2011 MASSACHUSETTS FAMILY IMPACT SEMINAR

MASSMEN

Men at risk

The Physical, Mental and Social Health of Men in Massachusetts

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Public Enterprise

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BRIEFING REPORT

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Purpose and Presenters

In 2009, Clark University was accepted as the university to represent Massachusetts in the National Policy Institute for Family Impact Seminars at the University of Wisconsin – Madison (http://familyimpactseminars.org). Family Impact Seminars are a series of annual seminars, briefing reports, and discussion sessions that provide up-to-date, solution-oriented research on current issues for state legislators, their aides, and legislative support bureau personnel. The seminars provide objective, nonpartisan research on current issues and do not lobby for particular policies. Seminar participants discuss policy options and identify common ground where it exists.

Men at Risk: The Physical, Mental, and Social Health of Men in Massachusetts is the second Massachusetts Family Impact Seminar, and it is designed to emphasize a family perspective in policymaking on issues related to the hidden crisis of men's health in the Commonwealth. In general, Family Impact Seminars analyze the consequences an issue, policy, or program may have for families.

THIS SEMINAR FEATURES THE FOLLOWING SPEAKERS:

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Executive Summary

BY DENISE A. HINES, PH.D.

The state of men's physical, mental, and social health in the Commonwealth of Massachusetts is cause for concern, particularly given our current economic climate of high unemployment, a climate that tends to exacerbate these already highly problematic issues for men. This briefing report features three essays by experts – James Mahalik, Michael Addis, and Emily Douglas – who focus on each of these three aspects of men's health.

Although this report treats these issues separately, they are very much intertwined. Research demonstrates that mental and physical health have a reciprocal relationship with each other, with poor mental health influencing poor physical health and vice versa. Moreover, they both are intertwined with men's social health, in that men who are divorced or separated, in comparison to their married counterparts, have poorer physical health, eat fewer fruits and vegetables, drink and smoke more, and are at greater risk of committing suicide.

Gender is the strongest and most consistent predictor of health and longevity. Men die earlier than women, with women's average age at death in the U.S. at 83 and men's at 78. Men die at higher rates from 14 of the 15 leading causes of death, except for Alzheimer's disease; 3 out of every 4 persons under the age of 65 who die of heart disease are men, and men have a 1 in 2 lifetime risk of developing cancer, compared to 1 in 3 for women.

The majority of these gender differences in health are due to lifestyle differences that are modifiable. Hundreds of empirical studies show that men are more likely than women to engage in almost every health risk behavior that increases their risk of disease, injury, and death. These risks include not getting preventive care or delaying seeking healthcare when symptoms arise.

All too often, we accept men's shorter lives as inevitable, natural, or inherent. However, policymakers in Massachusetts need to be concerned about men's shorter life span, more severe disease states, and riskier health behaviors because they cost hundreds of billions of dollars per year in lost productivity and health care costs. Thus, governments end up absorbing the enormous costs that the premature death and disability of men incurs, including the costs of caring for dependents who were left behind.

What causes men's poorer health? James Mahalik's research shows three prominent themes: (1) the way we socialize men to be men is antithetical to health-promoting behaviors, and men's adherence to traditional masculine norms is a consistent predictor of health-risk behaviors; (2) men's beliefs about other men's health behaviors is that it is normal for men to engage in health-risk behaviors, and when men perceive that other men are engaging in health-risk behaviors, they are more likely to report engaging in health-risk behaviors as well; and (3) society is full of barriers to men engaging in health-promoting behaviors; for example, missing work, or not being able to leave work to make physician's appointments that are typically scheduled from 9 to 5, are prominently identified as barriers for men.

Michael Addis then introduces us to some disturbing statistics regarding men's mental health, including that men commit suicide at four times the rate of women; that clinical depression is under-diagnosed in men; that men have higher rates of alcohol and substance abuse than women; and that despite these figures, men are far less likely than women to utilize available mental health services.

Dr. Addis' work shows that we are taught from a young age that men are expected to be tough, strong and stoic at all times. Consequently, when men struggle with real mental health problems, they are met by social stigma and a lack of support. This harsh reality has led many men to hide their mental health problems and suffer alone. As a result, men dealing with a mental health issue often experience an escalation of distress and pathology that can leave them out of work, detached from loved-ones, addicted to alcohol or other drugs, and on the brink of committing suicide.

Researchers have also demonstrated that individuals who avoid seeking mental health care end up using a greater amount of health services than those who receive treatment early on. This results in greater social and financial costs to the individual, family, and society.

Unemployment, which is currently a state for many Massachusetts men during this "Man-cession", only exacerbates these issues. Men are especially vulnerable to mental health issues when facing unemployment, including suicide, alcohol and substance abuse, and depression. In fact, in comparison to women, men have been shown to suffer more psychological problems from unemployment.

These undiagnosed and untreated mental health problems for men are associated with excessive burdens to the state and families. For example: (1) untreated and mistreated mental illness in the United States results in $150 billion in lost productivity and $8 billion in crime and welfare costs every year; (2) if businesses and government increased spending on mental health treatment by 5.5%, these costs could be reduced by 50%; and (3) people living with major mental illness die 25 years earlier on average than other Americans.

In addition to these burdensome physical and mental health issues, the family health of men is also in peril, as discussed by Emily Douglas. Divorce and loss of child custody are issues faced by up to 50% of men. In Massachusetts, the divorce rate is 2.3 per 1,000 persons, and most men do not retain physical or residential custody of their children after divorce. Moreover, contrary to popular belief, men's social health often suffers after divorce or family disruption, and such distress includes lower incomes, increased financial burdens, depression and emotional pain, alcohol abuse, feeling shut out of their children's lives, and not being able to be a father in the way they had once been.

Men's adjustment to post-divorce life is closely tied to their relationships with their children and former partners. Research documents that, unless there is evidence of maltreatment or violence, children and fathers are better off when they have regular and frequent access with each other. Moreover, fathers who are involved with their children are also more likely pay child support and to emotionally support their former partners.

Somewhat linked to the issues of divorce and child custody is the issue of domestic violence (DV), and what most policymakers do not know is that men are often the victims of domestic violence as well. In fact, current estimates are that over 800,000 men per year are the victims of domestic violence in the U.S., yet because of many of the reasons discussed about accessing physical and mental health care, men do not readily admit to or seek help for this issue.

Nonetheless, men's domestic violence victimization has been shown to result in physical injuries, mental health problems, and poorer physical health. What is particularly troublesome is that their efforts at seeking help often exacerbate their mental health issues. Often, men report being turned away from DV agencies and hotlines because the agencies say that they only help women; others report that agency staff ridicule them for being "wimps" and "letting" their partners abuse them. Overall, the majority of men who do seek help from first responders – DV agencies, DV hotlines, and the police – report these agencies to be not at all helpful.

What can Massachusetts do to improve the physical, mental, and social health of men? Several suggestions and policy options are forwarded in these three reports, and they all focus on a multi-level and multi-pronged approach to dealing with this hidden crisis. A few of the more consistent suggestions will be summarized here.

Massachusetts is a leader in providing high quality physical and mental health services in this country; however, more effort is needed to get men to utilize these existing services. Massachusetts is also a leader in providing high quality domestic violence victim services, but these services need to consistently be made available to men.

One overarching recommendation is the creation of a Men's Health Commission for Massachusetts. We have a Men's Health Partnership, under the direction of the Department of Public Health, but it is limited in its scope. Men's Health Commissions have been established in a few states, and their goals could encompass the men's health issues raised in this report.

Public education campaigns would be a powerful tool. Our nation and the Commonwealth have tackled important health and social conditions through the use of public education about a variety of topics, including the health risks of smoking, violence against women, shaken baby syndrome, Sudden Infant Death Syndrome and the "Back-to-Sleep" campaign, and child sexual abuse prevention. Similar campaigns can be undertaken to promote men's physical, mental, and social health.

As our experts recommend, such campaigns need address men as men, and consider the ways that we have socialized men, normative beliefs about men's behavior, and the public's perceptions of men. Thus, campaigns should strive to have both high-profile and everyday men discussing their struggles with health, mental health, divorce, and domestic violence victimization, and that it is manly to get help for these problems.

Another prominent suggestion is to begin education on these issues early, since many of these beliefs and behaviors start when men are boys. If we can socialize boys early on about the manliness of being healthy and seeking help when necessary – for example, through health-promotion classes in schools – the health of men in this country would improve greatly, and the costs for Massachusetts and the families living here would decrease substantially.

