Male Mental Health: A Peek Inside the Black Box

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16.1 Introduction

Mental illness is a worldwide leading cause of poor health and disability, with approximately 450 million people currently suffering from mental illness [1]. The prevalence of mental health struggles in North America makes it an important topic of discussion. This chapter will examine the impact of mental health in adult males.

Approximately 10 % of Canadian and 16.8 % of American males suffer from mental illness [2, 3]. Men tend to be diagnosed with externalizing [e.g., schizophrenia, antisocial personality disorder, attention deficit hyperactivity disorder (ADHD), conduct disorder] and substance disorders more often than women [4]. In the United States, approximately 17 % of men and 8 % of women develop alcohol dependence during their lives [5].

Women are more often diagnosed with mood and anxiety disorders than men. The fairly stable 2:1 ratio seen across cultures might reason for a biological rationalization for depression, but research across countries suggests that social explanations are at play [6–8]. Interestingly, research suggests that this gender gap may even widen as we age [4]. A study on gender differences in mental disorders that included over 70,000 adults from 15 different countries and 4 different age groups showed that gender differences in major depressive disorder (MDD) and substance disorders were significantly smaller in younger cohorts [4]. The gender role hypothesis suggests that gender differences in mental health disturbances may become more prominent as the societal roles of males and females become more distinct. This is especially noted in more developed areas of the world such as North

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America, where gender roles of males and females are becoming more alike. Thus, recognizing the importance and role of gender norms and psychosocial factors in male mental health is crucial in improving their overall health and quality of life (QoL).

16.1.1 Screening Tools

Physicians play an essential role in identifying depression, which is considered a first step to improving mental health. Valid and reliable screening instruments are imperative. Accurate yet easy-to-administer depression screens can make it more convenient for physicians to incorporate psychological screening into clinical routines. Ideally, a diagnostic test should meet three criteria: provide accurate diagnostic information, support the need for therapy, and provide an index for improved patient outcomes [9].

Although there are many mental health and depression screening tools (for a review, see Anderson et al. [9]), two valid and reliable screening tools used in our clinic and research lab are the general health questionnaire twelve (GHQ-12; to assess general mental health) and the primary care evaluation of mental disorders (PRIME-MD; to assess depression) (see Table 16.1) [9]. The GHQ-12 is a self-administered screen used to identify current mental disturbances and disorders [10]. With only 12 items, the GHQ-12 is convenient for clinicians to use as an initial screening tool. It assesses a wide variety of mental disorders defined by the DSM-IV

Table 16.1 Mental health screening tools

Name	Abbreviation	Authors	Number of items	Administration	Description
General health questionnaire twelve	GHQ-12	Goldberg and Hillier	12	Self-administered	Measures the risk of developing psychological disorders
Patient health questionnaire nine	PRIME-MD/ PHQ-9	Kroenke, Spitzer, and Williams	9	Self-administered	Screens for depression
Patient health questionnaire two	PRIME-MD/ PHQ-2	Kroenke, Spitzer, and Williams	2–6	Clinician administered	Screens for depression. If answers to the first two questions are positive, four more specific questions are asked

including substance abuse, psychiatric disorders, mood disorders, and anxiety disorders.

To screen for depression, a self-report version of the PRIME-MD known as the patient health questionnaire nine (PHQ-9) can be easily completed in approximately 3 min by the patient [11]. The PHQ-9 provides a potential diagnosis and a depression severity score, making it a convenient tool to follow outcomes of therapeutic intervention [9]. The PHQ-9 is also a valid and reliable tool, making it applicable to both clinical and research purposes. To quickly screen for depression, a brief version of the PRIME-MD, the patient health questionnaire two (PHQ-2), requires the patient to answer 2 questions: (1) Have you been bothered by little interest or pleasure in doing things? (2) Have you been feeling down, depressed, or hopeless in the last month? If the patient responds yes to these questions, the healthcare provider should inquire further with questions related to sleep disturbance, appetite change, low self-esteem, and anhedonia (i.e., inability to experience pleasure). If the patient reports two or more of these additional disturbances, the provider should consider more comprehensive questioning of current stressors, supports, and physical comorbidities alongside immediate and longer-term treatment options [12].

