Mindful
Continuing Education

The Stigma of Men's Mental Health

Introduction

Mental health issues are being discussed more in current generations than ever before. Historically people who have struggled with a mental illness might have done so in private and with fear. They might have avoided asking for help, engaging in relationships, or even attending work because of their illnesses. They likely experienced significant shame, anxiety, and worry related to the stigma that has always existed in public as related to mental illness.

While current generations and young people appear far more willing to talk about their difficulties, stigma remains. This is especially true for men. For various reasons that will be discussed, men have been socialized to believe that they must remain strong, firm, and reliable. These are things that are often thought of as antithetical to mental illness. While men who live with mental illnesses and professionals in the field know this is not true, many fear the shame and rejection they might experience if they "come out" with their mental illness. Because of this, they remain silent in their struggle and their symptoms become worse. This causes poor health outcomes such as substance use and self-harm, for example.

Men's mental health must become a normal topic of conversation in communities and the field of mental health by professionals. There are ways that mental health professionals can improve the experience, and therefore outcomes, of men who need to or do access mental health services.

This course will explore men's mental health in-depth: common diagnoses and experiences, common reasons for stigma and shame, and appropriate ways that mental health professionals can interact with men when providing behavioral mental health services.

Section 1: Prevalence and Statistics

Section 1: Introduction

Men and women are impacted by mental illness in different ways. This is caused by a variety of reasons: biology, environment, and socialized norms and beliefs about gender roles. Because of this, mental health professionals must understand the differences between the sexes and genders where diagnosing and treatment is concerned.

Men are less likely to access mental health services than women are. When they do, the care they receive must be person-centered, appropriate, and consistent with their unique needs and experiences. The following information discusses the difference between men and women in the prevalence of mental illness.

Section 1: Prevalence

Because men are often less likely to report mental health disorders, it is difficult to capture the true prevalence of mental illness in this cohort of the United States population. According to Mental Health America (2020), there are 151,781,326 million men in the US and generally, they are most impacted by depression, anxiety, bipolar disorder, psychotic conditions, and eating disorders.

6 million men in the US report experiencing depression every year. Men are more often diagnosed with depression as related to fatigue, irritability, and loss of interest in pleasurable activities, whereas women are more likely to report feelings of sadness and emptiness.

Where 19.1 million adults in the US report anxiety, 3,020,000 men report experiencing anxiety, panic, or agoraphobia. Generally, the age of onset for men is from 16-25 years old.

A smaller percentage of the population experiences bipolar disorder than depression and anxiety. 2.3 million Americans generally report a diagnosis of bipolar disorder, and it appears that there is an equal amount of men and women who experience this. The age of onset for men is generally between 16 and 25 years old.

Surprisingly, one million more individuals report a psychotic condition than bipolar disorder. Approximately 3.5 million people in the US report psychosis or schizophrenia, however, 90% of those individuals diagnosed by age 30 are men. This number is staggering in its discrepancy between men and women.

Finally, men make up only 10% of the population that is treated with anorexia and bulimia, and approximately 35% of those who are treated for a binge-eating disorder (Mental Health America, 2020).

In addition to these statistics identified by Mental Health America, the University of Rochester Medical Center (2020) states that men also commonly experience Post Traumatic Stress Disorder (PTSD). While women often experience PTSD because of physical or sexual violence as well as other situations, many men report PTSD symptoms

from their time in the military and this is something the university suggests in their research (University of Rochester Medical Center, 2020). This isn't to say that women don't also experience PTSD from military service, but men generally enter the military at higher rates than women. In fact, according to the Council on Human Relations (2020) only 16% of military service members are women. Men with PTSD might be commonly on guard or anxious, be emotionally withdrawn or feel numb, become angry and aggressive, or use substances to cope (University of Rochester Medical Center, 2020).

Section 1: Men and Suicide

While men may report fewer mental illnesses, they are unfortunately more likely to attempt or die by suicide. This is important for mental health professionals to consider when working with male patients. The highest suicide rates in the United States, according to Mental Health of America (2020), are caucasian men over the age of 85 years old. Additional statistics report:

- Suicide in men has been increasing since 2000
- Suicide is the 7th leading cause of death in men
- Gay men are more likely to attempt or die by suicide, especially gay men under 25 years old
- In 2010, more than ¾ of the suicide deaths in the US were men
- Men are more than 4X as likely as women to die by suicide

According to this research, the risk factors for increased suicide among men include the following:

- Social isolation
- Substance use
- Unemployment
- Military-related issues and traumas
- Genetic predisposition
- Mood disorders (Mental Health America, 2020)

The following recommended steps are made for safety planning related to suicidal ideation:

1. Identify the patient's warning signs - this will indicate to patients that the crisis plan should be enacted/implemented (US Department of Veterans Affairs, 2020)
2. Identify any internal coping strategies - patients will identify what tools and resources within them that they can use to cope with the suicidal thoughts and triggers. For example napping, deep-breathing, journaling, or any other strategy that helps them to reduce the severity of the feeling
3. Identify social contacts who can help - patients should work with their clinicians to identify the people in their lives who can be kind, loving, and supportive during their moments of feeling suicidal. Clinicians should be prepared to help patients to identify who and what can serve as a distraction during a crisis
4. Identify family members or close friends who can support - patients should have at least one to two people in their lives who they can lean on in times of significant crisis. If using the individuals in step three as a kind of distraction is unsuccessful, they should rely on closer relations who can help them navigate the crisis that could lead to suicide
5. Identify professional agencies to call for help - patients should identify the specific agencies that can support them as needed during suicidal ideation. This could include their local hospital, their counselor, their primary care provider, and anyone else they feel could support them
6. Create a safer environment - clinicians and patients should work together to reduce the risk in their environment that leads to death or severe harm. It is important to note that many veterans and men have access to weapons and firearms. It is ideal if these can be removed or handled by a safer party who lives in the home. Reducing access to lethal means will improve the likelihood of patients staying alive while feeling suicidal (US Department of Veterans Affairs, 2020)

Section 1: Summary

One of the most important considerations for mental health professionals when treating men is the difference in likelihood for men to die by suicide compared to women. Men are more likely to engage in suicidal ideation, planning, and attempts than women.

Mental health professionals must be prepared to safety plan around suicidal ideation and prevent risk as much as possible.

Additionally, men are not unlikely to have a mental illness, despite what society wants its people to believe. Men can have depression, anxiety, personality disorders, psychosis, and any other mental illness. While they may be more likely to have some disorders than others, professionals must be prepared for effectively treating men in the mental healthcare system.

Section 2: Differences in Symptoms

Section 2: Introduction

Men and women are biologically different. They are also socialized differently and have different norms, customs, and expectations that they are taught to adhere to. It is no wonder then, given these differences, that they present with various discrepancies in the symptomology of mental illness. The following section discusses those differences in-depth as well as the differences in substance use behavior between men and women, as there are significant differences there as well.