Assessing the Impact of Policies & Programs on Families

FAMILY IMPACT CHECKLIST

The first step in developing family-friendly policies is to ask the right questions:

- **What can government and community institutions do to enhance the family's capacity to help itself and others?**
- **What effect does (or will) this policy (or program) have for families? Will it help or hurt, strengthen or weaken family life?**

These questions sound simple, but they can be difficult to answer. These questions are the core of a family impact analysis that assesses the intended and unintended consequences of policies, programs, and organizations on family stability, family relationships, and family responsibilities. Family impact analysis delves broadly and deeply into the ways in which families contribute to problems, how they are affected by problems, and whether families should be involved in solutions. Guidelines for conducting a family impact analysis can be found at www.familyimpactseminars.org/fi_howtocondfia.pdf.

Family impact questions can be used to review legislation and laws for their impact on families; to prepare family-centered questions or testimony for hearings, board meetings, or public forums; and to evaluate programs and operating procedures of agencies and organizations for their sensitivity to families. Six basic principles serve as the criteria of how sensitive to and supportive of families policies and programs are. Each principle is accompanied by a series of family impact questions.

The principles are not rank-ordered and sometimes they conflict with each other, requiring trade-offs. Cost effectiveness also must be considered. Some questions are value-neutral and others incorporate specific values. This tool, however, reflects a broad bi-partisan consensus, and it can be useful to people across the political spectrum.

Principle 1.

FAMILY SUPPORT & RESPONSIBILITIES.

Policies and programs should aim to support and supplement family functioning and provide substitute services only as a last resort.

Does the proposal or program:

- support and supplement parents' and other family members' ability to carry out their responsibilities?
- provide incentives for other persons to take over family functioning when doing so may not be necessary?
- set unrealistic expectations for families to assume financial and/or caregiving responsibilities for dependent, seriously ill, or disabled family members?
- enforce absent parents' obligations to provide financial support for their children?

Principle 2.

FAMILY MEMBERSHIP & STABILITY.

Whenever possible, policies and programs should encourage and reinforce marital, parental, and family commitment and stability, especially when children are involved. Intervention in family membership and living arrangements is usually justified only to protect family members from serious harm or at the request of the family itself.

Does the policy or program:

- provide incentives or disincentives to marry, separate, or divorce?
- provide incentives or disincentives to give birth to, foster, or adopt children?
- strengthen marital commitment or parental obligations?
- use appropriate criteria to justify removal of a child or adult from the family?
- allocate resources to help keep the marriage or family together when this is the appropriate goal?
- recognize that major changes in family relationships such as divorce or adoption are processes that extend over time and require continuing support and attention?

Principle 3.

FAMILY INVOLVEMENT & INTERDEPENDENCE.

Policies and programs must recognize the interdependence of family relationships, the strength and persistence of family ties and obligations, and the wealth of resources that families can mobilize to help their members.

To what extent does the policy or program:

- recognize the reciprocal influence of family needs on individual needs, and the influence of individual needs on family needs?
- recognize the complexity and responsibilities involved in caring for family members with special needs (e.g., physically or mentally disabled, or chronically ill)?
- involve immediate and extended family members in working toward a solution?
- acknowledge the power and persistence of family ties, even when they are problematic or destructive?
- build on informal social support networks (such as community/neighborhood organizations, religious communities) that are essential to families' lives?
- respect family decisions about the division of labor?
- address issues of power inequity in families?
- ensure perspectives of all family members are represented?
- assess and balance the competing needs, rights, and interests of various family members?
- protect the rights and safety of families while respecting parents' rights and family integrity?

Principle 4.
FAMILY PARTNERSHIP & EMPOWERMENT.

Policies and programs must encourage individuals and their close family members to collaborate as partners with program professionals in delivery of services to an individual. In addition, parent and family representatives are an essential resource in policy and program development, implementation, and evaluation.

In what specific ways does the policy or program:

- provide full information and a range of choices to families?
- respect family autonomy and allow families to make their own decisions? On what principles are family autonomy breached and program staff allowed to intervene and make decisions?
- encourage professionals to work in collaboration with the families of their clients, patients, or students?
- take into account the family's need to coordinate the multiple services required? Does it integrate well with other programs and services that the families use?
- make services easily accessible to families in terms of location, operating hours, and easy-to-use application and intake forms?
- prevent participating families from being devalued, stigmatized, or subjected to humiliating circumstances?
- involve parents and family representatives in policy and program development, implementation, and evaluation?

Principle 5.
FAMILY DIVERSITY.

Families come in many forms and configurations, and policies and programs must take into account their varying effects on different types of families. Policies and programs must acknowledge and value the diversity of family life and not discriminate against or penalize families solely for reasons of structure, roles, cultural values, or life stage.

How does the policy or program:

- affect various types of families?
- account for its benefits to some family types but not others? Is one family form preferred over another? Does it provide sufficient justification for advantaging some family types and for discriminating against or penalizing others?
- identify and respect the different values, attitudes, and behavior of families from various racial, ethnic, religious, cultural, and geographic backgrounds that are relevant to program effectiveness?
- acknowledge intergenerational relationships and responsibilities among family members?

Principle 6.
SUPPORT OF VULNERABLE FAMILIES.

Families in greatest economic and social need, as well as those determined to be most vulnerable to breakdown, should be included in government policies and programs.

Does the policy or program:

- identify and publicly support services for families in the most extreme economic or social need?
- give support to families who are most vulnerable to breakdown and have the fewest resources?
- target efforts and resources toward preventing family problems before they become serious crises or chronic situations?

Acknowledgements

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The Status of Men's Physical Health: A Cause for Concern for the Commonwealth of Massachusetts

BY JAMES R. MAHALIK, PH.D., WITH THE ASSISTANCE OF DENISE A. HINES, PH.D.

Men's health status in the United States and Massachusetts is a hidden cause for alarm, but is increasingly becoming a concern for policymakers [1]. Most of us already know that men die earlier than women; the current estimate is that women's average age at death in the U.S. is 83, whereas it is 78 for men. However, what most people do not know is that the life expectancy gap between men and women has increased from one year in the 1920s to more than 5 years today [2]; therefore, this gap is not inevitable. Nonetheless, this gap also exists across the Western world, such that in no Western country does the life expectancy of men even come close to the life expectancy of women [1].

Of course, the direct victims of this health crisis are the men themselves, but this issue also affects the family members the men leave behind and the State in which the men die. According to the Census Bureau, the ratio of men to women in the early retirement years (ages 65-69) is 85 men per 100 women, and this ratio gets worse as the years go on. In addition, more than half of elderly widows who are living in poverty were not poverty-stricken before their husbands died. Thus, federal and state governments end up absorbing the enormous costs that the premature death and disability of men incurs, including the costs of caring for dependents who were left behind [2].

THE PROBLEM

Gender is the strongest and most consistent predictor of health and longevity [3]. Research that compares men and women on health outcomes consistently finds that men die earlier than women and that they have higher rates of disease, particularly heart disease and cancers [1, 4-6].

For example, in the United States, mortality statistics indicate that not only do men die 5.4 years earlier than women, but they have a 43% greater age-adjusted death rate than women, and die at higher rates from 14 of the 15 leading causes of death, except for Alzheimer's disease [4]. In addition, although heart disease is the leading cause of death for both men and women, 3 out of every 4 persons under the age of 65 who die of heart disease are men [7], and men have a 1 in 2 lifetime risk of developing cancer, compared to 1 in 3 for women [8].

Moreover, "men are at greater risk than women of developing nearly all major diseases that can affect both sexes" [1]. If we exclude people over the age of 75 (when women greatly outnumber men), men are almost twice as likely to die as women across almost all major disease states, including diseases of the circulatory system, mental disorders, lung cancer, liver disease and cirrhosis, and traffic accidents [1].

THE CAUSES

Biological differences between men and women do influence some of these differences in health indicators, but the explanatory power of biology is small. Health scientists increasingly believe that modifiable health behaviors, such as diet, exercise, substance use, use of social support, safety practices, and management of stress and anger are the most important contributors to health. In fact, research shows that 50% of mortality and morbidity are due to health behaviors, such as smoking, alcohol use, and not getting checkups or preventive screenings [9].

Thus, the majority of these gender differences in health are due to lifestyle differences that are modifiable. For example, higher rates of lung cancer in men reflect men's higher rates of smoking, and greater deaths due to liver cancer and cirrhosis reflect their higher rates of alcoholism. The fact that 75% of people who die from heart disease before age 65 are men reflects the fact that men get less cardiovascular exercise and eat fattier diets, along with smoking and drinking more.

Men are also less likely to delay seeking healthcare when problems emerge, which has been shown in studies assessing gender differences in healthcare seeking among people with HIV/AIDS, emotional problems, and chest pain, and is particularly acute among younger men [1].