16.2 Depression in Men

The incidence of depression is on the rise, with approximately 5 % suffering from the condition [13]. As many as 6 % of Canadians and 8 % of Americans are currently suffering from depression [14, 15]. Depression is the leading cause of disability for Americans between the ages of 15 and 44 years [16]. More specifically, within the United States, approximately six million men report depression each year [17]. A person diagnosed with a depressive disorder is experiencing a sad, empty, or irritable mood, accompanied by somatic and cognitive changes that greatly affect their ability to function [18]. Depressive disorders can range in severity and symptoms depending on the individual case. Therefore, targeting therapy to fit the individual is an important consideration.

Fewer men than women are diagnosed with depression in developed countries with a ratio of 2:1 [6, 7], but the underreporting of mental illness in men may account for this discrepancy. In addition, men may not exhibit the conventionally viewed symptoms of depression [19]. Men's depression symptoms may be expressed in terms of increases in fatigue, irritability and anger (sometimes abusive in nature), loss of interest in work or hobbies, and sleep disturbances rather than the traditional depressive sad affect [20]. It has also been suggested that men use more drugs and alcohol than women, perhaps to self-medicate their depression, which can hide symptoms of depression, making diagnosis and treatment more difficult. Therefore, a lower prevalence in men may be part underreporting, misdiagnosis due to nontraditional symptoms, and avoidance of services.

Although reported rates of depression in men are lower, suicide death rates are four times higher in men than women [21]. Suicide in men has been described as a "silent epidemic" due to its high prevalence and a lack of public awareness [22].

The incidence of male suicide increases with age, peaking in the late 40s [22]. Men's traditionally low levels of help-seeking behaviors may contribute to discrepancies in suicide rates. Indeed, in the year before suicide, an average of 58 % of women visited a mental health professional, while only 35 % of men sought out mental healthcare in the year before suicide [23]. Importantly, 78 % of men who died by suicide were in contact with their primary care provider (e.g., physician) within the year of their suicide. Receiving medical and/or psychological assistance from a healthcare professional can help counteract suicidal thinking, further supporting the role of primary care providers in mental health. Some men may even feel more comfortable going to see their physician than a psychologist. If the physician is able to screen for depression and suicidal tendencies, they will be in a much better position to encourage men to seek further help from a mental health professional.

16.3 What Promotes Mental Health Struggles in Males?

Understanding is a key start in any treatment approach. The dominant narrative about men is that men are more reluctant to seek help than women, regardless of the health concern. Likewise, according to the mental health literature, men are more likely to be resistant to seeking help for distress [24, 25]. However, research shows the links between gender and mental health struggles are more complex than once believed. In particular, the following areas have been promoted as key factors in male mental health:

16.3.1 Stigma

Stigma is the most prominent obstacle to seeking out and accessing mental health services for men [26]. Stigma refers to a set of negative beliefs, attitudes, and behaviors that labels individuals and disseminates stereotypes. Reducing stigma is necessary to increase the use of mental health services, in turn, enhancing mental health in general. When it comes to mental health, there are three main stereotypical elements involved in public stigma: dangerousness, avoidance, and character weakness [27]. A person with a mental illness is often believed to be violent or unpredictable [28, 29], leading others to avoid contact. These beliefs are unfortunately embedded in North American culture and may lead to reluctance in reporting poor mental health.

Men tend to have higher stigmatizing attitudes than women when it comes to mental health. In studies of depression stigmatization, men report higher proportions of stigmatizing attitudes than women. More specifically, men believed that depressed individuals could "snap out of it," should be avoided, and are unpredictable [26]. Previous research has indicated that education programs that raise awareness and increase mental health knowledge can help to reduce stigma [27]. By reducing stigmatizing beliefs in men, their own mental health may be

improved, especially if this leads to greater engagement in available mental health resources.

16.3.2 Help-Seeking Behaviors

There are several important factors that inhibit help-seeking behaviors in men: treatment fears (i.e., social stigma), fear of emotional display or experiences, anticipated risks, and self-disclosure [30]. Treatment fears refer to hesitation to seek assistance due to negative expectations, which is in part stigma, regarding mental health services. Help-seeking behaviors may also be impeded if the person is afraid to discuss painful emotions. The risk of opening up to another person and being misunderstood can lead to avoidance of mental health services. Finally, many men may not feel initial comfort in disclosing personal information with a healthcare provider or mental health professional.