Section 2: Differences

While men and women are both experiencing a variety of mental illnesses every day in this country, men do generally display a different set of symptoms than women will. This could be related to a variety of causes: hormonal differences, socialized norms, or simply differences in genetic predisposition. Common symptoms that men present are as follows:

- Anger (National Institute of Mental Health, 2015)
- Mood changes
- Changes in energy level
- Changes in appetite
- Difficulty sleeping
- Increased worry
- Increased substance use

- Suicidal thoughts
- Flat affect
- Engaging in high-risk activities
- Aches, headaches, and digestive issues
- Obsessive thoughts or compulsive actions
- Interference with work
- Unusual or concerning thought process (National Institute of Mental Health, 2015)

It is worth noting that while women also experience a variety of the above-listed symptoms, men are more likely to engage in high-risk activities, act out in anger, and experience suicidal ideation, planning, or attempts.

Section 2: Men and Substance Use

One of the most significant discrepancies between men and women, besides suicidal ideation, is the amount of substance use that men use versus women. According to the National Institute of Health (NIH) (2020), men are using more illegal substances than women are. This often causes more visits to emergency rooms and accidental overdoses and death in men than women. Men have higher rates of dependence on illegal drugs and alcohol than women do. While women are equally as likely as men to have a substance use disorder, men are using more dangerous substances than women are. According to the NIH, the following illegal and legal drug information pertains to men and women:

1. Marijuana - Men use more marijuana than women do. Using marijuana is frequently associated with depression and anxiety, however, in men who use marijuana, there are higher rates of antisocial personality disorder. Men develop more marijuana use disorders than women do
2. Stimulants - While women generally use larger amounts of cocaine, men exhibit blood flow abnormalities when taking cocaine. This suggests that cocaine may be more detrimental in men than in women. Women generally use methamphetamine more than men do, however, men generally are less likely to access treatment for their methamphetamine use

3. Ecstasy - Ecstasy results in more overdose deaths in women than men, however, men generally have a higher blood pressure response to ecstasy than women do. Women also experience more hallucinations when taking ecstasy than men do. The difference in usage is unclear

4. Heroin: Men generally use more rates of heroin than women do. They are also more likely to inject heroin than women are. Women are more likely to experience peer pressure and sexual pressure from their male counterparts that results in injection heroin use

5. Alcohol - men have higher rates of alcohol use and binge drinking than women do across the lifespan, except for from the ages of 12-20 when women generally drink more alcohol than men do. Women metabolize alcohol differently than men do and therefore are more easily able to become intoxicated compared to men

6. Nicotine - men smoke more cigarettes than women do and inhale more than women do. Men often smoke for different reasons than women do. For example, women are more likely to smoke for mood-regulating reasons, whereas men are more likely to smoke as a routine or habit. Women are more likely to quit smoking and relapse multiple times compared to men (National Institute of Health, 2020)

Unfortunately, women are more likely than men are to seek treatment and women have access generally to better treatment programs compared to men (Green, 2020). Women who attend treatment programs also have better outcomes than men who attend treatment programs where staying sober is concerned (Green, 2020). The following recommendations are made for treating men with substance use issues:

1. Help men understand the reasons for their substance use issues instead of just assuming that substance use and masculinity are inherently connected (Addiction Center, 2020)

2. Help men to reframe the idea that they are weak or a failure by needing treatment

3. Support men to have to be less stoic and apply vulnerability in their lives

4. Help men to establish relationships with other men separate from drugs and alcohol as men are more likely to use substances in groups than women are (Addiction Center, 2020)

Section 2: Summary

Major differences in symptomatology occur that differentiates men from women. One of the most common examples is that men tend to have fewer presentations of hopeless and self-hating symptoms and an increased presentation of impulsivity and anger-related symptoms. This could be related to masculinity norms and pressures. Additionally, men are more likely to be at risk for illegal substance use behavior and often have more shame related to accessing necessary substance use treatment programs. Mental health professionals must be prepared for how to best support men with their impulsivity, anger, substance use, and other symptoms that set them apart from women.

Section 3: Men and Stigmatized disorders

Section 3: Introduction

While men's mental health is generally less discussed and diagnosed for a variety of reasons, they are also at increased risk for disorder-specific stigma. Many afflictions that might be considered common in women are highly stigmatized in men. In this section, those disorders are discussed.

Section 3: Eating Disorders and Men

Mainstream media and medical field professionals are quick to assume that men are not impacted by societal norms regarding what "beautiful" is and how it looks. This is anything but true, however. Approximately 1 in 4 individuals diagnosed with anorexia are men (Zaydlin, 2017). 36% of those who are diagnosed with bulimia are men (Wooldridge & Lemberg, 2016). The binge-eating disorder impacts more men than the combination of anorexia and bulimia. Finally, research is showing that men are developing disordered eating habits faster than women for the first time in history. This is concerning because there is still little research on disordered eating that includes men (Wooldrige & Lemberg, 2016).

The beauty ideal in women is often perceived as the female body being thin and toned (Zaydlin, 2017). For men, perfection is defined as being lean, muscular, and sexualized. Many men develop eating disorders as a way of attempting to achieve this body presentation. Additionally, men develop eating disorders as a way of coping with emotional turmoil.

Men are taught that they should be strong and engage in masculine activities such as exercise and sporting events. Approximately 1 in 10 men who attend a gym may

experience a form of body dysmorphia called muscle dysmorphic disorder (MDD). This causes men to feel preoccupied with becoming large-muscled. This disorder leads to compulsive exercise, bodybuilding, and eating lean. It may also contribute to compulsive participation in weight training and "cutting," which is a form of restrictive eating. Many negative side effects of this form of body dysmorphia occur including anxiety, depression, injuries such as stress fractures and muscle strains, and excessive weight loss. Forcing the body to change in an unhealthy way to be consistent with societal norms and ideals is often celebrated instead of community members inquiring if their friends are doing okay. When people are praised for changing their body, it often fuels the eating disorder. Men are not immune to this (Maydlin, 2017).

There are many reasons that eating disorders are underdiagnosed in men compared to women. One explanation for this is because men often present with excessive exercise instead of restricting or purging food (Rogers Behavioral Health, 2018). Because of this, and because men may be less likely to appear sickly or emaciated, the signs and symptoms of their mental illness are often missed. Additionally, because eating disorders are often considered a "female issue," men are less likely to seek support or address their compulsive exercising or disordered eating behavior. This kind of public stigma and shame is directly correlated with men avoiding necessary supports (Rogers Behavioral Health, 2018).

It also appears that men have a high likelihood of co-occurring issues with their eating disorders (Bloomer, 2019). The following characteristics are common among male patients with eating disorders:

- High levels of substance use, personality disorders, and depression
- High levels of accidents, injuries, and self-harm
- High use of prescription drugs, antipsychotics, and antidepressants
- High rates of gastrointestinal issues and drugs for these issues

It could be that because these issues are common, that the eating disorder struggles are overlooked because those consequences took priority, whereas the disordered eating disorder did not or was not detected at all. Mental health and medical professionals should be prepared to notice the correlation between eating disorders in men and these other health/mental health struggles (Bloomer, 2019).

