Psychosocial Well-Being of Men

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a physician, behavioral health professional, or Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

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Faculty Disclosure

Contributing faculty, Lori L. Alexander, MTPW, ELS, MWC, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Contributing faculty, John M. Leonard, MD, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for physicians, physician assistants, nurses, and behavioral health professionals seeking to enhance their knowledge of issues related to men's psychosocial well-being.

Accreditations & Approvals

JOINTLY ACCREDITED PROVIDER™ INTERPROFESSIONAL CONTINUING EDUCATION

In support of improving patient care, NetCE is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

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A complete Works Cited list begins on page 9.

Mention of commercial products does not indicate endorsement.

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Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to 1 MOC point in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program. Participants will earn MOC points equivalent to the amount of CME credits claimed for the activity. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM MOC credit. Completion of this course constitutes permission to share the completion data with ACCME.

Successful completion of this CME activity, which includes participation in the evaluation component, enables the learner to earn credit toward the CME and Self-Assessment requirements of the American Board of Surgery's Continuous Certification program. It is the CME activity provider's responsibility to submit learner completion information to ACCME for the purpose of granting ABS credit.

This activity has been approved for the American Board of Anesthesiology's® (ABA) requirements for Part II: Lifelong Learning and Self-Assessment of the American Board of Anesthesiology's (ABA) redesigned Maintenance of Certification in Anesthesiology Program® (MOCA®), known as MOCA 2.0®. Please consult the ABA website, www.theABA.org, for a list of all MOCA 2.0 requirements. Maintenance of Certification in Anesthesiology Program® and MOCA® are registered certification marks of the American Board of Anesthesiology®. MOCA 2.0® is a trademark of the American Board of Anesthesiology®.

Successful completion of this CME activity, which includes participation in the activity with individual assessments of the participant and feedback to the participant, enables the participant to earn 1 MOC points in the American Board of Pediatrics' (ABP) Maintenance of Certification (MOC) program. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABP MOC credit.

This activity has been designated for 1 Lifelong Learning (Part II) credit for the American Board of Pathology Continuing Certification Program.

Through an agreement between the Accreditation Council for Continuing Medical Education and the Royal College of Physicians and Surgeons of Canada, medical practitioners participating in the Royal College MOC Program may record completion of accredited activities registered under the ACCME's "CME in Support of MOC" program in Section 3 of the Royal College's MOC Program.

NetCE designates this continuing education activity for 1 ANCC contact hour.

This activity was planned by and for the healthcare team, and learners will receive 1 Interprofessional Continuing Education (IPCE) credit for learning and change.

NetCE designates this continuing education activity for 1.2 hours for Alabama nurses.

AACN Synergy CERP Category A.

Social workers completing this intermediate-to-advanced course receive 1 Clinical continuing education credit.

NetCE designates this continuing education activity for 0.5 NBCC clock hour.

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Special Approvals
This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency, and California Assembly Bill 241, Implicit Bias.

About the Sponsor
The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

Disclosure Statement
It is the policy of NetCE not to accept commercial support. Furthermore, commercial interests are prohibited from distributing or providing access to this activity to learners.

Course Objective
The purpose of this course is to provide health and mental healthcare professionals with necessary information regarding psychosocial conditions and issues that affect men in order to facilitate more effective diagnosis, treatment, and care.

Learning Objectives
Upon completion of this course, you should be able to:

1. Describe the impact of stress and anger on men.
2. Outline the presentation and approaches to treatment for substance use disorder in men.
3. Describe the diagnosis and treatment of depression in male patients.

EVIDENCE-BASED PRACTICE RECOMMENDATION

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

Psychosocial well-being is important to men, and many conditions or situations can disrupt the sense of well-being. Among the more common factors that can have a negative effect on well-being for both sexes are everyday stressors (positive as well as negative), personal conflicts, traumatic events, and depression. In general, men lack the social support and interpersonal relationships that help women to cope with stresses [1]. Because of this, men differ in their ability to handle stress, with many men resorting to anger, violence, and substance misuse to deal with stress or depression [2; 3]. As a result, stress/anger, substance misuse, and depression are among the psychosocial conditions with the most serious health implications for men. Most men will not seek help for psychosocial disorders and may not recognize the symptoms of depression [3; 4; 5]. Thus, it is important for healthcare providers to address psychosocial well-being and potential threats to well-being as part of routine health evaluations of men.