Men's reluctance to seek help leads to underreported suffering in men [24, 31, 32]. Men are also more likely to deny the presence of a mental illness and engage in traditional positive self-management practices (e.g., talking therapy). Indeed, men are more likely to self-medicate with drugs and alcohol and engage in excessive working and infidelity than to communicate their distress [25].

Health-promoting behaviors seem to be associated with femininity, whereas risk-taking behaviors are interconnected with masculinity [33]. Illness is associated with weakness and vulnerability, contradicting the stoicism associated with masculinity [33]. This stereotypical thinking is thought to contribute to health differences between men and women. Therefore, this perception of "weakness" may contribute to men's hesitancy toward seeking treatment. Identifying and overcoming these traditional masculine stereotypes may play an important role in enhancing help-seeking behaviors.

16.3.3 Coping/Self-Regulation

Understanding how men manage stressful situations increases understanding of how to improve their mental health. Coping refers to a person's fluctuating cognitive and behavioral attempts to manage an internal or external demand [34]. The primary stressors men report are often related to work/finances and relationships with friends and lovers [35]. Men often use emotional suppression (e.g., ignoring or pretending that the stressor is not there) and problem-focused coping methods when they encounter a stressor [35]. Problem-focused coping involves active attempts to deal with stress, whereas emotion-focused coping involves ruminative and emotional responses, and for men problem-focused coping has better mental health outcomes [36, 37]. Emotional suppression in men is related to negative mood, decreased interpersonal functioning, and higher levels of psychopathology [38–40]. Therefore, coping strategies, especially a reduction in the use of emotional suppression, can be an important area of development for men in psychotherapy.

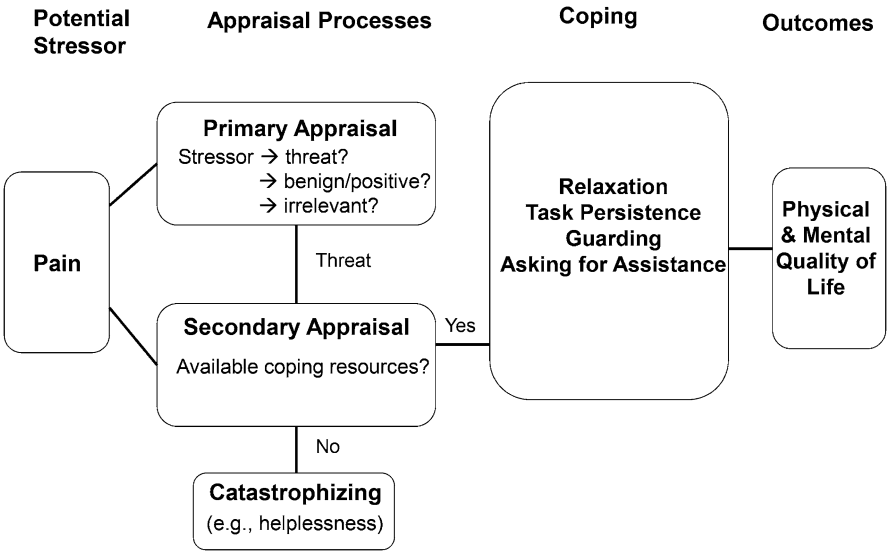

Fig. 16.1 Transactional model of stress applied to pain

Self-regulation theory describes an individual's ability to control or cope with their thoughts, feelings, and behaviors [41]. Self-regulation theory suggests that coping is influenced by appraisals of the stressor and expectancies for effective coping [42]. Lazarus and Folkman's transactional stress model suggests that the chosen coping strategy is a result of a series of appraisals (Fig. 16.1) [34]. For example, a chronic pain patient perceives their pain as a stressor. In their primary appraisal of the pain, they may interpret it as threatening, benign positive, or irrelevant [43]. If the pain is considered a threat, then the individual engages in secondary appraisal. At this stage, the individual contemplates their available coping resources in order to manage the situation. If the individual perceives that their coping resources are inadequate, negative appraisals can manifest such as feelings of helplessness.