The National Eating Disorder Association recommends the following for supporting men who are struggling with disordered eating:

- Schedule time to talk to a professional (Zaydlin, 2017)
- Communicate concerns about your health to a professional or friend
- Communicate concerns to the person you are worried could have an eating disorder
- Avoid conflicts or battles of “will” with friends who are struggling
- Avoid placing shame or guilt on individuals with disordered eating behavior
- Avoid giving solutions to people with disordered eating and instead, just create space for them to share their feelings
- Express support as often as possible (Zaydlin, 2017)

Wooldridge & Lemberg (2016) report this process for treating eating disorders:

1. Engage the patient - in this initial step in treatment, the patient and the clinician must work together to identify the disordered eating behavior. Once it is identified, medical professionals must provide immediate treatment to return any physical symptoms to baseline (or as close as possible). This is an area that is often under-addressed in men as a result of stigma in the medical field where male eating disorder patients are concerned. During this initial phase in treatment, it is essential that the treatment team address any underlying embarrassment than the male patient may have where disordered eating is concerned. They must also address any negative beliefs that the male patient holds toward mental health services and therapy. The interventions utilized should address the beliefs that men do not need mental health treatment. This process should aim toward reducing toxic masculinity
2. Assessment and diagnosis - in the second step of treatment, formal assessments should occur to diagnose the specific type and severity of the eating disorder. It is important to acknowledge that formal assessment questions in disordered eating are often geared toward women instead of men. This is an area of the field that needs to be addressed and made more gender-neutral. Because of this, men often score less significant levels of distress on eating disorder assessments. Although their even though psychopathology is actually consistent with women, the assessment questions simply do not appropriately target them. Additional considerations need to be made for the LGBTQ+ community as well. Gay and transgender men are at increased risk for inappropriately using diet pills and

laxatives to attempt to control the physical presentation of their bodies. Finally, athletes are at an increased risk for eating disorders. This is especially true for boys and men who participate in boxing, wrestling, gymnastics, and cross-country. These boys and men are more likely to purge, fast, and over-exercise although no assessments are specifically tailored to this population

3. Treatment - treating eating disorders is generally more successful when done from a multidisciplinary team approach. Treatment teams should include the following: a psychologist, a psychiatrist, a social worker, a physician, a dietician, and anyone else who the patient feels is appropriate for the treatment team (Wooldridge & Lemberg, 2016)

Section 3: Men and Borderline Personality Disorder

Borderline personality disorder (BPD) is a Cluster B personality disorder characterized by a lifelong experience of mood instability, emotional regulation issues, and severe feelings of self-worthlessness, shame, and self-hate. It is often thought of as an affliction that disproportionately impacts women, but this couldn't be further from the truth.

Amongst professionals, the rates of BPD are assumed to be equally dispersed between men and women ; however, women receive BPD diagnoses at higher rates than men do (Schwartz, 2019). 75% of those diagnosed with BPD are women. This is unacceptable because many men who are suffering are going without necessary treatment.

The following reasons are identified as potential causes for the discrepancy in diagnosing BPD between men and women:

1. Men with BPD often have behavior considered more "explosive" in nature than women. This can often be misdiagnosed as substance use disorders, narcissistic personality disorder, and antisocial personality disorder. Misdiagnosis is common for men with BPD and prevents them from accessing necessary treatments and services. It is important to note that research finds that men have equal levels of emotional turmoil and distress when compared to women with BPD. They are also likely to engage in self-harm, whereas it is often thought that they are not likely to do so

2. Men are incarcerated more than women are and because of this, they are often treated for disorders that lead to incarceration at higher rates than BPD. For example, substance use issues or narcissism are commonly identified and treatment is attempted in jail for such issues

3. Symptoms consistent with BPD may be viewed as more socially acceptable in men than women and therefore diagnosed less. For example, anger is a common symptom for people with BPD, however, it is viewed as more normal in men than it is in women. Explosiveness and impulsivity are also common for people with BPD but may be viewed as "boys being boys," whereas they could be a trigger for diagnoses in women

4. Men are more likely to access substance use treatment services when compared to accessing therapy or pharmacology. Because of this, they may be less likely to be screened for any other condition than substance use and their BPD diagnosis may be missed (Schwartz, 2019)

According to the National Alliance on Mental Illness (NAMI) (2020) the following are red flags that clinicians should look for in men when attempting to diagnose BPD:

1. Frequent intimate relationships - men with BPD often date multiple women and have a difficult time committing to monogamous relationships as the result of their fear of abandonment. They might struggle to stay in one relationship for long periods, which may be related to other difficult BPD symptoms (aggression or impulsiveness, for example). This can often lead to entering another relationship quickly thereafter or even before the initial relationship ends

2. Dramatic behavior or attitudes - while behavior perceived as dramatic may look different in men, it is common for men with BPD to have behavior considered emotional or erratic. Examples include texting old romantic partners years later or becoming emotionally detached for no apparent reason

3. Roller coaster of emotions - men with BPD will often display behavior that transitions or cycles rapidly. They may present as "hot" or "cold" soon after one another in how they interact with others. They may be angry and then calm. This kind of cycling is many less easy to see in men but will be present in someone with BPD

4. Difficulty interpreting the behavior of others - many men with BPD will struggle to understand body language, emotions, and interpret communication that they receive from others. An example of this could be a man becoming very upset or worried when his wife talks to another man in public, even when she isn't behaving inappropriately at all

5. Frequent suicide attempts or self-harming behavior - men have higher rates of suicidal ideation and planning and certainly, patients with BPD have even higher rates of suicidal behavior. Men with BPD may engage in cutting, headbanging, and other self-harm

6. Attention seeking behavior - while this is also considered a “classic” symptom of BPD when thinking about women, men also display attention-seeking behavior. Examples include flirting with women inappropriately in public, picking fights, domestic abuse, unprotected sex, or gang participation (NAMI, 2020)

Section 3: Men and Self-Harm

Self-harm is highly stigmatized where men are concerned. It is almost as if self-harm is thought of as “not that big of a deal” for girls and women by the general public because it is thought of as so common, whereas if men are engaging in these behaviors are perceived as “weak” or “feminine.” Because of this, men fail to be appropriately supported or even ask for help on their journey to recovery with self-harm.

What is especially interesting about this stigma is that while young girls may be engaging in self-injurious behaviors at higher rates than boys, in young adulthood and adulthood the statistics show that self-harming rates are similar between men and women (CAMH, 2020).

Mental health clinicians who work with men who harm themselves should be prepared for how to reduce the stigma associated with these practices. They can do so by teaching the individual about self-harm. The following information by NAMI (2020) can be helpful to teach to patients as psychoeducation:

- Self-harm is commonly associated with depression, anxiety, personality disorders, eating disorders, and trauma - offering a diagnosis (more information) can be liberating to the client and mental health professionals should aim to do this
- Self-harm is associated with higher substance use rates
- Self-harm is a way of coping with emotional distress
- By self-harming, often the emotional distress becomes worse in the long-run, despite having an immediate reduction in discomfort at the moment
- Self-harm often causes feelings of shame. This is especially true if the person has a scar or multiple scars on their body that are visible

- Self-harm is not the same as attempting suicide but it can increase the risk of suicidal ideation
- Self-harm is treatable through therapy and learning new coping mechanisms (NAMI, 2020)

Section 3: Summary

Disordered eating and borderline personality disorder are two of the most stigmatized mental illnesses for men to experience. Society teaches men to be lean and muscular and that frequent exercise should be celebrated. This is counter-intuitive to health because it is often celebrated despite acknowledging the compulsive behavior related to exercise. Men are not immune from eating disorders and they face male-specific body dysmorphia issues often as a result of the pressure to be muscular and lean.

