Guys in Therapy:

Assessing the mental health needs of college-aged men, with 10 innovative approaches to working with them

A White Paper by
Aqualus M. Gordon, Ph.D.
Post-Doctoral Fellow at the University of New Hampshire
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Introduction:

No matter how you slice it, men and boys, as a population, are struggling both psychologically and socially in the U.S. The consequences of these struggles not only affect individual men – they also have large impacts on the communities in which these men live. Nevertheless, there are few services and resources that target men specifically – or address problems and experiences specific to men – in ways that are accessible to them, understanding of their particular concerns, and receptive to traditionally masculine dispositions.

This paper offers an overview of some of the most serious issues men face, with particular emphasis on college-aged men (roughly, 17 to 25 years of age). The *status quo* for mental health treatment options available to men will be critiqued, followed by proposed improvements to the current system, based on the writer's experience with male psychotherapy clients and research in the area of male psychology – particularly research by Spencer-Thomas, et al. and the Man Therapy project.

The Problems:

An Abundance of Shame

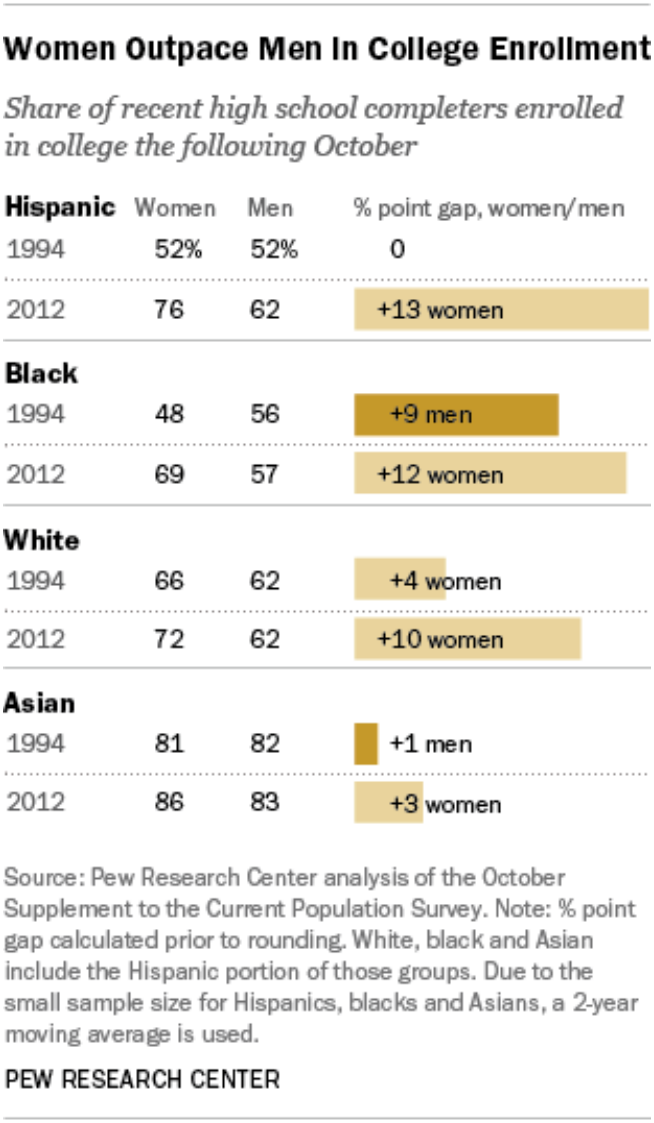
It is the opinion of this writer that of all the issues and themes that cause distress in the psychology of men, **shame** is the most prominent. A man's experience of shame may be connected to any number of issues -- some of which will be discussed further in this paper, but often seem to include shame related to aggressive or sexual feelings, past actions or thoughts, and/or not living up to a culturally sanctioned masculine ideal.

A Lack of Confidence

Many men find it difficult to act in positive ways without some semblance of confidence in themselves and/or their abilities. This doesn't necessarily mean that a man must feel confident in all things; however, in my experiences with men in therapy, men who believe that they have no outstanding or redeeming qualities will undermine themselves and greatly underestimate their ability to be successful at anything except failure.

Declining College Enrollment

College enrollment among men has been stagnant (or declining by some measures) in the past two decades. Whereas the enrollment of young men and women in college had been relatively equal in the 1990s, with 61% of male high school graduates attending college and 63% of female graduates. Recent surveys estimate that the enrollment of young men has remained at 61%, while the enrollment of young women has increased to 71 percent. This trend is noted across all racial groups, with the change in disparity being most significant among Black Americans. See Figure 1.



Inhibited Social Connectedness / Relationships

In addition to educational consequences, as a population, men's social connections also show evidence of distress. Because men and boys are often expected to be self-reliant and un-emotional, many boys and men find it difficult to be open or emotional in their relationships, even when doing so would be beneficial to them.