16.4 Case in Point: Importance of Mental Health in Males with Urological Conditions

Mental health, including depression, has been a long-standing concern in urological health for decades. There are several urological conditions affecting men [e.g., benign prosthetic hypoplasia (BPH; enlargement of the prostate gland), prostate cancer, lower urinary tract symptoms (LUTS), erectile dysfunction (ED), interstitial cystitis (IC), chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS)]. Urological disturbances can lead to pain and a reduced QoL, especially when the condition is unmanaged. Men with urological diseases experience elevated levels of anxiety and depression [44, 45]. For instance, the risk of suicide in men with prostate cancer is over four times greater than men without it [46], and men with LUTS experience

higher levels of psychological distress including anxiety and depression [47]. Approximately 10 % of men with ED experience depression [19, 48]. Further, depression is significantly comorbid in CP/CPPS [49]. Therefore, psychological factors related to the distress experienced by men with urological conditions are an important area of research. Considering that urological conditions are common in aging men, it is important to examine the psychosocial impact these disorders can have.

Our research group has examined the implications of urological health for over 20 years. Recently, our research with men has focused on chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS), a disease characterized by a painful, persistent, nonbacterial inflammation of the prostate. Symptoms include urinary urgency and frequency and chronic pelvic pain. Prevalence rates are surprisingly high for CP/CPPS symptoms, between 2 and 16 % in North America [50, 51]. Unfortunately, symptoms experienced by these men may not subside, with 66 % of patients in a community-based sample continuing to experience symptoms 1 year after diagnosis [52]. The etiology of CP/CPPS is poorly understood, stressing symptom management and mental health.

Research suggests that 80 % of patients with CP/CPPS report some form of depression [49] and that 5 % of these men report suicidal thinking. Pain and urinary symptoms are exacerbated with depression [53], which can contribute to a diminished QoL. Depression has been described as a psychosomatic factor in CP/CPPS symptoms [54] and depression, urinary scores, and pain are predictors of poorer physical QoL [55, 56].

We know that how a patient copes with their symptoms can contribute to poorer QoL. There are two main behavioral coping strategies now considered in the urologic research: "wellness-focused" or active coping (WFC) and "illness-focused" or passive coping (IFC). WFC, such as relaxation and a person's persistence to stay on attempts to complete a chore or task, allows the individual to function despite pain [57]. IFC, which involves behaviors such as adopting a sedentary lifestyle (pain-contingent resting) and guarding (taking comforting physical positions when in pain), may lead the individual to surrender control to symptoms like pain. Indeed, pain-contingent resting is a predictor of poorer physical QoL in patients with CP/CPPS [56] and IFC has also been shown to be a mechanism that promotes higher pain and thus poorer mental and physical QoL in CP/CPPS [58]. Therefore, behavioral coping strategies play an important role in the management of CP/CPPS QoL and depression.

How CP/CPPS patients appraise symptoms is important to understand when considering disease management. Catastrophizing, a negative cognitive appraisal process for pain (see Sullivan, Bishop, and Pivik 1995 for the scale) [59], plays a critical role in mental QoL [58, 60]. Catastrophizing includes three components: rumination (inability to redirect thoughts away from the pain), magnification (expectancies for negative outcomes), and helplessness. Catastrophizing in men with CP/CPPS is associated with greater disability, depression, urinary symptoms, and pain [61]. More specifically, it has been shown that the helplessness component of catastrophizing predicts diminished mental QoL in men with CP/CPPS [56]. It is suggested that experiencing chronic symptoms (e.g., pain) alongside no effective standard medical therapy may generate a sense of helplessness in patients over time [62].

Social support plays an important role in patient management. Patients who report lower support also report diminished QoL, greater depression, disability, and pain severity [63]. There are three primary categories of social support from a significant other: (1) solicitous (e.g., "tries to get me to rest," "does some of my chores"), (2) distracting (e.g., "tries to get me involved in some activity"), and (3) negative or punishing (e.g., "gets angry with me"). In chronic pain conditions, these spousal responses to a partner's pain are associated with depression, disability, pain catastrophizing, and greater pain [64–67]. In men with CP/CPPS, highly solicitous responses to pain increase the negative impact of pain on disability [68]. Solicitous responses may encourage pain behaviors such as pain-contingent resting, as discussed earlier. In contrast, distracting responses to pain decrease the negative impact of pain on disability. Therefore, encouraging men to stay active in their lives and providing distraction techniques (e.g., puzzles, watching media programs, calling friends) may be an important component in preventing disability in CP/CPPS [62].