Men may also experience borderline personality disorder, which is commonly thought of as being only diagnosed in women, despite being equally as present in men. Men with BPD often present with different symptoms than women, but they are just as likely to be impacted and struggle with the self-hate, fear of rejection, and other difficulties that come with a BPD diagnosis. Clinicians must be prepared for how to identify and treat BPD in men.

Finally, men are not immune to self-harming behavior and while this is not a diagnosis-specific issue, it is necessary to discuss. Men are self-harming, similar to women. It must be discussed and recognized by mental health professionals. It must be normalized and alternative coping mechanisms should be identified as well as clinicians should help reduce the self-stigma that occurs when men self-harm.

Section 4: Men and Therapy

Section 4: Introduction

Men are impacted by mental health issues and their consequences. As discussed above, they commonly experience depression, anxiety, and a variety of other mental illnesses. They can also encounter any other mental illness at any time, just as women can. It is assumed, however, that they experience them less because men have historically not sought help or participated in research studies related to mental illness. Because of this, there is less data to pull from and a diminished understanding of the most effective way to treat men with behavioral health needs.

Section 4: The differences between men and women in therapy

There are a variety of reasons that men avoid asking for support when they are struggling with behavioral health issues. Before discussing this, however, it is essential to understand the reality of how often men are accessing mental healthcare. According to Gateway Counseling (2017), Only about ⅓ of patients receiving mental health services are men. The following interesting statistics show the discrepancies between how men and women access mental health services:

- 72% of women with depression attend treatment whereas 60% of men with depression attend treatment
- 9% of women utilize outpatient mental health services and 5% of men utilize outpatient mental health services
- 16% of women utilize the medication for mental health and behavioral health needs and 9% of men do so (Gateway Counseling, 2017)

A study published online by Liddon, Kingerlee, and Barry (2018) found many discrepancies between men and women not only in how often men access services but in the types of services they access, as well as in their coping strategies. Their research found the following:

- Women like traditional talk psychotherapy more than men do
- Men like support group therapy more than women do
- When coping with stress, women share their emotions more than men do
- Women find talking with mental health professionals more comfortable than men do
- Women tend to attend therapy sooner after identifying a need than men do, while men traditionally “put off” therapy
- Most men do not have a preference for the sex of their therapist whereas most women prefer to see female therapists
- Women are more likely than men to discuss their struggles with friends
- Women are more likely to engage in maladaptive “comfort eating” than men
- Women are more likely than men to ruminate when stressed

- Men are more likely than women to want a “quick fix” solution when in therapy
- Men are more likely than women to utilize substances when stressed
- Men are more likely than women to utilize porn, sex, and gambling as a maladaptive coping strategy for stress and worry
- Women are more likely than men to rely on their self-understanding and self-awareness when they begin to struggle whereas men have a more difficult time identifying their oncoming mental health struggles
- Men are more likely to seek mental healthcare if prompted by a family member than women are
- Men are more likely than women to not seek help at all and believe they can solve their problems or struggles
- Men are more likely than women to report systemic barriers to accessing mental healthcare (Liddon, Kingerlee, & Barry, 2018)

Section 4: Why is There a Discrepancy and So Much Stigma?

The research shows that women are accessing mental health services at a much higher rate than men are, even though men are experiencing mental illnesses at sometimes equal or increased rates, depending on the illness being examined. So, why is there a discrepancy?

Unfortunately, this is a complex question with a complex answer.

Toughness and dominance

Masculinity has long been viewed through the “tough” lens. Men who are perceived as strong, gritty, able to stand on their own and support others, have been consistently celebrated in societies for decades, if not centuries.

The pressure put on men to feel “tough” is dangerous to their mental health (Gateway Counseling, 2017). Because men have been taught to be able to weather any storm, they may struggle to understand or read their own emotions. For example, a man might be depressed and he might not even understand or be able to name that because he has not been taught to in the same way that a woman might have learned to notice these symptoms growing up.

Men have historically been told things such as “don’t cry” and “rub some dirt in it” from an early age. These kinds of statements are internalized and therefore some men truly believe that to feel emotions is to be weak. This kind of long-standing belief is preventing many men from accessing mental health services that could change or save their lives.

Independence

In addition to feeling as though they must be tough, men also face the socialized belief that they must be independent at all times. Growing up boys are often told to do things on their own or to go help their siblings. They are not taught to ask for help the same way that little girls are expected to ask for assistance when needed. Because of this, men are unwilling or even afraid to seek support from a counselor, doctor, or friend.

When we teach boys and men that they must be completely self-sufficient but we do not teach them to notice and name their emotions, there is a serious risk in our communities where unmet male mental health needs are concerned. As mental illness rates rise, these kinds of socialized beliefs and norms must be torn down.

Trust

Men also struggle to trust others because they are taught to only trust themselves or their family where meeting needs are concerned. It is difficult for many men to believe that they can connect with or depend on a therapist or establish a therapeutic relationship. Some experts find that men have been raised to be on guard and hesitant where trust is concerned (Gateway Counseling, 2017). This would make participating in mental health services very difficult because the bulk of the benefit of the work comes after a trusting, therapeutic relationship has been established.

Control

Men are also taught that they should constantly be in control of their environment (Mental Health Foundation, 2020). Often when people are struggling with mental health symptoms or illnesses, they report feeling out of control. For men who have been socialized to believe they must always be able to manage their situations, the thought of feeling out of control may seem daunting or shameful. Because of this, many men might frantically try to maintain their sense of control or simply ignore the symptoms that make them feel like they are not in charge. While this is managed in the short-term, it becomes difficult to cope with the long-term. This can lead to burnout, exhaustion, and other negative consequences.