EVIDENCE-BASED PRACTICE RECOMMENDATION

The American Psychological Association (APA) recommends that psychologists and other mental health professionals should strive to reduce the high rates of problems boys and men face and act out in their lives such as aggression, violence, substance abuse, and suicide.

(https://www.apa.org/about/policy/boys-men-practice-guidelines.pdf. Last accessed March 21, 2025.)

Level of Evidence: Expert Opinion/Consensus Statement

STRESS/ANGER

Stress and anger have long been associated with negative health consequences. Most of the earlier research focused on the effects of stress and hostility on coronary heart disease, and additional research has found a link between hostility and a more rapid decline in lung function in older men [6; 7; 8]. Appropriate expression of anger has been suggested as a way to improve health, and controlling anger has been shown to promote well-being in older individuals [9].

Safety is also of concern, as anger has been associated with an increased incidence of injuries and violence. In one study, higher levels of anger (at a given moment) were associated with an increased risk of injury, especially in men [10]. In that study, nearly 32% of individuals who had been injured reported having some degree of irritability before the injury.

Men are the usual perpetrators of intimate partner violence causing injury, and these men tend to be younger (18 to 35 years of age), to be from a racial/ethnic minority population, and to have low socioeconomic status [11; 12]. Substance misuse and unemployment are also associated with such violence [11]. However, identifying a perpetrator of intimate partner violence in a clinical setting is difficult [12]. It is important to remember that men can also be victims of intimate partner violence, and this is especially true for men who have sex with men (MSM) [13].

Although the U.S. Preventive Services Task Force (USPSTF) found insufficient evidence for or against routine screening for intimate partner violence (including child abuse and elder abuse), a survey of patients within a private family practice network showed that 97% of respondents believed that physicians should ask patients about family stress and conflict [14; 15]. The survey sample included women who had been physically hurt by intimate partner violence as well as men who had admitted perpetrating such injury. These findings support early studies that indicated patient preference for clinicians to ask questions about physical and sexual abuse [16]. The American Academy of Family Physicians (AAFP) notes that family physicians have the opportunity to provide early intervention in family violence through routine screening and identification of abuse; thus, physicians should be alert for the presence of family violence in virtually every patient encounter [17]. It seems reasonable and appropriate for clinicians to include within routine health assessments of men questions about feelings of anger and frustration and urges to strike family members [11; 13]. Suggestions for strategies that focus on anger management and conflict resolution may be helpful, especially for adolescents and young men [13].

SUBSTANCE MISUSE

As noted, substance misuse is higher among men than among women in all age categories, and men are more likely to have psychosocial problems related to the misuse [2; 11]. Although the rate of alcohol misuse is highest among younger men, men older than 65 years of age are of special concern because they are much more likely than women to be "problem" drinkers and to misuse a wide range of illicit as well as prescription drugs [11]. As the general population ages, the misuse of illicit drugs is expected to increase [18]. Adding to this problem is the low rate of screening for alcohol misuse in the older population and the secrecy of many men about drug use [18; 19].

Additional concerns are the use of anabolic steroids among adolescents and young adult men and the use of methamphetamine among MSM. Use of anabolic steroids begins during the teenage years in approximately 25% of cases, and about 10% of all users are teenagers [20]. The prevalence of methamphetamine use among MSM is approximately 10% to 20%, a rate that is 10 times higher than that in the general population [21].

Several professional organizations, including the USPSTF, recommend screening and behavioral counseling intervention to reduce alcohol misuse [22]. However, reported rates of screening have been low [23]. Several screening instruments have been developed, and they vary in the number of questions, the populations for which they are best suited, and their usefulness in specific situations; no one tool is perfect [24; 25; 26; 27]. The CAGE questionnaire, which includes four questions, is best for detecting alcohol dependency and is easy and quick to perform [24; 25]. However, the test may not detect low, but risky, levels of drinking [11; 28]. The Alcohol Use Disorders Identification Test (AUDIT) is the most accurate for detecting problem drinking [23; 26].