16.4.1 A Biopsychosocial Approach to Treating CP/CPPS?

The biomedical model is limited in scope, but a biopsychosocial model accounts for demographic, physical function, cognitive/ behavioral, and environmental patient domains. The biomedical CP/CPPS model has been criticized for its ineffectiveness in symptom management [69]. The integration of psychosocial interventions can contribute to better patient outcomes. For example, an eight-week psychosocial management program for CP/CPPS that was designed to teach patients to identify/

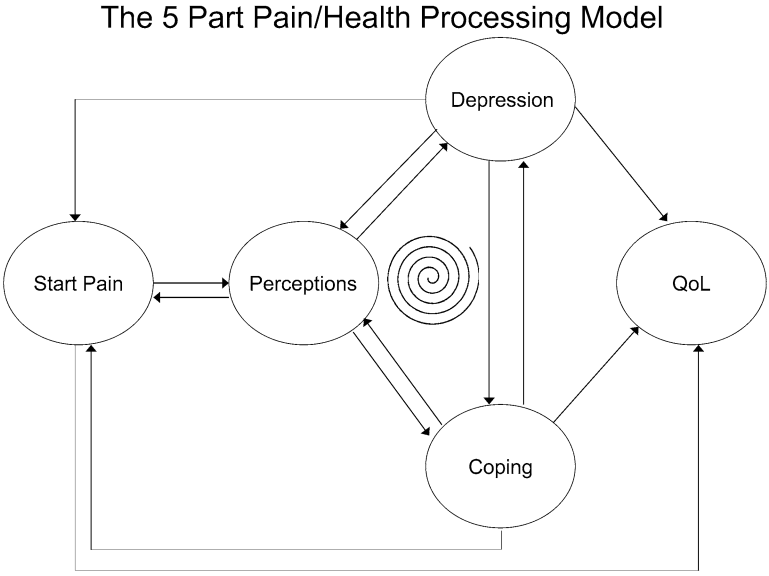

Fig. 16.2 The 5-part pain/health processing model. How pain is perceived influences how a patient copes. Perceptions of unmanageability can lead a patient to experience depressive symptoms. Depressive symptoms and poor coping strategies can exacerbate pain and decrease quality of life

dispute catastrophic thinking and to encourage health-focused behaviors has achieved reductions in patient pain, disability, and catastrophizing [70] (see Fig. 16.2). The authors suggest that by targeting both physical and psychosocial contributions to the patient experience, overall patient outcomes can be improved.

16.5 Psychological Support in Males

The data is clear; men suffering from CP/CPPS or male mental health in general are an underserviced group in need of psychological supports. Cognitive behavioral therapy (CBT) is a form of psychological treatment that focuses on the relationship between thoughts, feelings, and actions (e.g., Tripp et al. [70]). CBT practitioners often use an ABCDE model [71] to explain how positive self-regulation can go awry and be mended. As shown in Fig. 16.3, the event that creates upset or difficulty or triggers stress or worry for the patient is identified as an activating event (A). The patient may have rational (adaptive) or irrational (maladaptive) beliefs (B) regarding the cause or course of the activating event (e.g., "I created this pain," "It will never get any better," "My doctor cannot help me at all"). Positive beliefs about one's ability to manage or see hope in the future are likely to lead to more positive emotional, cognitive, and behavioral consequences, whereas negative beliefs, as suggested above, are likely to lead to anxiety, fear, and/or sadness (C). Operating with a therapist, patients work to identify irrational beliefs and then dispute them (D). Patients are encouraged to challenge their irrational beliefs by replacing negative/irrational thinking with a more adaptive evaluation of the situation (e.g.,