Stigma

Chatmon (2020) provides further information on the above data. Benita Chatmon's research defines stigma around mental health as "an umbrella term that includes social stigma, self-stigma, professional stigma, and cultural stigma." They are further defined below:

1. Social stigma: the attitudes toward individuals with mental illness that are negative and disapproving. This is often rooted in the belief that a mental health struggle makes an individual weak. The impact of social stigma is often discrimination, avoidance, and rejection of the person experiencing mental illness. This is very dangerous because it leaves people alone and unsupported

2. Self-stigma: when individuals internalize the social stigma that they receive in their communities. Essentially, people who are struggling begin to believe that they are weak and unworthy because those in their surroundings imply or express this. The impact of self-stigma is often shame. This can result in self-harming behavior or suicidality very easily

3. Professional stigma: when systems reinforce the stigma from societies. Examples of this include the healthcare system and legal system

4. Cultural stigma: when familial and cultural communities reinforce societal stigmas. Examples of this include when religious communities shame or judge someone for using substances. Culture considers a person's values, beliefs, and the norms that they participate in when they belong to a specific group. The culture an individual is raised in will help them to develop their ideas and behaviors. This will promote whether they feel it is appropriate or acceptable to ask for help or not. It will guide the type of help that they seek. It will influence the coping skills they utilize or do not utilize. Chatmon (2020) references an example in the Black community: "distrust of the health-care system still exists… Black culture may find it difficult to accept a mental health problem or diagnosis and seek help"

The American Psychiatric Association (2020) offers these examples of public stigma:

1. Believing that people who live with a mental illness are dangerous or unable to support themselves

2. Believing that people who live with a mental illness are unpredictable and incompetent

This kind of public stigma often results in:

1. Lack of employment because employers do not want to hire the individual with a mental illness
2. Lack of housing because landlords do not want to rent to the individual
3. Poor healthcare because professionals provide lower-quality care to the individual with a mental illness when compared to a neurotypical individual

The American Psychiatric Association also identifies several examples of self-stigma:

1. Individuals with mental illness may believe that they are dangerous
2. They believe they are incompetent or stupid
3. They believe that their mental illness is their fault

This kind of self-stigma often results in:

1. Poor self-esteem
2. Poor self-efficacy
3. Poor self-worth

Finally, the American Psychiatric Association teaches that when these stereotypes and stigmas are included in systems or institutions, then there is a significant loss of opportunity for the individuals who have a stigmatized disorder (American Psychiatric Association, 2020).

Chatmon also names the problem impacting men in mental health: masculine norms. Chatmon (2020) states that “the standards of masculinity are killing them” when referring to men not accessing necessary mental health services and dying by suicide at such high rates. Hegemonic masculinity is defined by power, dominance, and privilege when compared to women. Masculinity is further categorized into toxic masculinity when individuals are participating in masculine norms to such extremes that they restrict necessary behaviors to ensure that their masculine identity and status remains intact. For example, avoiding going to the doctor or therapy when necessary is behavior consistent with toxic masculinity.

Toxic masculinity often results in difficulty with the expression of emotions, aggression, and violence. With this kind of culture or belief system, boys are taught to “be boys” and that it is acceptable to break the rules to get ahead. Toxic masculinity often results in:

- Increased depression and anxiety
- Substance use
- Health risks (cardiovascular health)
- Difficulties with dating and intimacy
- Increased risk of violence
- Increased psychological distress
- Homophobia
- Decreased access to necessary mental healthcare and physical healthcare (Chatmon, 2020)

Section 4: Summary

There are significant differences in the rates of women who access mental health therapy versus men who access mental health therapy. Men are accessing therapy less likely than women are and they are often seeking less intensive or intimate forms of treatment such as coaching instead of therapy.

The difference between men's and women’s access in services is often related to various forms of stigma: self-stigma, public-stigma, and systemic-stigma. Stigma, or the negative association or belief about something, is more present for men with regards to mental health than it is for women. This often prevents men from accessing necessary services and receiving a proper diagnosis of their conditions. The stigma must be reduced for men to meet their mental health needs.

Section 5: What is the Impact of Stigma on Men’s Mental Healthcare?

Section 5: Introduction

Stigma has many negative and dangerous health outcomes. The association or belief that men who have mental illnesses or struggles are weak often prevents them from

asking for help and receiving necessary support. Men must know that they can ask for help and that this makes them brave and not inferior. In this section, the negative impact of mental health stigma related to men is discussed.

Section 5: The impact of stigma

Stigma in men's mental health is unfortunately dangerous as evidenced by the higher rates of suicidal attempts and death by suicide in men. Stigma often results in worse symptoms in mental health. (American Psychiatric Association, 2020). It also results in a lower likelihood that men access mental health services when they need them.

Stigma often results in:

- Less hope for recovery or overcoming the mental health struggle
- Lower self-esteem
- Increase in symptoms (when they go untreated this is very dangerous)
- Difficulties in interpersonal relationships
- Difficulties with employment (this often impacts housing)
- Lower likelihood of adhering to treatment suggestions or staying in a treatment program
- Poor long-term recovery (often patients with higher self-stigma are more likely to need to attend multiple rounds of treatment)
- Isolation from others
- Poor familial support
- Fewer opportunities to engage in pleasurable social activities
- Bullying, harassment, or being subjected to physical violence
- Poor coverage of needs via health insurance
- Poor belief in the individual's future (American Psychiatric Association, 2020)
- Avoidance behaviors - for example, substance use (BMI Healthcare, 2020)
- Substance use behavior often reduces the positive impacts of mental health medications

- Self-harming behavior
- Extreme anxiety
- Paranoia
- Feeling out of control or a lower sense of control
- Situations that can endanger the man or someone else
- Increase in depressive episodes
- Poor sleep hygiene (BMI Healthcare, 2020)
- Sexual dysfunction (Stiawa, Muller-Stierlin, Staiger, Killian, Becker, Gundel, Beschoner, Grinschgl, Frasch, Schmaub, Panzirsch, Mayer, Sittenberger, Krumm, 2015)

The Stiawa, et al. (2015) study found that men are often less perceptive with regards to their mental health than women because of a combination of stigma and masculine norms. Mental health professionals in the research study reported that men had less insight than women into their health status and their motivation to begin treatment and improve their health status was delayed. This is an important impact of stigma because it shows that men have a lower emotional intelligence when compared to women. This study also found that men have expectations that treatment will be effective in a shorter duration than women believe. This is generally because men underestimate the severity of their needs as well as the time and effort that it takes to achieve a recovered state or to find a healthier baseline. Men are wired to search for solutions and because the solution in mental health treatment is not always straightforward or easily identified, this can be frustrating to them.

Section 5: Summary

Stigma related to men's mental health is often associated with dangerous behaviors. Substance use, suicidal ideation and planning, and gang-affiliation are some of the more dangerous examples. Men are facing such significant pressure to be perceived as masculine, capable of solving problems independently, and taking care of others that their own mental health needs are often ignored, overlooked, or downplayed. The stigma associated with men's mental health must be addressed so that current and future generations of men feel safe and empowered to ask for support.

Section 6: How to Alleviate Stigma Related to Men's Mental Healthcare?

Section 6: Introduction

As discussed above, stigma results in dangerous situations for men. It puts them at risk for mental health crises and behavior that could result in incarceration or death. Because of this, mental health professionals and community members must work together to reduce the stigma in men's mental healthcare.

Section 6: Ways to Reduce Stigma

Reducing the stigma associated with men's mental health is crucial in literally keeping men alive as Chatmon (2020) referenced in the research journal. Because of the disparities between men and women's mental health access, the following recommendations are made to promote better mental healthcare for men:

- Develop policies that offer mandatory cultural competency training to professionals in the mental health field
- Implement public campaigns related to reducing stigma
- Ensure that the provider pool in mental health is diverse and competent in men's health
- Redefine what "manhood" or "masculinity" is and how we interpret it in communities
- Promote the need to help men communicate their feelings effectively
- Ensure that there are positive and diverse role models communicating the importance of men accessing mental health services (Chatmon, 2020)

The American Psychiatric Association (2020) also discusses many ways to reduce stigma in men's mental health. The first point they address is that simply knowing someone and intentionally having contact or being exposed to the individual and his or her struggle with mental illness can help reduce stigma. Therefore, it is essential that people who struggle with mental illness talk about their difficulties and share their stories. This is often done via media: social media, podcasting, books, etc. It should be acceptable to discuss mental health openly in conversations with friends and family. Young men,

especially, are more interested in learning about their mental illness through the storytelling of peers and individuals they can look up to.