Hundreds of empirical studies consistently show that men are more likely than women to engage in almost every health risk behavior that increases their risk of disease, injury, and death [3]. These include:

- Men visit physicians less often and use fewer health care services than women, even when they have health problems. Because they do not receive regular or timely health care, their health problems are often serious when they do seek help.
- Men are less likely than women to have regular cholesterol, blood pressure, or cancer screenings, or to do regular self-exams.
- Men are less likely to stay in bed for either acute or chronic conditions, or to persist in their treatment regimen for more major health problems (e.g., taking prescribed medications, eating the right foods).
- Men take fewer steps to protect themselves from the sun – they are less likely to seek out shade, apply sunscreen, or wear protective clothing, and 2 out of every 3 deaths due to melanoma are to men.
- Men eat less fiber and fewer fruits and vegetables, which is associated with higher risks of cancer and heart disease.
- Men consume more salt, saturated fat and dietary cholesterol, are less likely to limit their intake of red meat, and are more likely to eat convenience and restaurant foods.
- Men are more likely to be overweight and obese, but are less likely to take steps to lose weight.
- Although men are slightly more physically active than women, women are more likely to engage in the types of physical activities (i.e., regular moderate aerobic activity) that reduce health risks, whereas men are more likely to engage in physical activities (i.e., infrequent, strenuous activity) that put them at risk for injury and death.
- Men are more likely than women to use and abuse tobacco, alcohol, anabolic steroids, and other drugs or substances, and to begin using them at an earlier age.
- Men are more likely than women to engage in a broad range of risky and physically dangerous activities, such as riding a bicycle or motorcycle without a helmet, driving recklessly (e.g., tailgating, running red lights, speeding), drinking and driving, and not wearing a seatbelt.
- Men are more at risk for STDs because they are more likely to be sexually active, begin sexual activity early in life, have more sexual partners, have sex under the influence of drugs or alcohol, and be nonmonogomous.
- Men are more likely to be both the perpetrators and victims of violence, aggression, and homicide, and to be involved in criminal behavior.
- Men have fewer sources of social support, and smaller, less intimate support networks than women do.

- The highest risk occupations are almost exclusively held by men – for example, timber cutting, fishing, mining, construction, truck driving, farming, foresting, police officers, firefighters — therefore, men account for 94% of all fatal injuries on the job and are exposed to more chemical hazards.

WHY IS MEN'S HEALTH A CONCERN FOR MASSACHUSETTS?

Rarely is the question posed as to why men engage in more health-risk behaviors; all too often, we accept men's shorter lives as inevitable, natural, or inherent. However, policymakers in Massachusetts need to be concerned about men's shorter life span, more severe disease states, and riskier health behaviors because they cost hundreds of billions of dollars per year in lost productivity and health care costs.

A straightforward means to improve men's health and reduce costs would be to increase men's health-promoting behaviors. This task needs to be tackled at many levels, not just with the family doctor, especially given that men delay or avoid seeing their family doctor. Even when men do go to the doctor, they receive less physician time than women do; they are provided with fewer and briefer explanations, less advice about changing risk factors, and less instruction on self-exams [3], and on average, they ask their doctors no questions. Thus, we cannot rely on just the family doctor to tackle this problem.

Action is required at the state level. All areas of policy — particularly health, social, education, employment, crime, and housing policies — should address how men's lifestyles and behavior influence their long-term health needs [1]. And we need to think about how to start these initiatives early because boys, too, are encouraged and raised to engage in behaviors that increase their health risks [3]. Many health risk behaviors, such as physical activity, smoking, and poor dietary habits, become ingrained relatively early in life and carry through into later adulthood [10].

HOW DO WE MODIFY MEN'S HEALTH-PROMOTING BEHAVIORS?

Research by Mahalik has sought to determine why men engage in health risk and health-promoting behaviors. Examining men's general health behaviors, as well as heart healthy behaviors specifically, Mahalik's research and others have consistently found the following results.

Men's Masculine Socialization Influences Their Health Risk Behaviors

More traditionally masculine men consistently report greater health risk behaviors and fewer health promoting behaviors [11-16]. Traditional masculinity is defined as the importance of winning, emotional control, risk-taking, violence, dominance, being a playboy, self-reliance, endorsing the primacy of work, needing power over women, having disdain for homosexuals, and the pursuit of status.

In fact, in the U.S. and other places around the world [14, 15], traditional masculinity has been shown to be related to fewer health-promoting behaviors and more health risks for men, including:

- coronary prone behaviors [17]
- difficulty with managing anger [14]
- eating less fiber and fruit [15]
- neglecting health screenings [14]
- not consulting a health care provider when having unfamiliar physical symptoms [15]
- not following physicians' orders after a coronary event [18]
- not going to health care appointments [14]
- not seeing health care providers after warning signs of a heart problem [19]
- not seeking help for emotional difficulties [14]
- not wearing sunscreen or protective clothing in the sun [14, 15]
- taking risks generally, and risky behavior with automobiles and sexual practices specifically [14]
- unhealthy alcohol use [14]
- violence and aggression [11, 14, 16]

Moreover, research reports that more traditionally masculine men are four times more likely to die from coronary heart disease [20], suffer more severe heart attacks, and delay seeking treatment longer for cardiac problems [19].

Overall, men's notions of and adherence to traditional masculinity is antithetical to health beliefs and behaviors. In other words, health risk behaviors may be manifestations of how some men construct masculinity. Men are socialized to adopt masculine ideals that may put their health at risk. Men are reinforced for adopting behaviors and attitudes consistent with traditional masculine norms, and punished or shamed when they do not conform to traditional masculine norms [14].

Thus, men may take – or not take – certain actions based on their understanding of the world (e.g., ignore pain because they are told to be tough, refuse help because they are told to be self-reliant). For example, when a boy at age 8 scrapes his knee, he's told, "Big boys don't cry." That teaches him not to listen to what his body is telling him. What's going to happen when that boy is 50 years old and having chest pain? [15].

The man who constructs masculinity as being a risk-taker may engage in high-risk behaviors such as smoking, excessive drinking, or refusing to wear a seatbelt. The man who constructs masculinity as putting work ahead of all other responsibilities may not make time for self-care. Similarly, the man who constructs masculinity as being self-reliant may never seek help from health care professionals [13].

- *Implication 1. Health promotion efforts for men need to address men as men,* particularly since more traditionally masculine men will view general health promotion efforts as not relevant to them.
- *Implication 2. Health promotion efforts should be framed in ways to help men be more effective as men* (e.g., help them to be stronger, help them to live healthier lives so they can be more effective fathers and husbands, help them be more productive and successful at work). Interventions could focus on changing men's unhealthy beliefs by focusing on the illogic of their current beliefs and linking a health-promoting belief to masculinity – for example, "I don't want to have the health problems my father had. I want to be energetic at work and home, and eating a healthy diet can help with those concerns."

Men's Normative Beliefs About Other Men Influences Their Health Behavior

When men perceive that other men engage in health promoting behaviors, they are more likely to report engaging in health promoting behaviors. Conversely, when men perceive that other men are engaging in health risk behaviors, they are more likely to report engaging in health risk behaviors. Women's health behaviors, on the other hand, have no influence on men's health behaviors [13].

Perceptions of other men's health behaviors may be communicating social proof about health behaviors which then guide their own health behaviors. These perceptions provide information about how individual men should act – or not act – in terms of the health behaviors they adopt. Perceptions of normative health behaviors in other men exert a particularly powerful influence on the health behaviors that individual men adopt [13].

A more distal group influence may be men's perceptions of the health behaviors of typical men in their country. Men may observe an action-hero who does not get medical attention after a bloody fight, or men in burger commercials eating 'man-sized' triple-patty cheeseburgers and conclude that these are normative health behaviors for men in his country. If perceived as normative for males in one's country, men would be more likely to adopt those health behaviors [21].

- *Implication 3. It is important that men see other men engaging in health promotion efforts.* This could be in the media, in their family, at the workplace, or in other public arenas (e.g., sporting events).

One particularly effective way of achieving this goal may be through social norms campaigns, the utility of which has been shown in work on alcohol, drug, and tobacco use and abuse [21]. This work has shown that people tend to overestimate the extent to which their peers engage in such maladaptive behaviors; however, when presented with campaigns that give them accurate information about their peers' behaviors, it has the effect of lowering the rates of use/abuse of these substances.

Similarly, there is evidence that men tend to view other men as engaging in more health-risk behaviors than men actually do, and therefore, social norms campaigns can educate men about the health-promoting behaviors men actually engage in. Overall, we need to portray health-promoting behaviors as normative and masculine, and health risk behaviors as aberrant.

