful drinking, in which students increase awareness of their moods and motives for drinking [64]. Nurses in student health clinics could play a key role in presenting educational programming at fraternity houses and other environments that encourage heavy consumption of alcohol.

There is considerable debate about the best treatment for men who have become addicted to substances. Despite the notable success of 12-step programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), these programs do not work for men who find it objectionable to admit powerlessness over alcohol/drugs and adopt reliance on a higher power [65]. Clinicians may achieve greater success when presenting a variety of treatment options rather than solely emphasizing 12-step programs. The effectiveness of cognitive-behavioral and motivational enhancement interventions is equal to AA-based substance abuse programs [66]. Motivational interviewing is receiving increased attention in the literature. The clinician asks open-ended questions ("How does alcohol help you feel more manly?"); listens reflectively ("It sounds like you are giving up control and giving in to others if you stop drinking."); affirms the patient ("It takes real strength to acknowledge this problem."); summarizes ("You're tired of being told what to do,"), and elicits self-motivational statements ("What has helped you in the past to make changes?") [67].

Prevention strategies

Prevention of maladaptive emotional behavior must begin with educating parents to permit their sons to display the full gamut of human emotions. Boys must get the message that it is not shameful to feel fear and sadness. They must learn to express anger with words, not fists. Because excessive harsh punishment contributes to boys' hostility, parents must be taught behavioral science principles of rewarding good behavior and using fair, nonviolent, measures when discipline is necessary. Parents are powerful role models for young children and must eschew unhealthy ways of handling their own emotions. Emotional literacy programs for children have proven effectiveness in reducing aggressive behavior and increasing competence in positive interactions with peers [52]. Schools are an ideal locale for such programs. Nurses and other mental health professionals are prepared to

conduct these programs or serve as consultants to parents and teachers. Teachers could be advised to seize teachable moments when boys are fighting in the schoolyard, showing the boys how to modulate intense anger arousal and resolve conflicts through dialog [28]. Successful evidence-based programs such as the Responding in Peaceful and Positive Ways Program [68] can be emulated in other communities.

General treatment recommendations

Several studies have shown that men are less likely to seek counseling and psychotherapy than women [69]. Men are reluctant to initiate psychotherapy, because they do not want to admit weakness in managing their emotional problems [70]. Brooks and Good [71] assert that many therapists are poorly prepared to engage reluctant men in treatment and fail to tailor their therapeutic approaches to serve male patients better. Clinicians may not see the connection between men's presenting problem and their emotional pain. Cooper [43] alleges that therapists must walk a tightrope when trying to do emotion work with men. They must balance the need to encourage them to talk about feelings, such as grief, with the need to proceed slowly, mindful that premature pressure to talk about feelings may drive them from therapy. As noted previously, many men do not have the language to talk about their feelings. Asking them to talk about reactions or responses may be less threatening. Psychoeducation about gender role socialization and the physiology and vocabulary of emotions is recommended [72].

Addis and Mahalik [73] contend that men are more prone to seek help when they perceive their problems as normative and central to an important quality of the self. Help-seeking is also dependent upon characteristics of the social groups to which they belong, characteristics of the potential helpers, and the degree of perceived control they feel they can maintain. Men are less receptive to therapy if they estimate rejection by peers or sacrifice of autonomy. If they have never known another man with depression or chemical dependency, they may view themselves as deviant or deficient. The cost of revealing their deficiency to a therapist may be too great, especially when they may not be convinced that treatment will help. Courtenay [2] urges clinicians to assist men to reframe help-seeking as an act of strength and courage. He suggests saying, "Contacting me when you did was the best thing you could have done" [2].

Courtenay [2] also exhorts clinicians to engage in some self-examination about their attitudes regarding men and masculinity. He suggests asking, "How do I feel when I see a man who is not in control of his emotions?" "Am I likely just to see a man's hostility and fail to see the pain and sadness underneath?" "Does my manner make men feel safe?" [2].

Therapeutic approaches such as coaching or life skills training may be less threatening to men than therapy. Psychoeducational programs, such as anger

management and emotional intelligence seminars, may attract men who would not see themselves as needing therapy. Employee assistance workshops, offered within the corporate environment, could lessen the stigma of accepting help to deal with life stressors such as divorce. Men's groups may provide a safe climate for exploring gender stereotypes and concerns about adequacy as a man.

Men are more comfortable seeking help when they have an opportunity to reciprocate [74]. Involvement in groups affords them that opportunity. The Internet also provides a venue for mutual help with its discussion groups and chat rooms.

Summary

Contemporary scholars are calling on men to rethink “the male deal.” As Samuels [75] describes it, “In the male deal, the little boy, at around the age of 3 or 4, strikes a bargain with the social world in which he lives. If he will turn away from soft things, feminine things, maternal things...then the world will reward his gender certainty by giving him all the goodies in its possession.” But the “deal” can have damaging effects, as shown in the studies reviewed in this article. Clinicians can help men to rethink the restrictions of the “male deal” so that they may experience the freedom of a wider emotional repertoire and move toward greater joy and wholeness.

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