Anti-stigma research and marketing must continue. These kinds of campaigns, when directed at men's mental health, are effective in increasing the use of mental health services. This reduces stigma and therefore the negative impacts associated with stigma.

The American Psychiatric Association (2020) also identifies the following ways to reduce stigma:

- Openly share and discuss mental illness and mental health
- Educate others about the reality of mental illnesses - this helps to reduce the common misconceptions
- Notice the language used - words significantly impact the way that communities view mental illness. Person-centered language should be used at all times
- Equality should be encouraged - this is especially true when comparing mental and physical illnesses. Neither should be prioritized
- Be compassionate - community members should try to be as compassionate as possible to one another - mental health professionals should emphasize this to patients they are treating
- Be honest about how the treatment is going - if individuals are honest about the realities of mental health treatment when sharing, the stigma will be reduced. When it is hidden, there is a greater stigma associated with mental healthcare
- Choose to be empowered - many men feel disempowered by their mental health struggles. By empowering people to feel neutral or even proud of their mental health struggle and recovery, stigma is reduced

The Association also addresses the need to reduce stigma and discrimination in the workforce. This can be done through the following:

- Properly funding insurance
- Allowing mental health days to be utilized
- Promoting the use of an employee assistance program

- Following a proper chain of command and maintaining anonymity by management and supervisors
- Openly discussing the health (both physical and mental) of employees as being a priority (American Psychiatric Association, 2020)

Section 6: Summary

Some of the easiest ways to begin breaking down the stigma associated with men's mental health and mental health services generally include simply being willing to discuss mental health struggles. By storytelling and practicing vulnerability in conversation with others, individuals promote the belief that it is okay to struggle. At mezzo levels, mental health professionals should be engaging in ongoing education, credentialing, and advocacy to create policies and procedures that promote men accessing mental health. Programs must serve men and their norms just as well as they do women. At macro levels, large programs should be specifically targeting men in the treatment process. Educators and teachers should be discussing mental health in the classroom. No one solution will reduce stigma, but rather a combination of solutions at all levels will eventually support the reduction in stigma associated with men's mental health.

Section 7: How Mental Health Professionals Should Work with Men

Section 7: Introduction

Mental health professionals need to interact with men differently than they do women. They may need to take it slower in sessions and focus more on reducing the self-stigma that men may be more likely to hold and present than women. Clinicians must be prepared for how to support men in a way that is collaborative and engages men in the process. This is the only way to ensure that they have access to the care that they need.

Section 7: Supporting Men

Mental health professionals must be prepared to work with men and boys in a way that is inherently different than supporting women. The rules of masculinity that men have been taught often must be negotiated through and considered during the therapeutic relationship. The American Psychological Association (2018) recommends the following guidelines for therapists when working with male patients:

1. Recognize that masculinity is socially constructed and there are social and cultural perspectives to consider from each patient - therapists must consider that masculinity is different in white culture versus Latino culture versus any other racial or ethnic background. The therapist should work to assess and understand these norms and the impact they have on the patient.

2. Recognize that boys and men will integrate many different social and cultural identities in their lives - identity is multi contextual and this must be understood. The intersection of various identities will impact the way that men are or are not willing to access mental health services. Various factors to consider include race, age, religious affiliation, sexuality, professional identity, education, military service or not, ability (physical or mental health), etc. Therapists should also understand the risk associated with some of these identities. For example, a person with a military service history may be more likely to use substances or have Post-Traumatic Stress Disorder than another person.

3. Recognize the impact of power and privilege on boys as they develop into men and the impact this has on their relationships - while power is often something that boys and men inherently experience, it does come with the requirement of participating in stereotypical male roles and promoting masculinity. Because of this, mental health professionals may have to tackle men who have ingrained toxic masculinity that requires unlearning. They should be prepared to work with male patients in a way that addresses these positions of power and helps men learn the impact of privilege. The APA identifies a few examples: gender-based violence, choosing stereotypical masculine careers, and work-family conflicts.

4. Develop an understanding of what influences the interpersonal relationships of boys and men - it is important to understand that many boys and men were taught to avoid emotional intimacy and discussing their feelings. This often has serious negative impacts in later life when relationships are hugely important. Additionally, masculinity has taught men that sexuality should focus on power and promiscuity. For example, men are more likely to prompt unprotected sex and have more interest in “hooking up.” Men also are more likely to have fewer close friends than women are because masculinity teaches boys to avoid discussing feelings, which are the very thing that helps people become close.

5. Encourage healthy and positive relationships between boys and their fathers and family - many fathers report feeling unsure of the best ways to parent because women are viewed as the primary caregivers. Because there are more resources

and training programs available to women in parenting, men are often left feeling unsupported and unprepared for parenthood. This can result in difficulties bonding with children and can leave the father feeling inadequate like he is not a good parent. Additionally, when men begin to parent they are often confronted with the impact of their childhood and how their father was or was not involved in their lives. Mental health professionals should support patients in a way that promotes emotional health for both children and fathers. They should teach men how to engage in the family system in an emotionally-present way.

6. Support education that responds to the needs of boys and men - data suggests that a large number of school-aged boys are underperforming. This could be related to the socialized masculinity norm that often values physical performance over intellectual or academic performance. It is also important for mental health professionals to understand that boys and men are more likely to have learning disabilities than girls and women. Boys are also often punished more in the classroom than girls are, and especially boys of color. These classroom experiences often shape the development and mental health of men. Therefore, mental health professionals must be prepared to support school-aged boys through the system in a way that promotes learning and development. They should also be prepared to support adult men in processing the impact that their school years had on their mental health. Mental health professionals must act as advocates to promote healthier and more sustainable educational systems through policy and program development.

7. Reduce the rate of aggression, violence, substance use, and suicide that boys and men face - boys and men commit almost 90% of the violent crime that occurs in the United States. This kind of behavior is often taught or reinforced by mainstream media such as television, movies, music, and video games. Violence is often a way that men prove their masculinity and enhance their confidence. Mental health professionals must be prepared to address such maladaptive and dangerous thought processes and provide teaching of healthier thought patterns. Mental health professionals must also be prepared to teach about suicidal ideation, planning, and preventing risk. Men and boys who attend therapy must have a safety plan to prevent suicidal planning or attempts. It is also essential to understand the impact that adverse childhood experiences have on boys as they grow into men. Mental health professionals must be trauma-informed in their work.

8. Utilize methods that support men in engaging in healthy behaviors - according to the APA, men have a shorter life expectancy by at least five years when compared to women. Accidents are the leading cause of death for men and this is often directly correlated with risky behavior. For example, speeding while driving, climbing rocks unprepared, and other accidents are common in males. Additionally, men are less likely to attend important medical screenings and appointments and other preventative medical services. Mental health professionals should be prepared to offer psychoeducation on such important health-related behaviors. This supports men in adopting lifestyles that are conducive to health and longevity.