Men are Deterred by Barriers to Engaging in Health-Promoting Behaviors

Men demonstrating high conformity to traditional masculine norms report less health-promoting behaviors when they believe there are barriers to engaging in those behaviors. Examples of such barriers include no access to fruits/vegetables or blood pressure screenings; doctor's exams being perceived as too invasive, embarrassing, or expensive; unsupportive family/friends; the perception that low-fat foods do not taste good; or that such behaviors interfere with one's regular schedule [12].

Thus, when men experience barriers to health promoting behaviors, they are less likely to engage in those health behaviors. Missing work, or not being able to leave work to make physician's appointments that are typically scheduled from 9 to 5, are prominently identified as barriers for men [12].

- ***Implication 4. Bring health promotion efforts into workplaces and structure health promotion efforts to be available outside of the working day.*** Health screening at work, particularly ones where top-level male employees are participating, would help reduce barriers to health-promoting behaviors. Moreover, healthcare providers should be given incentives for having office hours outside of the normal business hours.

Men's Cultural Backgrounds Can Inhibit Health-Promoting Behaviors

Men's cultural background may inhibit participating in health promotion efforts, and can play a significant role in the association between their health behaviors and masculinity.

For example, among men from various African nations, having a sexually transmitted disease is viewed as a badge of honor, confirming manhood for African men [22]. Moreover, ignoring self-care is associated with masculinity [14] because real men do not get sick [23].

A particularly prominent example is with Latino men. Latino men (41.3%) are less likely than both African American (59.4%) and White (56.9%) men to get screened for prostate cancer [24], even though prostate cancer is the most common cancer diagnosis among Latino men in the United States [25]. Therefore, they are 3.7 times more likely to be diagnosed at a later stage than non-Latinos [26].

In a qualitative study of Latino men and their thoughts on prostate cancer screenings [27], particularly the digital rectal exam (DRE), Latino men talked about masculinity in terms of being in control of their health behaviors and having a sense of invulnerability to illness, and they remarked that health care is not necessary in the absence of symptoms.

They talked about friends who avoided the DRE in order to maintain a heterosexual masculine identity; in other words, getting the DRE was viewed as a homosexual act: "In the majority of Latino countries, the concept of the macho man and the idea of turning around and of someone inserting a finger, honestly, is something that one does not tell [others]...It's almost the worst thing that could happen to you as a man." [27]

One man said that his friend remarked about getting a DRE: "Oh, NO, they are going to insert a finger and I will no longer be a man." Thus, Latino men have difficulty talking about the DRE seriously because it interferes with their sense of manliness and sexuality [27].

- ***Implication 5. Health promotion efforts must address cultural barriers such as misinformation or stigma.*** We need to especially target working-class and men with low levels of formal education and acculturation because they are more likely to espouse such maladaptive masculine notions. Educational materials need to be multilingual, presented at low literacy levels, and include pictures to enhance the material's appeal. As with health-promotion campaigns for the larger culture, educational materials should target perceptions about health and masculinity and reframe them in a way that makes health-promoting behaviors masculine [27].

WHAT IS BEING DONE IN THE FEDERAL GOVERNMENT, OTHER STATES, AND MASSACHUSETTS

There is no centralized national effort to promote awareness, prevention, and research efforts on men's health needs. The federal government is also not reaching out to men and engaging them in the healthcare system in the United States [2]. This lack of effort stands in stark contrast to the various offices and promotions located within several federal agencies that have been established for women's health.

On a State level, a handful of states have established State Commissions on Men's Health. These include:

- Georgia (http://www.georgia.gov/00/channel_title/0,2094,31446711_40095489,00.html),
- Louisiana (http://www.legis.state.la.us/boards/board_members.asp?board=793), and
- Maryland (http://fha.maryland.gov/pdf/cdp/mens%20health.pdf and http://www.dhmh.state.md.us/hd/mensrepmat.htm).

Again, the very few states that have such State Commissions on Men's Health stand in stark contrast to the number of states that have such commissions for women's health. Overall, the goal of these State Commissions on Men's Health is "to identify, assess, and develop strategies for men and boys, including community outreach activities, public-private partnerships, and coordination of community and state resources, to:

- Encourage an awareness of men's health needs;
- Examine the causes for, and recommend solutions to low participation in medical care;
- Develop strategies to lower the suicide rate among boys and men; and
- Examine the causes of work site deaths and injuries and develop strategies to enhance work site safety" [2].

In Massachusetts, we have a Massachusetts Commission on the Status of Women; however, we have no State Commission on Men's Health. We do have a Men's Health Partnership in Massachusetts that is part of the Department of Public Health.

Men's Health Partnership programs are located in health centers, hospitals and community-based agencies statewide. The primary goal of the Men's Health Partnership is to serve the preventive health needs of men in the community ***who are uninsured or underinsured***, by offering free screenings for prostate cancer, heart disease, diabetes and stroke, and then to link men to medical care following the screening. Thus, it is limited in its scope to address the health-promoting behaviors of all men in Massachusetts.

Therefore, we do not have any comprehensive Massachusetts State policies or programs to address the health-promoting needs of men in this state.

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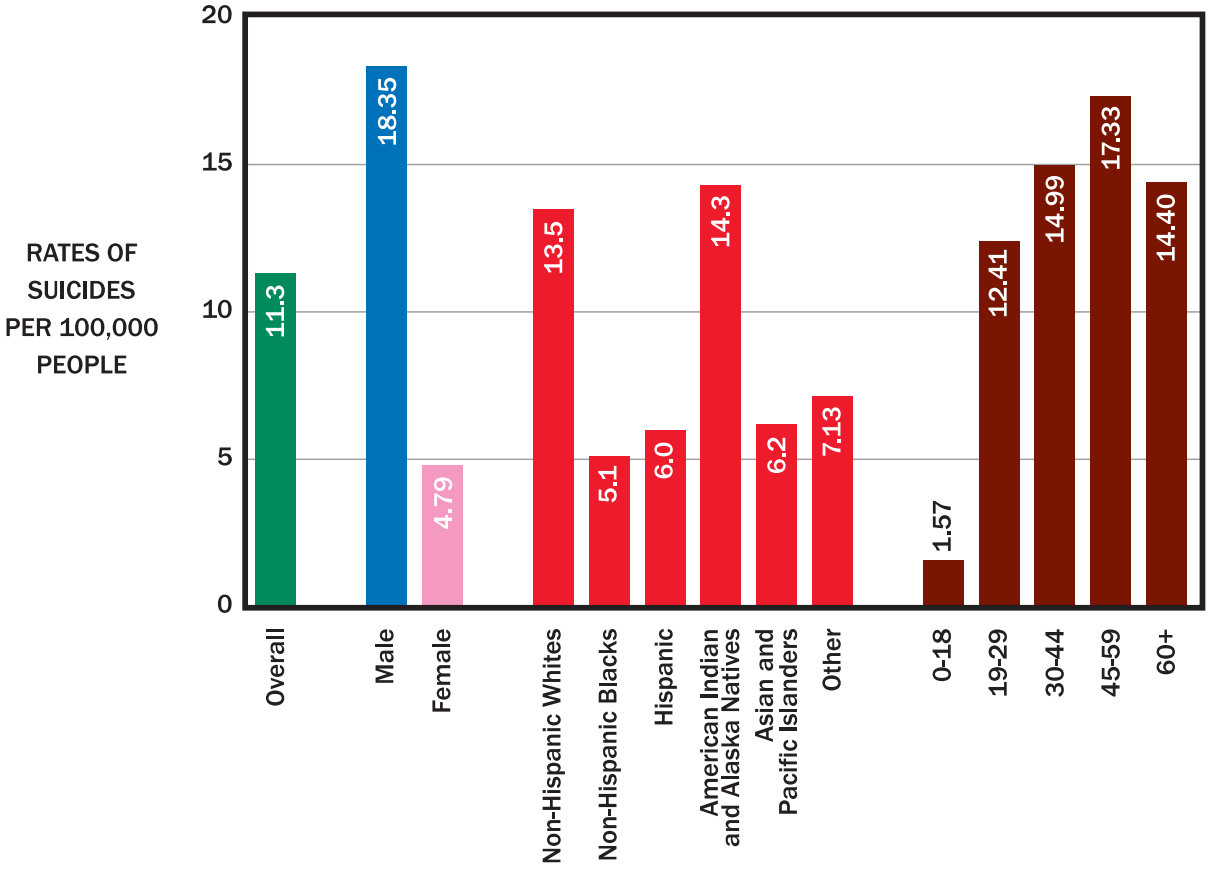
Men's Mental Health in Massachusetts: Stigma, Substance Abuse, Suicide and Unemployment

BY MICHAEL E. ADDIS, PH.D., WITH THE ASSISTANCE OF CHRISTOPHER S. REIGELUTH

National studies and statistics have revealed alarming facts about men's mental health and trends that continue to get worse:

- Men commit suicide at four times the rate of women; [1] (see Figure 1)
- Clinical depression, often a precursor to suicide, is under-diagnosed in men; [2]
- Men outnumber women in rates of substance abuse; [3] (see Table 1)
- Men are far less likely than women to take advantage of available mental health services that can effectively treat their problems; [4] and
- The costs of untreated mental health problems in men are substantial. [5] (See Figure 2).