Screening in the older population is especially important, as low levels of alcohol use can cause morbidity due to age-related physiologic changes, comorbidities, and the use of prescription medications [29]. Screening tools developed specifically for older individuals should be used, such as the geriatric version of the Michigan Alcohol Screening Test (MAST) or the Alcohol-Related Problems Survey (ARPS) [29; 30; 31]. Clinicians should also ask specific questions about drug use.

A medical history is also helpful, and a family history of alcoholism is a risk factor [23]. Clues to a problem with alcohol can be provided by such symptoms as amnesic episodes, mood swings, chronic fatigue, gastrointestinal symptoms, anxiety, and excessive sweating [23]. Several physical findings can suggest that a patient has a problem with alcohol or drugs, including [23; 28]:

- Mild tremor
- Unsteady gait
- Tachycardia
- Odor of alcohol or marijuana
- Enlarged, tender liver
- Nasal irritation (cocaine use)
- Conjunctival irritation (marijuana use)
- Excessive use of aftershave or mouthwash
- Signs of chronic obstructive pulmonary disease, hepatitis B or C, or HIV infection

Signs that should raise a "red flag" about substance misuse are frequent absences from work or school, history of frequent trauma or accidental injuries, depression or anxiety, other substance misuse, labile hypertension, sexual dysfunction, sleep disorders, poor nutrition, gastrointestinal symptoms, and interpersonal conflicts [11; 23; 28].

Clinicians should provide brief interventions, such as short counseling strategies, for men who are identified to have at-risk drinking. These interventions have been shown to be effective [23; 28; 32]. Alcoholism and drug addiction are best treated by an addiction medicine specialist or through an inpatient or outpatient program [28]. Primary care providers should have referrals for counseling and treatment readily available, as well as resources on support groups, such as Alcoholics Anonymous and Narcotics Anonymous.

To help healthcare professionals carry out the appropriate diagnosis and treatment of patients with alcohol problems, the National Institutes on Alcoholism and Alcohol Abuse (NIAAA) developed the publication Core Resource on Alcohol, which features an updated guideline on screening and brief intervention. These resources are available on the NIAAA website at https://www.niaaa.nih.gov/health-professionals-communities/core-resource-on-alcohol.

DEPRESSION

Depression is often regarded as a "woman's disease" because it is diagnosed more frequently in women than men. However, researchers and the health community at large now realize that depression is of serious concern in men and is underdiagnosed [2; 33]. According to data from 2020, the prevalence of major depressive episode was 6.2% among men and 10.5% among women [34].

Despite the lower rates of depression in men compared with women, the rate of completed suicide is nearly four times higher for men (25.8 vs. 7.1 per 100,000) [35]. Suicide is a leading cause of death for men in many age groups and across all racial/ethnic populations, except for the Black population [35]. There is some evidence that loneliness, while experienced by both men and women with depression, may be a stronger predictor of suicidal ideation among younger men than other demographic groups [36]. Researchers have hypothesized that feeling understood and loneliness likely function as serial mediators rather than as parallel mediators. In essence, the positive effect of disclosure of distress and feeling understood on depression and suicidality scores may be explained through loneliness measures [37].

The underdiagnosis of depression in men involves clinician-related and patient-related factors. Clinicians' lack of appropriate training and discomfort with dealing with depression contribute to a low rate of diagnosis, estimated to be about 50% [38; 39]. In addition, no screening instrument for suicide risk has been shown to reliably detect suicide risk in primary care populations [40]. This is unfortunate, as primary care providers appear to be in a position to intervene. As many as 83% of people who died by suicide had contact with their primary care physician in the year before death, with approximately 20% seeing their physician one day before death [38; 41]. In addition, 50% to 66% of individuals who committed suicide saw their primary care physician within one month of their death, with 10% to 40% committing suicide within one week of the visit [40]. Thus, better recognition of depression and suicide risk by primary care providers may help reduce suicide rates.