9. Promote gender-sensitive mental health services - much research has found that men often do not seek out mental healthcare because they believe that the services are not aligned with the norms they have been subjected to. Because of this, it is essential that mental healthcare not further support the belief that people who access care are weak or should feel shame. Care provided must be affirming to all identities but it should also understand that many men will have a difficult time expressing emotions. Clinicians must understand that traditional signs and symptoms of mental illness may look different in men when compared to women. Externalized behaviors, such as aggression or risk-taking behavior, must be noticed and treated more in men often than in women. These symptoms are often masking depression, for example. Clinicians must also understand that often men will under-represent their severity of difficulty or symptomatology. It can be beneficial to refer to mental health services or to adopt practices such as coaching or consultation. Often this can feel less stigmatized or intimidating to traditional male roles and culture.

10. Work toward cultural and systemic change that prevents men from accessing necessary mental health services - men are often disproportionately impacted by systems in United States culture. For example, men make up 93% of those individuals who are currently incarcerated. This is an important data point to understand because the judicial system should serve and support men better than it does. Mental health professionals working in macrosystems should strive to improve the systems that men interact with. Another example is traditional healthcare. Better screening, prevention, and education for common disorders such as anxiety and depression should be implemented. Men are also more likely to be discriminated against for housing, especially where public housing is concerned. Mental health professionals and advocates must work toward

improvement in housing systems. This is essential because housing significantly impacts mental health. For example, those who are living unhoused are less likely to be mentally and emotionally at baseline than those who are housed (American Psychological Association, 2018).

Men must learn to identify and name their emotions. This should be a focus of the mental health therapy process when working with male patients. Boys are taught to avoid their emotions as early as elementary school (Gruber, 2018). This results in men suppressing their feelings later in life and difficulty regulating emotional states. Emotional regulation skills are learned through practice and trial and error. If men are missing these essential opportunities to practice, it is obvious that the result is an inability to name and address emotions (Gruber, 2018). The following recommendations are made to teach boys and men to identify and name their emotions:

1. Give individuals vocabulary for their emotions - for children, it can be helpful to use a poster with emotional states labeled and drawings (Fitzell, 2020)
2. Make a habit of asking the individual what their feeling state is. Language such as "what are you feeling?" or "can you name that feeling?" can be helpful
3. Roleplay can be used to identify feeling states
4. Teach boys and men to notice body language - both theirs and others. Noticing their body language is often a key way for men to name their feelings. This also helps men to understand how their body language impacts others in interpersonal relationships, work settings, and other environments
5. Teach boys and men that anger is a secondary emotion - often men think that anger is a primary emotion that they experience often. This should be addressed because anger is often masking other feelings such as sadness, anxiety, jealousy, and more. Once boys and men can understand that anger doesn't serve them as well as naming and processing the primary emotion does, they will be less likely to use substances or engage in inappropriate domestic violence, verbal aggression, and other risk-taking behaviors
6. Teach boys and men empathy - teaching empathy promotes emotional intelligence because it asks the individual to notice, validate, and make space for the emotions of others (Fitzell, 2020)

Section 7: Summary

Mental health professionals may be interacting with men in various systems differently than the way in which they generally interact with women. For example, because men are incarcerated more and attempt suicide more, mental health professionals may be meeting men in moments of crisis more often than they do women. This will impact the therapeutic relationship. Clinicians must be prepared to normalize whatever setting and situation that the male patient is in while effectively establishing a therapeutic relationship. It is also important that clinicians are prepared to not immediately tear down the masculine standards and norms but rather operate around and within them while the therapeutic relationship is being established. If this does not occur, the relationship could be adversely impacted and the man may not want to return to treatment. Supporting men simply is different than supporting women because of the differences in symptoms, presentation, and life experience that men have in the world.

Section 8: Case Studies

Case Study #1: Jose

Jose is a 37-year-old man who resides with his long-term girlfriend. They have been together for almost 15 years and just recently his girlfriend gave him an ultimatum of sorts because he has been struggling with substance use issues for much of their time together. Jose's drug of choice is heroin, although he does not use it daily. He generally goes through several weeks of using and then several months of not. This has been a struggle in his relationship for many years, but his girlfriend has stayed with him because they have a deep love for one another and they grew up together. Jose and his girlfriend were raised in a low-income neighborhood and neither had parents who were consistently around. Jose was responsible for supporting his mother and younger siblings financially from the age of 16 on. Jose's father was in and out of jail and passed away several years ago. This is when Jose began using heroin.

Jose's girlfriend asked him to attend treatment for his substance use issues because she is no longer feeling safe in the relationship with him. She is unsure if she can remain in the relationship with him the way that it currently is. He saw a therapist and together they decided it would be more helpful for Jose to attend an inpatient treatment program to address his substance use behavior rather than attend outpatient services. Inpatient treatment will allow him to access intensive supports to ensure that he can achieve and maintain sobriety while also addressing the reasons that he uses heroin.

When in treatment, Jose was able to participate in cognitive behavioral groups and acknowledge that his substance use behavior was related to years worth of feeling insecure and that he was not worthy of love. Jose worked with his therapist around the trauma of having a father who was not present and who was aggressive when present. Jose learned to identify and name his emotions. He found that as he began naming his emotions and using adaptive coping strategies (such as exercise, journaling, reframing, and deep breathing) that his desire to use substances was reduced. After approximately four weeks in inpatient treatment, Jose was discharged into an outpatient treatment program. He began seeing a therapist weekly and attending groups that focus on sobriety.

Approximately 12 months after treatment, Jose remained sober and reported that his relationship was the strongest it had ever been.

Jose's case illustrates how substance use often masks internal pain and emotional distress in men. Once he addressed that pain, he felt less compelled to use substances.

Case Study #2: Trevor

Trevor is a 46-year-old man who has a history of depression and anxiety. He can remember feeling anxious as young as 6 years old. He was told by his father to "shut up and ignore it" growing up when he would try to express the fear and panic he was experiencing. This led to Trevor avoiding managing his anxiety, which eventually led to many depressive episodes in adulthood that went untreated. Trevor's anxiety recently began increasing again. He had been having panic attacks daily that would cause him to call out of work approximately once per week for months. After years with the same employer, Trevor was fired because of missing too much work. He was devastated and realized it was time to address this lifelong experience with mental illness.

Trevor established care with a therapist. Together they had to process the trauma associated with being told to ignore his sustained anxious states. This led to his inability to navigate adult relationships and intimacy. Trevor feels devastated because he acknowledges that his life could have been more full of love, connection, and joy than it has been.

Trevor's therapist starts very small with him. Together they work at naming emotions and developing a toolbox of coping skills. These skills include a cope-ahead plan for leaving his home, despite anxiety and panic; grounding strategies; mindfulness strategies; and the use of anti-anxiety medication. Trevor and his therapist work together to reframe his thoughts so that he no longer perceives his emotions as being

weak and shameful, but rather as essential for feeling joy. They also work through the self-stigma he has. Initially, in therapy, he was referring to himself negatively by using crude names and language, and they were able to neutralize the language.