FIGURE 1
Rate of Suicides in the U.S. by Sex Race, and Age in 2007



Source: Centers for Disease Control and Prevention [1] *Data Courtesy of CDC*

TABLE 1

	WOMEN	MEN	BOTH
Any Anxiety Disorder	23.4%	14.3%	19.1%
Any Mood Disorder	11.6%	7.7%	9.7%
Any Impulse-Control Disorder	9.3%	11.7%	10.5%
Any Substance Disorder	11.6%	15.4%	13.4%
Any Disorder	34.7%	29.9%	32.4%

Information from the National Comorbidity Survey [3]

Men's mental health has been a historically neglected topic at the national, state and local government levels. Most of us are taught from a young age that men should be tough, strong and stoic at all times. [6] Consequently, when men struggle with real emotional, behavioral or mental health problems, they are met by social stigma and a lack of support. This harsh reality has led many men to hide their mental health problems and suffer alone. As a result, men dealing with a mental health issue can experience an escalation of distress and pathology that leaves them out of work, detached from loved ones, abusing drugs and alcohol, or contemplating taking their own lives.

This report will provide a brief overview of the mental health problems facing men in Massachusetts and will address such issues as stigma, substance abuse, suicide, and the impact of unemployment. It will also summarize current men's mental health data and speak to specific needs in Massachusetts. Lastly, several policy options will be highlighted that outline potential prevention and intervention measures for policymakers to consider.

STIGMA: THE KEY ISSUE

Men in Massachusetts and throughout the United States often feel ashamed and reluctant to seek mental health support. The stigma surrounding men showing emotional vulnerability, admitting to a problem or openly seeking help has caused many men to mask their symptoms and conceal their problems from society and loved ones. [4]

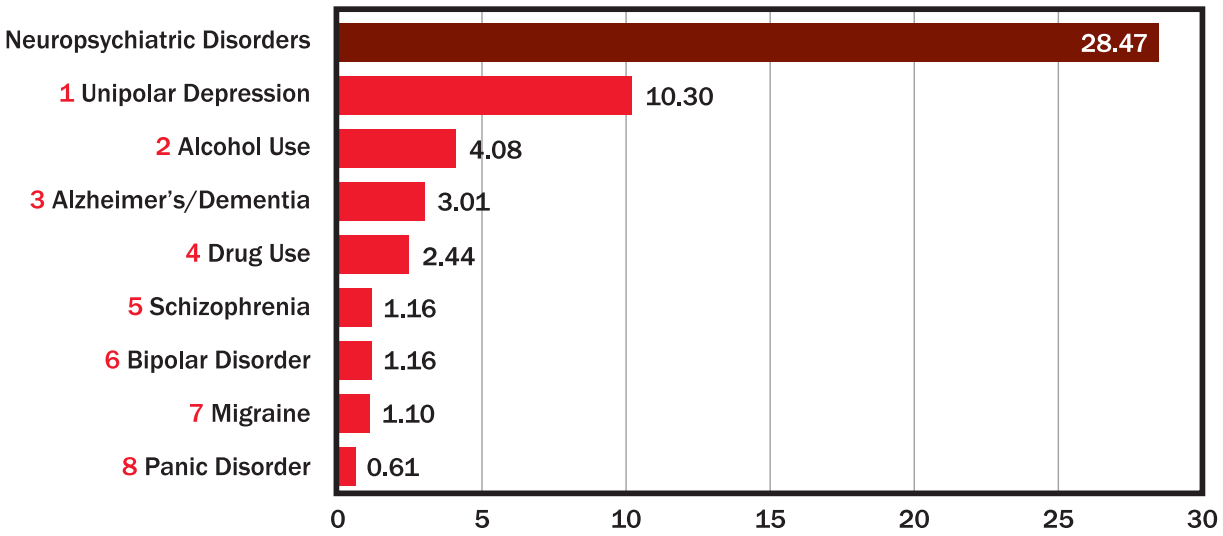
These men often worry that friends and family will consider them weak and deficient. The prospect of seeking treatment feels disempowering for many of these men. Consequently, many men do not take advantage of available mental health resources when they are suffering, and research shows that men are less likely than women to seek help. [4] The result of this ambivalence and underutilization of health services can lead to elevated levels of stress, substance abuse, suicide and unemployment for different men. [7]

Due to the stigma surrounding men and mental health, many men worry that if they seek mental health support, the following might happen:

- Friends and family members will view them negatively and lose respect;
- Their status as "real" men will be jeopardized;
- Male peers will reject and socially isolate them; and
- Co-workers will lose faith in their abilities and they might lose their job.

To further complicate matters, researchers have demonstrated that individuals who avoid seeking mental healthcare often end up using a greater amount of health services than those who receive treatment early on. [8] This results in substantial social and financial costs to both the individual and society.

FIGURE 2
Burden of Disease: Disability Adjusted Life Years for Neuropsychiatric Disorders



Disability-adjusted life years (DALYs) represent the total number of years lost to illness, disability, or premature death within a given population. Source: World Health Organization [5]

SUBSTANCE ABUSE

For many men, the result of mental health stigma and not seeking help leads to substance abuse or dependency. Many men turn to substance abuse as a way of coping with emotional, social, and mental health problems that they do not feel comfortable sharing with loved ones, much less discussing with a healthcare professional. This, in turn, leads to more issues, such as lost productivity at work or unemployment, relationship strain and other general health issues. [7, 9]

Research also demonstrates that men's substance abuse starts early. Adolescent boys are more likely to abuse substances than their female counterparts. [10] In addition, a recent study conducted at an American university in the Northeast demonstrated high binge drinking rates of 63% for females and 83% for males. [11] This indicates that men are out-drinking women from an early age.

These alarming trends continue into adulthood and men's higher rates of substance abuse lead to a number of mental health complications and results including:

- Increased risk for suicidal thoughts and unplanned suicide attempts in men; [12]
- Men are 3 times more likely than women to binge drink and 7 times more likely to participate in chronic drinking; [13]
- The death rate for alcohol-induced causes is 3.5 times higher in men than women; [14] and
- Massachusetts is 7th among states in the country for percentage of people classified as heavy drinkers. [15]

SUICIDE

The suffering that many men experience as a result of untreated mental health problems has led men to commit suicide 4 times more often than women. [1] It is especially alarming that while men commit suicide at a much higher rate than women, they are diagnosed for mental illness far less frequently. [16] (see Figure 3) Hence, the under-diagnosis of mental illness in men is a major problem.

The elevated suicide rates for men suggest that many men are suffering, are experiencing hopelessness and helplessness, and feel they have no other viable options besides ending their lives. The added tragedy for

these men is that help is available; yet, they are either unsure of how to seek support or are overpowered by the stigma associated with experiencing a mental health disorder and seeking treatment.

Finding ways to better encourage men to take advantage of existing mental health resources and services needs to be prioritized at the federal, state and local government levels. Until this is achieved, the following social problems will likely continue:

- Suicide is the 7th leading cause of death for males and the 15th leading cause for females; [17] and
- Suicide is the 10th leading cause of death in the U.S. and the third leading cause for individuals ages 15-24. More than 90% of suicides are associated with a diagnosable and treatable mental health problem. [18]