Additionally, because homophobia is a prevailing aspect of traditional masculinity, many men feel particularly uncomfortable forging strong emotional connections to other men (Messner, 1999). And once-prevalent organized positive social opportunities (like sports and mentor programs) are waning as an incorporated part of our education system. As a result, men may feel lonely and isolated, which can lead to Anxiety, Depression, and suicide (Eisold, 2013).

Substance Abuse

Men are more likely (than women) to turn to drug and alcohol abuse to cope with mental illness and psychological distress, which can lead to violent and destructive behaviors and accidental death (Eaton, et al., 2011). According to the most recent National Survey on Drug use and Health (2013), men are nearly twice as likely (10.4 – 11.5%) to abuse or be dependent on illicit drugs or alcohol than are women (4.1%).

This difference is particularly stark among college-aged individuals. Among 18 to 25 year old men, 14.5 – 15.1% reporting being dependent or having abused illicit drugs or alcohol within the last year. Additionally, 15.7% of this age-group of men reported abusing prescription drugs (US Dept. of HHS, 2013; Cotto, et al. 2010).

Perpetrators of Violence

The consequences of a lack of understanding and attentiveness to men as a population may be most evident in the recent rash of mass killings plaguing this country. The vast majority of perpetrators of these violent acts were young men with unaddressed psychological concerns. While both men and women are capable of committing violence against themselves and others, men are more likely to exhibit physical aggression as a result of psychological distress and illness. Men are also more likely to:

- Engage in stalking behaviors
- Engage in physical and sexual violence against their partners
- Employ more dangerous means of carrying out physical violence (e.g. guns)
- Direct their aggression towards strangers or acquaintances
- Direct their aggression towards other men

(Archer, 2004; Black, et al., 2011).

Victims of Violence

Childhood Sexual Abuse – One in six adult men report that they were sexually abused before the age of 18 (Dube, et al., 2005; Briere & Elliot, 2003). This is likely a low estimate because of the stigma attached with being sexually abused, especially for men. Men are also less likely than women (16% v. 64%) to describe their own childhood sexual experiences with adults as "abusive" (Widom & Morris, 1997); however, these experiences are often linked to serious mental health problems, including: symptoms of post-traumatic stress and depression, alcoholism and drug abuse, suicidal thoughts, suicide attempts, problems in intimate relationships, and underachievement at school and work (The 1 in 6 Statistic, n.d.)

Domestic Violence – A large-scale study ($N > 15{,}000$) by the Center for Disease Control in 2010 reported that within the past twelve months, more men than women had been victims of intimate partner physical violence and over 40% of severe physical violence was directed at men. The same study found that men were more likely to be subject to psychological/verbal abuses and deceptive sexual/reproductive practices (e.g. having an intimate partner attempt to get pregnant without knowledge or consent) (Black, et al., 2011).

Most Likely to Die by Suicide

Regardless of age, men (particularly White and Native American men) have the highest rates of suicide. Men die by suicide at four times the rate of women. This disparity of sex begins in adolescence and worsens through college, adulthood, and old age (65+), at which point the rate suicides my men is nearly seven times the rate of suicides by women. See Table 1 (Suicide Deaths per 100,000).

Age Range	Men	Women
10-24	11.45	2.76
25-64	25.37	7.35
65+	29.05	4.04

Table 1. Number of Suicide Deaths per 100,000

The *Status Quo*:

Research suggests that men's unwillingness to acknowledge mental health problems and their hesitation to seek treatment are key contributors to the problems noted above. While male rates of substance abuse, violence, and deaths by suicide suggest that men may be in greater need of mental health services, research finds that men are far less interested and less likely to access services. Only 9 – 15% of men with mental disorders seek treatment from mental health professions, compared to 16 – 26% of women (Spencer-Thomas, Hindman, and Conrad, 2012). At this Fellow's own UNH Counseling Center, men only make up 30% of the clients seen here, while they make up nearly half of the total UNH student population.

Even when men access (or attempt to access) mental health services, they may be misdiagnosed due to masculine depression symptoms, e.g. anger, substance use, social withdraw, overworking, impulsive behaviors. For instance, while there is no evidence that women experience depression at higher rates than men, men only account for 1 in 10 diagnosed cases of depression. In some other instances men are refused services or referred to less accessible services because of stated substance abuse/dependence or issues concerning aggression/violence or sex/sexuality, about which he may already feel ashamed.