Many patient-related factors in the underdiagnosis of depression are primarily related to gender issues, including [2; 3; 33; 38; 42; 43]:

- Reluctance of men to seek help
- Lack of men's recognition of the symptoms of depression
- Hesitancy of men to express emotions
- Tendency for men to see depression as a weakness
- Men's misconceptions about mental illness and its treatment

DIAGNOSIS

Because men are less likely to express their emotions, they may recognize and discuss only the physical symptoms of depression, making diagnosis a challenge [3; 5; 42]. A carefully taken history can elicit information about risk factors, which include a family history of depression, the use of some medications (beta blockers, histamine H2-receptor antagonists, benzodiazepines, and methyldopa), chronic illness or other comorbidity, lack of social support, recent life stressor, and single marital status [11; 44]. Substance misuse frequently occurs concomitantly with depression, more often in men than women, but the direction of the causal relationship is not clear [3; 44].

Many of the symptoms of depression reported by women are the same for men: depressed mood, changes in appetite and sleep habits, problems with concentration, and an inability to find pleasure in once pleasurable activities [3]. It has been proposed that the symptoms of depression in men represent a male depressive syndrome, characterized by such symptoms as irritability, acting-out, aggression, low tolerance of stress, low impulse control, tendency to blame others, and a greater willingness to take risk [2; 3; 38; 42]. Men with depression may thus present with a very different symptom profile [33].

EVIDENCE-BASED PRACTICE RECOMMENDATION

The APA recommends that those assessing boys and men strive to be aware of traditional masculine gender role characteristics that render underlying psychological states difficult to assess. In clinical settings, ask boys and men questions about mood and affect and be willing to probe more extensively when faced with brief responses. Clinicians should work to accurately assess masculine socialization and ideology using gender-sensitive assessment tools and to learn specific assessment strategies for masculine depression.

(https://www.apa.org/about/policy/boys-men-practice-guidelines.pdf. Last accessed March 21, 2025.)

Level of Evidence: Expert Opinion/Consensus Statement

Identification of suicide risk is an essential component of the evaluation of patients with depression. Many of the risk factors for suicide are similar to those for depression; when the circumstances surrounding completed suicides were reviewed, the following were found to be factors [35]:

- Loss of a partner (through death or other means)
- Loss of job
- History of mental illness
- Depressed mood
- Previous suicide attempts
- Physical health problems
- Intimate partner problem
- Preceding or impending crisis (within two weeks)
- Financial problem

Clinicians should ask questions to determine the duration of symptoms and explore possible triggers of depression [33]. Because of their lack of experience with discussing emotions, many men may be uncomfortable with open-ended questions such as, "How do you feel?"; rather, discussing emotions in situational contexts can help men better express what they are feeling and why [42]. It may also be helpful to de-emphasize the negative connotation of depression and frame questions within the overall context of health and well-being [18].

TREATMENT OPTIONS

The treatment approach will depend on the severity of symptoms and the patient's preference. In general, a combination of psychotherapy and pharmacologic management provides the best results for most men [33; 44]. Potential psychotherapy approaches include cognitive behavior therapy and interpersonal psychotherapy [3; 11; 33]. First-line pharmacologic treatment involves the use of selective serotonin reuptake inhibitors, such as paroxetine, sertraline, and fluoxetine [11]. This treatment approach has efficacy rates of 30% to 70% [33]. Clinicians should emphasize the importance of taking the medication as prescribed, as it may be two to four weeks before a benefit is evident [33]. Depression that is associated with chronic illness is often seen as an inevitable consequence of the disease, but the depression should be treated. Frequently, the treatment improves the overall outcome [44].

To improve outcomes for men with depression, it is crucial to address the underlying gender-related factors that contribute to underdiagnosis and undertreatment, including reducing stigma, promoting help-seeking and early intervention, and considerations of gender-specific factors when developing treatment plans.

CONCLUSION

The psychosocial well-being of men is a multifaceted issue that requires comprehensive attention from healthcare providers. Stress, anger, substance misuse, and depression are significant factors that can adversely affect men's health, often leading to severe consequences such as violence and suicide. Despite the challenges in diagnosis and treatment, particularly due to societal norms and personal reluctance, it is crucial for clinicians to incorporate routine screenings and interventions into their practice. By addressing these issues with sensitivity and providing appropriate resources and support, healthcare professionals can play a pivotal role in improving the mental health and overall well-being of men.

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

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