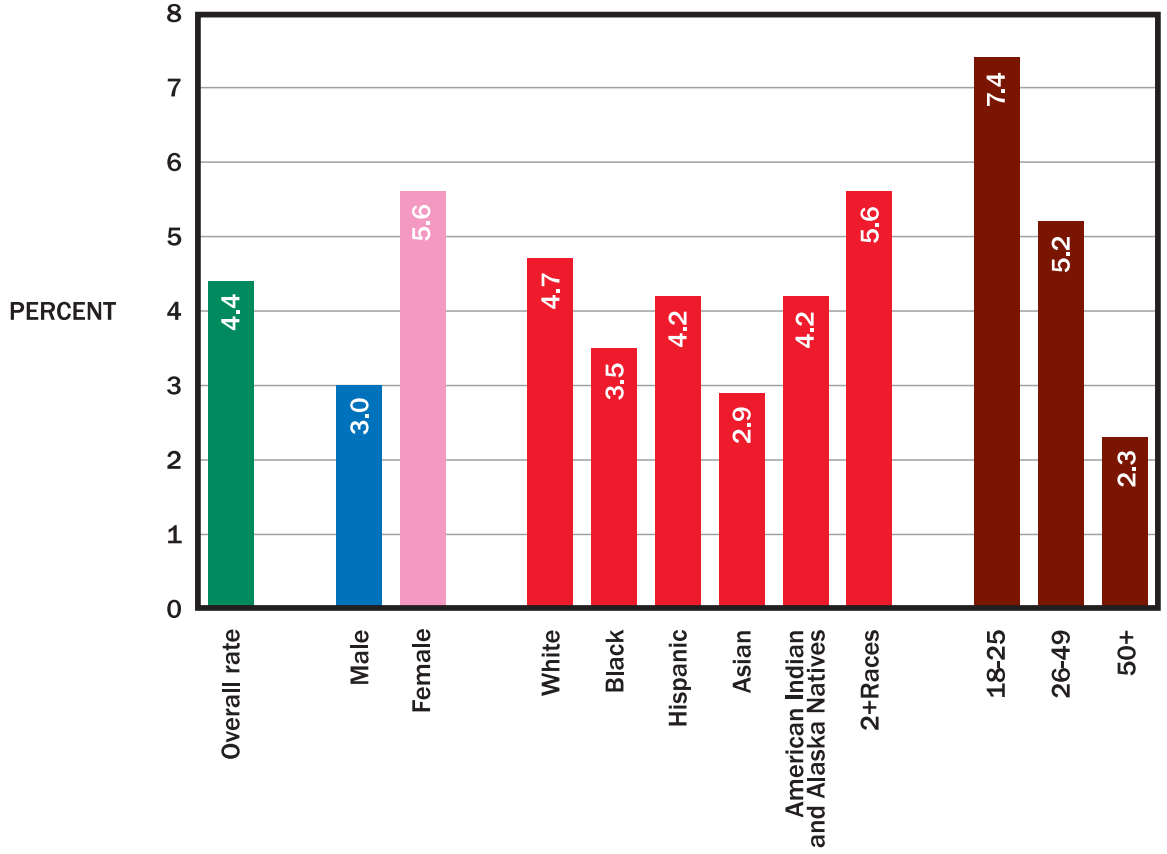
UNEMPLOYMENT AND THE MENTAL HEALTH CRISIS

Unemployment is a major life stressor that numerous Americans experienced in recent years. As was presented at the 2010 Massachusetts Family Impact Seminar, *The Great Recession and Its Impact on Families*: [19]

- Massachusetts lost 153,000 jobs from 2008 to 2009; [20]
- Unemployment doubled from 4.5% to 9.4%; [20] and
- Job loss and underemployment were most acutely experienced by men, specifically those in the lower 30% of the income distribution. [21]

FIGURE 3

Prevalence of Serious Mental Illness in the Past Year Among U.S. Adults in 2008



Source: National Survey on Drug Use and Health (NSDUH) [16] *Data Courtesy of SAMHSA*

Hence, the great recession has been termed the 'Man-cession' because a disproportionately high number of men found (and still find) themselves out of work. [22] This has major implications for men's mental health, and numerous studies and reports have demonstrated that men are especially vulnerable to mental health issues when facing unemployment. [23] For instance:

- Rates of suicide are linked with unemployment and economic depression for men, but not for women; [24]
- Unemployment puts men at greater risk of alcohol and substance abuse; [25]
- 34% of the unemployed have been shown to suffer from psychological problems, compared with only 16% of employed individuals; [26] and
- The connection between unemployment and depression is greatest in men, and individuals ages 29-37 are most at-risk. [27]

In addition, in comparison to women, men suffer more psychological problems from unemployment. [7] Men seem to have a harder time accepting unemployment, and being out of work takes a greater psychological toll. This may be due to the interaction of stress associated with unemployment and the added pressure that men can feel to be providers and 'bread winners' for their families. This pressure can lead to a greater loss of self-esteem and identity crisis for unemployed men.

The lost productivity that results from men who are out of work for psychological reasons, due to unemployment or as a result of prolonged unemployment associated with mental distress, leads to substantial financial and social costs. Past research demonstrates that:

- Mental illness in the United States results in $193.2 billion in lost earnings every year; [28] and
- People living with major mental illness face the added risk of also encountering chronic medical conditions and on average die 25 years earlier than other Americans. [8]

THE CURRENT SITUATION IN MASSACHUSETTS

What do we know about men's mental health in Massachusetts? We know that men are suffering from numerous social and mental health problems, including substance abuse, suicide, and unemployment. Yet like most states, Massachusetts has done very little to address the problems associated with undiagnosed and untreated mental health problems in men. At the state and local government levels, there currently exists:

- No state commission on men's mental health;
- No specific health care policies directed at education, prevention or treatment of men's mental health problems; and
- No specific programs for men's mental health.

The problems surrounding men's mental health are not due to a lack of mental health funding or services. Massachusetts is one of the nation's leaders in state money spent on mental health and is in a position to develop prevention initiatives and public health campaigns that will de-stigmatize men's mental health and get men into treatment and back to their lives and families. [29]

Massachusetts is at the forefront in the development and scientific evaluation of effective treatments for a range of mental health problems. Several institutions involved in cutting edge mental health research include Harvard University, McLean Hospital and Massachusetts General Hospital. Yet, a search of the MGH website for resources on men's mental health reveals that limited information exists. The article, *Men Get Postpartum Depression Too*, is currently featured on the MGH Center for Women's Mental Health webpage. However, there is no Center for Men's Mental Health webpage. This is a prime example of a lost opportunity to provide men with a resource through which to learn more about relevant mental health issues and services.

IDEAS FOR THE FUTURE

As Massachusetts' policymakers consider the need for comprehensive men's mental health prevention and intervention initiatives, several key problem areas should remain at the forefront:

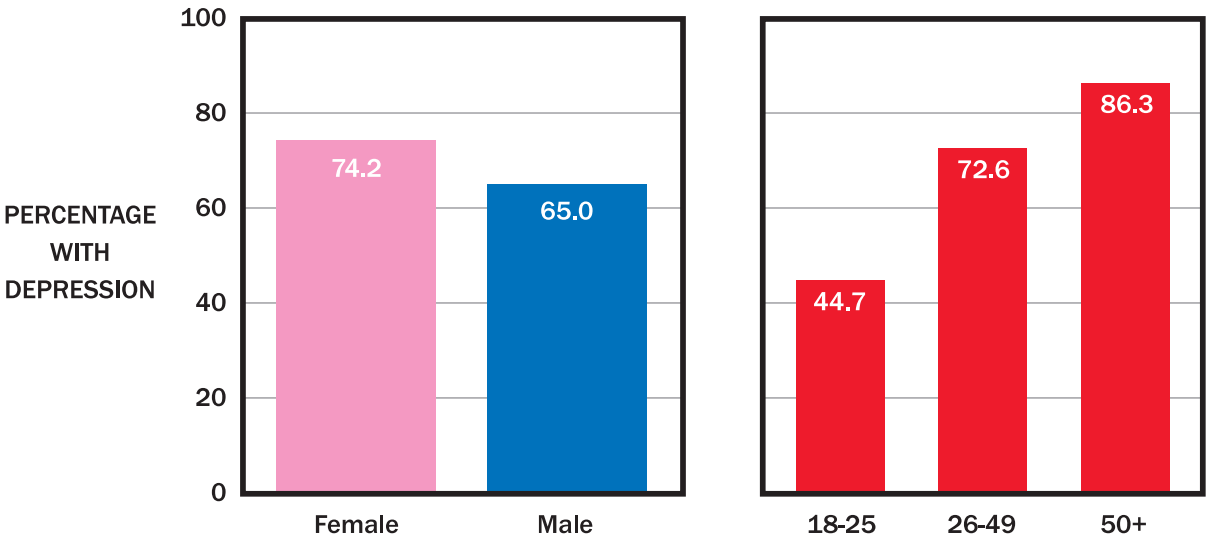
- The stigma and sustained "invisibility" surrounding men's mental health;
- The under-detection of mental health problems; and
- The underutilization of mental health services.

These three areas work together to perpetuate the principle social and mental health problems faced by men, including stress, substance abuse, suicide and unemployment. The social forces propelling mental health stigma cause many men to remain "invisible" in their suffering. As a result, men's psychological problems rarely come up for discussion or receive acknowledgment.

The stigma sustaining men's invisibility is further evidenced in the under-detection of mental health problems and the underutilization of mental health services. (Figure 4 provides an example of men's underutilization of services in the context of depression). As a group, men are reluctant to seek treatment and avoid communicating their distress. [4] Because many men suffer needlessly from mental health problems and do not seek treatment, their problems go undetected by clinicians.