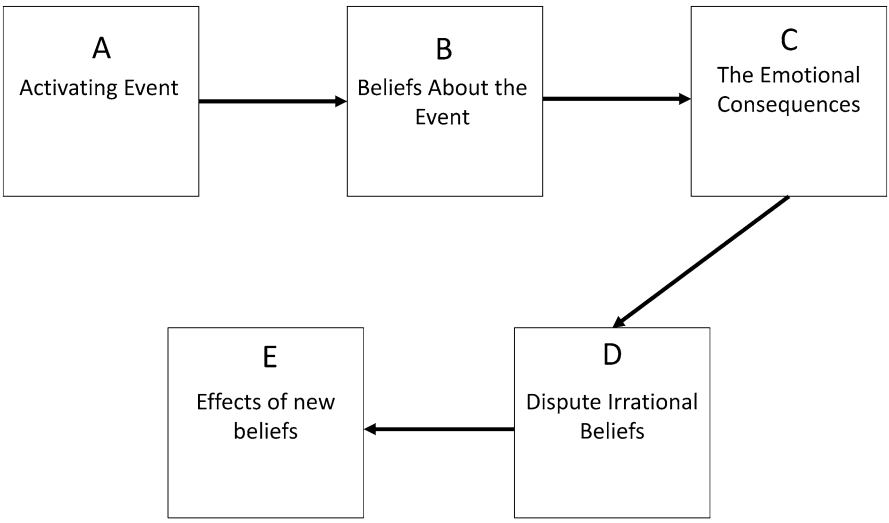

Fig. 16.3 ABCDE model of cognitive behavioral therapy [71]

consider alternate ways to cope versus sticking to one style that has not produced any improvements in the past—drinking alcohol, suppressing emotions, etc.). The last step is to employ the alternate beliefs or behaviors and to analyze the effects of such a change (E). With repeated attempts to work through this ABCDE cycle across a range of upsetting life events, patients in successful therapy will move toward having more self-enhancing responses (appraisals) to the situation and be more likely to cope in a manner that will promote more positive emotional, cognitive, and behavioral reactions.

Men are almost three times less likely to seek mental health services [72, 73], have negative attitudes toward therapy [74], and drop treatment prematurely compared to women [75]. Men's reluctance to be part of therapy can be manifest from their beliefs on how a "man" should feel and behave [74]. The commonly held belief for therapy in the popular media is that emotionally difficult self-disclosure is paramount to treatment. Unfortunately, many men would see this process in stark contrast to the traditional social norms they have been raised under. If emotional disclosure in therapy is suggested as an important component of patient success [76] and many men will rigidly view this as contrary or unacceptable with how they "see" their place in the world, we will need to adjust therapy or at least the male perception of therapy. This is ironic because CBT therapies are well suited to identify and dispute rigid/irrational thinking. For example, male gender role norms may manifest emotional suppression, superiority, and self-sufficiency, making many men more likely to respond to techniques that focus on beliefs and their behaviors, rather than on how they feel about an event. Indeed, in our therapy [70], men were provided with a focused behavioral approach to help manage stressful life events and told that the therapy was designed to help them "beat" pain and symptoms and "live" in spite of these factors. This sense of opposition and confrontation of their physical situation was well received, at least anecdotally. Clinicians focused on the treatment of men can also add subtle changes to connect with and accommodate men. For example, office space that has a traditional male-based theme, such as sports-themed art or memorabilia, or using male-friendly terms like "meetings" rather than "therapy sessions" may provide a more comfortable environment for men.

16.6 Conclusions

This chapter reports on data stressing that men's mental health is a warranted healthcare issue and an often-misinterpreted issue when it comes to quality of life. From mental health screening to treatment, male patient care maps must be considered and individualized as required. Depression is a salient aspect of male mental health and this chapter provides some insight into factors that may contribute (e.g., stigma, masculine gender norms, low help-seeking behaviors, and coping). A biopsychosocial model with concern for the gender-based norms of men is suggested

as a preferred approach in understanding men's health. Such a tactic will allow the consideration of physical, psychological, and environmental factors as key to enhancing patient well-being. Improved psychological support is necessary and psychological interventions such as cognitive behavioral therapy can benefit men, especially if they are tailored to approach men from a gender-based norm perspective.

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