According to Mansfield, Addis and Mahalik (in Spencer-Thomas, et al. 2012), when men consider seeking help, they often go through a series of internal questioning:

1. **Is my problem normal?** The degree to which men believe other men experience the same problem affects their decision to seek help. A prime example of this psychological process is erectile dysfunction. Before Senator Bob Doles' public disclosure, many men thought they were the only ones suffering from this highly common and highly treatable problem. After the public campaign, many more men sought help.
2. **Is my problem central to who I am?** If the mental health symptoms reflect an important quality about the person (for example the hypomania in bipolar disorder that impacts creativity or productivity), then the person will be less likely to seek help.
3. **Will others approve of my help-seeking?** If others, especially other men, are supportive, then the person will be more likely to go. Help--seeking is particularly likely if the group is important to the person and unanimous in their support.
4. **What will I lose if I ask for help?** For many the biggest obstacle to asking for help is fear of losing control: losing work privileges or status, being "locked up," or losing one's friends or family.
5. **Will I be able to reciprocate?** Usually, the mental health services offered do not allow opportunities for reciprocity. Because of ethical standards, the mental health practitioner is often not allowed to share personal information or receive favors, thus maintaining a position of power over the client. For some men, receiving help is acceptable only if they can return the favor later on; in the relationship with a mental health provider, this is often not possible. One exception is Alcoholics Anonymous (AA). According to their mission, "Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism." According to the AA fact file, men make up 65 percent of membership

in AA, indicating that this model of reciprocity is appealing to men. By contrast, among persons with any recent mental health disorder, a higher percentage of women (16%-26%) made mental health visits than men (9%-15%).

These data suggest that historical, traditional approaches to reaching men with mental health and suicide prevention messages have been mostly unsuccessful, and new innovative approaches need to be explored and developed (quoted from: Spencer-Thomas, et al., 2012, pp. 2-3).

Proposed Improvements & Solutions:

The following suggested approaches are taken from the work of Spencer-Thomas, et al. (2012) and their extensive research on connecting men to mental health resources. Some additions and adaptations have been made that are more specific to college-aged men.

#1 Better Contact & Communication with Men: Take the mental health language out of the communication, at least initially.

- Many at-risk men do not see their problems through a mental health lens, so communication such as, "if you are depressed, seek help," totally misses an important subgroup of men.

#2 Positive Role Models: Show male role models of hope and recovery so that men can imagine what help would look like for them.

- Share stories of men with "vicarious credibility" who have gone through tough times and found many alternative ways to healing.

#3 Positive Relationships / Mentors: Encourage men (and boys) to make positive connections with peers and mentors with whom they can talk about day-to-day stressors and other concerns.

#4 Identify Less Common, Masculine Symptoms of Distress: Be aware that male/masculine symptoms of distress may differ from expected symptomology. For example, men are more likely to express physical symptoms (changes in energy, sleep patterns, appetite, libido) in response to emotional issues.

#5 Meet Men Where They Are: Meet men where they are instead of trying to turn them into something they are not.

- Make messaging compelling to a male audience, even using dark humor. By taking a light-hearted approach, even poking fun at traditional therapy, we can open the doors to conversation.
- Bring the messages to where men show up (locations men frequent, media they pay attention to,

> **So long as we keep repeating the phrase, 'encourage male help-seeking behavior' in our grant applications, public health marketing, and outreach efforts, suicidal men with just keep dying. Hoping men will become more like women is costing us the lives of our fathers, brothers, sons, uncles, and nephews.**
>
> **- Paul Quinnett, 2010**

organizations and clubs they take part in, etc.)
- Use an internet-based approaches that allows for anonymity and self-assessment before making contact with a clinician

#6 Hurt people hurt people: Target "double jeopardy men": Men with the most risk factors who are also the least likely to seek help.

#7 Foster Connections with Others: Offer opportunities to give back and make meaning out of the struggle.
- Family, children, and legacy issues are often an important barrier to engaging in suicidal behavior.
- Volunteering, spiritual growth, and strengthened relationships are also helpful in finding meaning after despair and creating a sense of belonging.

#8 It Takes a Village: Coach the people around the high-risk men on what to look for and what to do
- Intimate partners are both the most likely cause for suicidal distress (e.g., divorce, separation, death) and the most likely person to intervene and influence a man to seek help.
- Peers, teachers, and co-workers need training, just like CPR, to help co-workers identify mental health concerns and suicidal distress and refer to helpful resources (www.ActiveMinds.org ; www.WorkingMinds.org).

#9 Help Men Help Themselves: Give men at least a chance to assess and "fix themselves."
- "Show me how to stitch up my own wound like Rambo," in-depth-interview participant.
- Focus on mastery--oriented intervention strategies that demonstrate progress and are time-limited.
- Simple, self--help strategies allow men to take action in smaller, concrete steps – many of them we know (e.g., sleeping and eating well) are critical to mental health

#10 Provide a safe space for men to discuss difficult issues: When working with male clients, be prepared to discuss and help them understand any aggressive or sexual issues they may experience without further shaming them about such content.
- The Dangers of Overreacting – When mental health providers react negatively or too harshly to a client's disclosure about difficult issues, men become hesitant to reveal thoughts, behaviors, and emotions that they have learned are "inappropriate" to discuss. The irony is that by not discussing these issues with men, they are left to their own devices about how to manage them, which can lead to additional psychological distress and destructive behaviors.
- The Dangers of Underreacting – When mental health providers minimize or dismiss difficult issues, environments, or relationships that a man may struggle with, the cultural notion that a man are entirely self-sufficient and the stigma of asking for help are reinforced. It is important that mental health providers not assume that men are less affected by serious issues like depression, suicide ideation, and abuse.

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