FIGURE 4

Service Use/Treatment Among U.S. Adults with Depression by Sex and Age



Source: National Survey on Drug Use and Health (NSDUH) [30]

Data courtesy of SAMHSA

For a state such as Massachusetts, the reality of men's invisibility and underutilization of mental health services is especially troublesome considering the universal healthcare mandate of the state and the availability of mental health resources. In 2007, of all the State Mental Health Agencies (SMHAs) reporting data, Massachusetts had the lowest utilization rate for mental health services at 424 per 100,000 people. [31]

At the state and local levels, it will be crucial to find effective ways to de-stigmatize men's mental health and normalize seeking appropriate care. Several initiatives that would reduce stigma and bring men's mental health into focus include:

- Develop appropriate message framing via public health awareness campaigns. It would be impacting and eye-opening to enlist famous, "masculine" men who have openly acknowledged their struggles with mental health issues to speak out about the reality of, and debilitating stigma, surrounding men and mental health;
- Initiate planning for the creation of a state commission on men's mental health;

- Draft and introduce health care policies directed at education, prevention and treatment of men's mental health problems;
- Create specific programs for men's mental health that address issues related to stress, stigma, substance abuse, suicide, and unemployment; and
- Implement policies that target schools and incorporate men's mental health into health and wellness classes that are already taking place.

There is less of a need to develop more costly tertiary care interventions, and more need to develop alternative lower cost and widely accessible interventions for prevention and early detection. These interventions include:

- Screening for depression, anxiety and substance abuse in men; and
- Screening for non-typical indicators of mental health problems that may be more common in men (e.g. anger, somatic symptoms and social withdrawal).

As noted above, in addition to launching policies and programs aimed at prevention and intervention with men, a tremendous opportunity exists to educate children on the destructive consequences of mental health stigma. Children need to receive the message that seeking help is important, and there is nothing to feel ashamed about in regard to mental health problems.

This message of openness, tolerance and support should echo over and over again throughout an individual's time in the Massachusetts school system and beyond. By educating children from a young age and implementing mental health prevention and intervention initiatives for men, Massachusetts can positively impact and reduce stigma, substance abuse, suicide and unemployment.

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Men's Social Health within Families and Intimate Relationships

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The previous two chapters have focused on educating about men's physical and mental health. Although people do not spend much time considering these issues—especially with regard to men – they are not likely unknown concepts. The concept of men's social health, however, may be a newer phenomenon. The current report will first discuss the concept of social health and then discuss how this features in the lives of men, both in the United States and in Massachusetts.

WHAT IS "SOCIAL HEALTH?"

The concept of "social health" appears in the professional literature as far back as 1925 [1]. Social health is simply an accounting or tally of our indicators of social well-being. Broadly speaking, these could include infant mortality, child maltreatment and family violence, poverty level, teen suicide, alcohol and drug abuse, high school completion rate, unemployment, children's access to safe and healthy relationships, health insurance coverage, homicides and rates of other crimes, and housing conditions [2, 3].

Thus, based on this definition, we could consider the social health of a nation, state, community, group, or individual. The focus of the current briefing report is men and their overall well-being—something which is not routinely explored. We will approach one aspect of men's social health—that which occurs within families and intimate relationships: divorce or family disruption and family violence.

DIVORCED FAMILIES AND MEN'S SOCIAL HEALTH

The Problem of Divorce

Over the past fifty years, fundamental changes have been made in the composition of American families. One of the most significant changes has occurred to relationships between men and their children. The rise in divorce rates that took place in the 1960s and 1970s increasingly separated children and fathers from living together. Today, the divorce rate hovers between 40-50% [4]; in 2007 there were 3.6 divorces per 1,000 population, nationwide [5]. In Massachusetts it was much lower, at 2.3 per 1,000 population [6].

Most of the research on divorce and family disruption—which includes divorce, separation, and dissolution of unions that did not involve marriage—has focused on the social, health, emotional, and economic consequences of parental separation on children [7-27]. A smaller portion of research has focused on the consequences of divorce on women [28-35]. An even smaller portion of research and professional literature, including my own work, has focused on the consequences of divorce and family disruption on men who are fathers [36-47].

The Effects of Divorce on Men

Most of the professional and popular literature about divorced and separated fathers focuses on the legal battles [48-51] and highlights the sometimes extreme views from fathers' rights organizations [52, 53]. The

attention paid to fathers of divorce rarely addresses the social and emotional consequences and costs to men who are separated from their children.

My work and others shows that most men do not retain physical or residential custody of their children after divorce or family dissolution [38, 54], although many do maintain the right to help make decisions about the major events in their children's lives [38, 55, 56]. Most states do not collect information about custodial arrangements as part of their vital statistics, but some estimates over the last 20 years indicate that up to 25% of divorced/disrupted families have a shared living arrangement and more than half have shared decision-making responsibilities.

What this means is that children primarily live in one home with their mothers, but spend a portion of their time with their fathers, too. There is enormous variation in how parents split their "residential or parenting" time. It may mean that children spend one weekend every-other-week with their fathers or that they spend as much as 30-50% of their time with their fathers. With regard to making decisions about their children, most parents agree to share that responsibility, especially concerning their children's education, religious training, and medical well-being [57].

Contrary to popular belief, men's social health often suffers after divorce or family disruption. For example, divorced fathers:

- Are likely to have lower income than married men and are less likely to have health insurance [58].
- Report feelings of depression and emotional pain concerning losing both a life partner and regular contact with their children [42].
- Are more likely to abuse alcohol than married men [58].
- Grieve the loss of the "role of father" from decreased contact with their children [59, 60].
- Often feel shut out of their children's lives. If they have high conflict poor communication with their former partners, which occurs 15-30% of the time [57], it can be difficult to learn about their children's activities and well-being [61-63].
- Are often uninformed about or do not participate in their children's educational well-being and activities [64]. Most schools have not developed ways to maintain contact with both sets of parents [65].
- Feel the financial strain of paying child support and trying to make their own residence feel like "home" for their children—with enough bedrooms, clothing, toys, etc. [36].
- Struggle with how to maintain an active parenting role in their children's lives; some become "Disneyland Dads" – relationships that are primarily recreational in nature, instead of the balanced approach of playmate, companion, guidance counselor, and disciplinarian [58].

Men's adjustment to post-divorce life is closely tied to their relationships with their children and former partners [58, 60]. There is a significant body of research which documents that, unless there is evidence of maltreatment or violence, children and fathers are better off when they have regular and frequent access with each other [43, 58, 66, 67]. Moreover, fathers who are involved with their children are also more likely pay child support and to emotionally support their former partners [36, 68, 69].

What Can Massachusetts Do?

If one accepts this premise, the question for policy- and decision-makers is how to achieve optimal outcomes for divorced fathers, which has a bearing on outcomes for children. Research previously presented in this briefing report shows that men who are in need of assistance, do not always seek help. Thus, how can we adequately support men who experience divorce or family disruption?

Massachusetts has already taken action in a number of ways to support the social health of men in divorced and disrupted families. For example, in 2010 the Massachusetts Department of Revenue reduced the interest rate on child support orders that are overdue [70]. Research has shown that some nonresidential parents who are out of compliance with child support orders have financial problems of their own [71, 72]. This reduction in interest rate still holds men responsible for their obligations, but takes a less punitive approach toward men who are unable to fulfill their financial obligations.

One of my books has evaluated the policies states enact in the areas of divorce and child custody. My review shows that some of the ways that states have supported the social health of men are:

Mediation. In some states, when divorcing/divorced families cannot resolve their differences, the couple is referred to mediation. Research which randomly assigned divorcing couples to settle their disputes through either mediation or the traditional adversarial legal system has shown that even 12 years later, those that were assigned to mediation are families with fathers who are more involved with their children. *In at least 38 states, this type of social policy is addressed in statute; in Massachusetts it is not* [57].

Parent Education. Some states require that when families divorce, parents attend a workshop that focuses on parents and children's adjustment to living as a divorced family. These brief two-to-four hour workshops have shown positive results in reducing parental conflict and increasing father involvement, among other things. Massachusetts requires that parents attend such a program before divorcing. Longer, more intense programs such as *New Beginnings in Arizona*, show even more positive results [57].

Parenting Plans. Parenting plans lay out the post-divorce family agreement with regard to parenting time, decision-making, and financial responsibilities. The spirit behind a parenting plan is to promote thoughtful, shared parenting in post-divorce life. *At least 25 states have laws addressing parenting plans; Massachusetts does not* [57].