After several months in therapy, Trevor's anxiety was under control enough for him to return to his past employment. Upon returning to work, Trevor felt such pride for managing his emotions and navigating anxiety, that he met someone in another department and felt enough confidence to ask her on a date. Trevor reported never feeling so confident and healthy in his life as he did after committing to therapy.

Several years after treatment, Trevor's anxiety is still being well managed with the combination of skills and medication management. He has been in a healthy relationship with his girlfriend and is attending work consistently. He no longer thinks of himself as weak for having anxiety and depression and simply recognizes that it is a part of him that ebbs and flows.

Trevor's case is an effective example of the impact that not addressing masculine norms has: individuals become anxious, depressed, and struggle to function in society. Trevor's treatment is representative of addressing the childhood trauma associated with not being supported in his feelings as well as addressing the impact of that trauma, which for him was anxiety and depression.

Case Study #3: Jason

Jason is a 19-year-old gay man who has not come out to anyone. He was raised in a traditional Christian household with parents who instilled gender norms and the importance of being a masculine man in him. He engages in behaviors that he believes will make others believe that he is straight and therefore love him: drinking beer, shooting guns, and studying business.

Jason has been in a relationship with a woman for approximately six months and they do not have sex because he knows that he is not attracted to her. Jason feels as though he has to either have sex with her or come out of the closet. He is afraid of the rejection he may likely face if he comes out as gay to his family.

Jason has begun feeling depressed and even suicidal. He has thought many times "it would be easier to die than to come out." Jason feels afraid of his health because these thoughts have continued to rise, despite his attempts to avoid thinking them.

Because of this, Jason recently began seeing a therapist, without telling his family. In therapy, Jason is diagnosed with depression. His therapist teaches him that it is not uncommon for gay men, and especially those who are closeted, to experience depression. This normalizes the experience for Jason, and he begins feeling more comfortable in therapy over time, despite being told by his family that therapy is not something that men attend.

Jason and his therapist work together to help him feel less shame about being gay and understand that this is not something that he can change about himself, nor is it a reason that his god would not love him. Jason's religious beliefs are important to him. His therapist helps him find a local Christian and affirming community for Jason to integrate with and also practice coming out in. As Jason begins coming out to individuals, he feels more and more comfortable being himself and is less depressed. He also feels safe to come out to his family knowing that he has a community of people supporting him. Jason's family, while not thrilled, was supportive and loving enough toward him for Jason to feel okay and accepted and his authentic self. Jason eventually left his girlfriend and began dating men.

In doing this, Jason also had to address the internalized role that masculinity has played in his life. He felt inadequate as a man because of being gay and made up for this in hyper-masculine ways: sporting, drinking, etc.

Within one year of attending therapy, Jason's depressive symptoms were greatly reduced and he feels comfortable being his authentic self. He even begins to mentor others through their process of coming out. Jason now feels great purpose and joy in his life, where this was missing before.

Jason's case demonstrates the impact of toxic masculinity as well as the influence of fear of rejection by family on mental health. His therapist supporting him to live his authentic self on his timeline and when he was ready was an important part of Jason's recovery story.

Case Study #4: Craig

Craig is a 22-year-old, black man. Craig experiences depression and psychosis; however, he has never been treated for a consistent amount of time because of the historical fear of physicians and therapists in the black community and because of his paranoia. Craig's paranoia has made it difficult for him to trust that another person could support him. He feels that he does not have psychosis, despite having had multiple doctors diagnose him. He believes when he is unmedicated that everyone is lying to him and that they are "the

crazy ones" and not him. Craig recently lost his housing because of the inability to maintain employment. This is often common for individuals with psychotic disorders and Craig is no exception. He had been employed at a local movie theatre and enjoyed his work but was let go because he stopped showing up to work or would refuse to complete some of the tasks that he was responsible for.

Craig's mother and siblings met with him and asked him to enter a treatment program after years of avoiding mental health services. Craig, while hesitant, accepted this offer because of his living situation and knowing that he has nowhere to go. He is afraid of being on the streets for too long because he knows that it could be dangerous for him.

Craig begins a treatment program and immediately begins to learn a great deal about himself. He realizes that his psychotic symptoms occurred in childhood but they were often overlooked because he was just thought of as being creative and energetic. In treatment, Craig learned to recognize the signs and symptoms that would indicate a psychotic episode was coming. He also learned skills to effectively communicate with friends, family, and employers when he was beginning to struggle with his symptoms. The treatment program helped him to access some disability services that will help him maintain employment in the future because he will have protected status. He has also been prescribed medication that would be effective in helping him manage his psychosis.

In treatment, Craig realized that he has been holding long-standing beliefs about his mental health. These include the thought that he is crazy, out of control, and unworthy. In treatment and outpatient care, Craig begins to address these stigmatizing thoughts and realizes that his quality of life could be much greater than it has been historically.

Within several years, Craig is much more functional than he was previously. He establishes care with a case manager and mental health therapist who was crucial in helping him to learn more adaptive strategies. He was able to find housing, access supportive employment, and begin to have more effective relationships with his family. Craig has a safety plan because he learned in treatment that he had been having suicidal ideation for years.

Craig's case illustrates how the combination of life supports (psychosocial supports, medication management, and case management) and processing self-stigma can have a positive impact on recovery.

Case Study #5: Steve

Steve is a 32-year-old man who has a diagnosis of borderline personality disorder. He has been in and out of treatment several times since he was an adult. While he was diagnosed in his early 20's, Steve still struggles to find a community of people to support him and understand his specific struggle with BPD. The majority of treatment programs he has attended for BPD have had female patients and his therapists have been female. He belongs to a few online recovery-focused groups through social media but he also notices that the majority of people who participate are women.

Steve has been struggling with the sense of isolation he feels because he is unable to find other men with whom he can connect with and feel normal around. This has resulted in Steve feeling depressed and shameful. He recently said something to his therapist that was concerning to her: "it's like nobody else is like me and I'd rather die than live this way." Steve has had multiple suicide attempts and hospitalizations. He has a crisis plan that he can follow as needed. He takes medication that helps reduce his depressive symptoms and he uses skills to manage his feelings of worthlessness, but Steve's symptoms have been steadily increasing.

Over the next few months, Steve's counselor works with him and his psychiatrist to adjust his medications to better address the increase in symptoms. They also do work around normalizing the experience of having BPD in men. His counselor directs him to a group of male providers and a male outpatient treatment program for him to become connected to. Eventually, Steve chooses to transition to the male therapists and attends a group one night per week for men with BPD.

Within a few months, Steve's sense of isolation and shame is reduced. He no longer feels as "crazy" or "different" as he once did. His depressive symptoms are under control and he is no longer feeling like he wants to die or disappear.

Steve's case is a good example of how the stigma around men having BPD or the lack of support and information for men compared to women with BPD can lead to poor outcomes. For Steve, this was isolation and depression, which can become very dangerous. It can lead to self-harm and suicide.

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