Joint/Shared Custody. Joint custody is when parents "jointly" share the residential care of children and/or the decision-making for their children. Sharing of custody does not require a 50-50 split in time and decision-making. Joint custody families split their responsibilities in ways that best suit them and the developmental needs of their children. Almost all states reference shared custody in statute, as does Massachusetts. *Over 25 states have laws encouraging "frequent and continuing contact" between children and their parents; Massachusetts does not* [57].

Presumption for Joint/Shared Custody. A presumption for joint custody in statute presumes that shared custody—either residential or pertaining to decision-making—is in the best interest of all families that appear before the court for divorce. Evidence of violence or maltreatment overrides such presumptions. Some have argued that a presumption of joint custody sends the message that shared and cooperative parenting is expected by society [73, 74]. Others disagree [75, 76]. *Only 11 states have presumptions for joint custody. Massachusetts does not* [57]. In 2004 there was a nonbinding ballot initiative in Massachusetts which queried the public concerning their opinions about a presumption for joint custody:

> *Shall the state representative from this district be instructed to vote for legislation to create a strong presumption in child custody cases in favor of joint physical and legal custody, so that the court will order that the children have equal access to both parents as much as possible, except where there is clear and convincing evidence that one parent is unfit, or that joint custody is not possible due to the fault of one of the parents?*

This ballot question was overwhelmingly approved with 84.5% of voters selecting "Yes" to this question [77]. Further, there is legislation currently pending in Massachusetts, *An Act Supporting Children and Strengthening Families* (HD03194) that would create a rebuttable presumption for joint custody in the Commonwealth [78]. Presumption laws can, and often do, include provisions concerning actions to take when violence or maltreatment are present in divorcing families, to ensure that children and victims are safe [57].

Collecting Information on Child Custody Outcomes. Most states do not collect information on child custody outcomes or arrangements. A minority – including New Hampshire—do, in accordance with state statute [79]. Such statutes do not improve the social health of men, but they do allow researchers, policy- and decision-makers, and providers to track and better understand the trends of families that are divorced/disrupted.

Tables 1 displays the different types of family policies that target divorcing families and their prevalence in the New England states.

TABLE 1
Legislation for Divorced/Disrupted Families in the New England States

STATE	MEDIATION	DIVORCE EDUCATION PROGRAMS	PARENTING PLANS	JOINT/SHARED CUSTODY	PRESUMPTION FOR JOINT/ SHARED CUSTODY
Connecticut	Yes, not mandatory	Yes, mandatory	Yes, mandatory in disputes	Permitted through statute	Yes, for joint decisionmaking, only when both parents agree
Maine	Yes, mandatory in disputes	Yes, not mandatory	No	Permitted through statue; encourages "frequent and continuing contact with both parents"	No
Massachusetts	No	Yes, mandatory	No	Permitted through statute	No
New Hampshire	Yes, not mandatory	Yes, mandatory	Yes, mandatory	Permitted through statute	Yes, for decisionmaking resp.only
Rhode Island	Yes, not mandatory	No	No	No provision	No
Vermont	No	Yes, not mandatory	Yes, mandatory	Permitted through statute	Yes—no specific guidelines

Note. Adapted from Douglas, E.M. (2006). Mending Broken Families: Social Policies for Divorced Families. Lanham, MD: Rowman & Littlefield

DOMESTIC VIOLENCE AND MEN'S SOCIAL HEALTH

The Problem of Domestic Violence

Domestic violence (DV), also called intimate partner violence (IPV), has been the focus of significant attention since the 1970s. This type of mistreatment includes physical, sexual, and psychological maltreatment of one partner against another and it affects hundreds of thousands of individuals and families a year [80, 81].

Most of the attention paid to IPV concerns male-to-female violence [82, 83], yet research since the 1970s has shown that female-to-male IPV also exists. This type of IPV and the threats to men's social health is also an important social issue. Statistics from the Department of Justice (DOJ) showed that in 2009, 117,210 men were physically assaulted by an intimate partner, the overwhelming majority of whom were women; in fact, men were 18% of all IPV victims that year [84]; that means that about 1.3 per 1,000 men are physically assaulted by a partner each year [85].

Another study, the 1995-1996 National Violence Against Women Survey, showed that 40% of all IPV victims during a one-year time period were men, and their study provided the well-documented statistic that there are over 800,000 men who are the victims of physical assault by a female partner in a one-year time period. [80]

The Effects of Domestic Violence Against Men

Men are not only assaulted by their female partners, they are also often injured, although not as frequently or severely as women are injured by their partners. Injuries for men who have been assaulted by a partner are estimated to occur in 1%-20% of men who sustain a physical assault [86-89]; this amounts to 12%-40% of all intimate partner injuries, and 27% of all injuries requiring medical attention [80].

There are other costs to men and society when men experience IPV, although there is little research that focuses on the social costs of experiencing partner violence among men.

- Studies that have focused on both men and women have found that victims of IPV are more likely to be depressed, to have chronic mental illness, and to abuse both illegal and prescription drugs [90, 91].
- Men who are abused are more likely to smoke [92], abuse alcohol [92, 93], have thoughts about committing suicide, and other mental health concerns, particularly symptoms of post-traumatic stress disorder [87, 94-98].
- Finally, abused men are also likely to have poorer overall health [91, 96, 99, 100], and are more likely to have sexual dysfunction[100], sexually transmitted diseases [100], functional disabilities [90, 92], and asthma [92].

My colleague and I have done extensive research on the mental and social health of male abuse victims. We have found that the reasons men stay in abusive relationships are similar to many of the reasons women stay in unhealthy relationships. Men report that they stay because they:

- Are concerned about their children.
- Have a commitment to marriage.
- Love their partners.
- Fear that they will be separated from their children.
- Believe that their partners will change.
- Do not have the financial resources to go any other place.
- Are embarrassed that friends and family will find out
- Worry that their partners will kill themselves or members of their families [101].

What Happens When Men Seek Help?

My colleague and I have also documented the barriers that men face when trying to get help for IPV victimization. Our work shows that when men do try to obtain help, it does not always prove easy to do. Some men report being turned away from domestic violence (DV) agencies because the agencies say that they only help women; others report that agency staff ridicule them for being "wimps" and "letting" their partners abuse them. This was true even among men who were disabled [102].

In a study we did that asked men about their experiences with seeking help from a variety of resources—DV agencies, DV hotlines, medical professionals, mental health professionals, online resources, and the police—men did not report very positive experiences. Those that were least helpful were first responders: DV agencies, DV hotlines, and the police [103]. Another national study of ours that assessed DV agency directors confirms many of these findings; directors report being less able and/or prepared to help men, of any sexual orientation, as compared with women [104].

What Can Massachusetts Do?

There is evidence that social programming and policy can be effective in lowering the incidence of IPV. According to the U.S. Department of Justice, between 1993-2004 there was a 61% decline in physical IPV toward women, which has been the target of significant attention for the past several decades. There has been much less focus on men as victims, which may be why the decline in the rate of IPV toward men for this same time period was only 19% [85]. There are multiple ways to reach out to men, without detracting from the important work that is already being accomplished in the area of IPV prevention. These methods are noted here.

Gender-Inclusive Language. Use gender-inclusive language when discussing IPV and educate the public about the concept that both women and men can be, and are victims of IPV [105, 106]. When the Violence

Against Women Act was reauthorized in 2005, much of the language restricting services and programs specifically to women was removed from the legislation [107]. The use of gender-inclusive language when discussing IPV may also be of help to individuals who are living in same-sex relationships that are abusive. Further, state-level legislation that fails to use gender-inclusive language has been ruled to deny all IPV victims equal protection under the law [108].

Maximize Resources Without Straining DV Agencies. Some DV agencies may not want to house men and women together in the same shelter and cannot afford to expand their onsite housing services. One way to provide services to all individuals, regardless of gender, is to maximize off-site housing options, such as hotel vouchers, "safe homes" (where victims stay in the homes of designated members of the public) or "transitional homes" (where victims are transitioning from dependence on a DV agency back into the community).

Treat Victims Together. There is some evidence that men and women can be treated together in the same DV agency without detrimental effects to women, children, or men. There are models to do so, such as in one shelter in Lancaster, California—the Valley Oasis Family Violence Shelter. In this DV agency, both men and women are treated together in the same counseling groups, but reside in separate locations [109].

Public Education. One way to create social change and to improve well-being and social functioning is through public education. Our nation and the Commonwealth have tackled important health and social conditions through the use of public education about a variety of topics, including the health risks of smoking [110], violence against women [107], shaken baby syndrome [111, 112], Sudden Infant Death Syndrome and the "Back-to-Sleep" campaign [113], and child sexual abuse prevention [114, 115]. It would be possible to provide gender-inclusive education to the public about the fact that anyone can be the target of IPV, regardless of gender or sexual orientation, and that resources are available to all victims.

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NOTES

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