



# Untold problems

A review of the essential issues in the  
mental health of men and boys

David Wilkins  
*Men's Health Forum*

Commissioned by



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# Executive Summary

## Introduction

This review is about the mental health of men and boys. It considers mental health from a male perspective and explores how good mental health can be achieved and maintained. It also looks the kinds of mental health problems that men and boys experience and asks how services can most effectively respond. To our knowledge this is the first time that the relevant evidence has been brought together and considered in this way.

It is well known that men generally have poorer physical health than women, although the reasons why that should be so are not fully understood. It is however increasingly accepted that services need to change and adapt if men's physical health is to be improved. Mental health appears at first sight to be a different matter. Women are diagnosed with the most common mental health problems significantly more often than men. The wider indicators of poorer mental health suggest however, that the situation is more complex than it seems. Suicide, substance misuse, anti-social behaviour, "disappearing" from home, homelessness and a variety of behavioural problems are all markedly more common in males. Men are also more likely to exhibit personality disorders. It seems probable therefore that we may not be identifying and tackling mental health problems in men and boys as well as we might. This review uses three main headings to identify the most important issues and to organise the evidence:

- The "male role" in family and society
- Men's mental health and anti-social behaviour
- Specific groups and conditions

## The "male role" in family and society

There is no absolute consensus on the explanations for the cultural and societal differences in gender roles. Some scientists across a variety of disciplines believe that these differences are predominantly reflective of biological differences between the sexes that are rooted in evolutionary processes. Others believe that the most important explanations lie in unchallenged cultural norms, upbringing ("socialisation") and/or vested political interests in maintaining the status quo. In practice, most accept that all these factors are at play. The debate tends to be about the balance between them.

If we look at the evidence, it is clear that the "male role", often asserted to be one primarily of advantage, can be a double-edged sword. Men continue to earn more than women for example, and are more likely to occupy senior positions in the workplace. Work confers social status and where it is satisfying and manageable, work is an important factor in good mental health. This is perhaps especially the case for men. Where work is unsatisfying, unreliable, physically unpleasant and/or unreasonably demanding of time however, it can cause significant mental distress. This is a particular issue for men who are twice as likely to work full time, much more likely to work long hours and, in two-parent families, more likely to have the "breadwinner" role. A consistently unhappy work experience can also have negative consequences for men's families and hence for the prospects of good mental health for future generations. The centrality of work in the lives of many men means that the loss of cultural certainty associated with unemployment can be more damaging for men than women.

In recent decades boys have tended to do less well at school than girls – a reversal of the position earlier in the last century. The consequence is that there are now fewer young men than young women in further education. Some particular population groups, most notably white and Afro-Caribbean boys from poorer families, are doing particularly badly. Boys are also very significantly more likely to be identified as having either a special educational need (SEN) or a behavioural, emotional or social difficulty (BESD). 80% of pupils permanently excluded from school and 75% of those on fixed term exclusions are male.

By a variety of measures, men also appear to have a narrower range of active social and family relationships than women – and those relationships that they do have are, in general, less intimate. This has obvious consequences for the availability of emotional support and encouragement to seek help. Fatherhood, which can be crucial for the mental health of children – especially boys – is acknowledged to be poorly supported by many agencies, and is often undervalued.

## Men's mental health and anti-social behaviour

All forms of physical violence are greatly more common in men. Knife crime, which has been the subject of significant public and political concern in recent years is predominantly a male behaviour. Men and boys are also more likely to commit most types of non-violent crime and to indulge in low-level anti-social behaviour. With the exceptions of sexual violence and domestic violence, most victims of violence are male.

A greater likelihood of violent behaviour in men is associated with a number of social factors, including being from a lower socio-economic group and being single, separated or divorced. The propensity for violence in adulthood has also been connected in numerous studies with a dysfunctional upbringing and adverse childhood experiences – factors which are often also predisposing factors for poorer mental health.

Violent behaviour is not strongly associated with diagnosed mental illness per se but it is associated with personality disorders, and drug and alcohol misuse, which are both more common in men. Male alcohol problems in particular, may be under-considered. It is believed that up to 800,000 men may be alcohol dependent. Boys in their mid teens are almost twice as likely to drink as girls, with both sexes drinking twice as much as they were twenty years ago. In the minds of some men, drinking alcohol in quantity functions as a marker of masculine status.

94% of adults in prison are male. Prisoners have a much higher incidence of mental health problems than the population as a whole and are at a significantly increased risk of death by suicide. There is consensus that the criminal justice system is not equipped to deal as well as it could with men who have mental health problems. Despite the great majority of prisoners being male, it seems probable that the relationship between masculinity, crime and mental health has not been fully taken into account in the planning of services for prisoners.

## Specific groups and conditions

The higher rate of suicide in men – particularly young men – has been the most widely acknowledged of those mental health issues that have a particularly male aspect (indeed, it is arguably the only such issue that has been regarded in this way by policy-makers). There are promising indications that the suicide rate is falling as a result, although there is still some way to go. There are obvious links between suicide and depression and a

number of authorities have suggested that depression may be under-diagnosed in men. This is partly because men may not present themselves for advice or treatment but also because the symptomatology for depression may differ between men and women. It is suggested that the conventional diagnostic approach is more likely to identify depression in women than in men.

Admissions to psychiatric hospitals are more common in men from some black and minority ethnic (BME) groups. In the case of some particular population groups the admission rates are higher to a very significant degree – for example black men are up to three times more likely than the population average to be treated as in-patients. Black men are also very much more likely to be the subject of compulsory admission and to have been referred to mental health services via the criminal justice system.

Research suggests that gay men have higher rates of common mental disorders than the population as a whole, and are at greater risk of both attempted and completed suicide. Public attitudes are an important influencing factor in the mental health of gay men but interestingly, are also relevant for the mental health of heterosexual men. The expression of emotional vulnerability is often caricatured as being “gay” – which may be one of the factors that limit the capacity of some men to admit emotional distress and to seek help.

Post traumatic stress disorder in services and ex-services personnel has been of some public interest in recent years. For obvious reasons, this may be a particularly male issue and some of those affected have suggested publicly that support services are inadequate. For different reasons, it may also be that men receive inadequate treatment for chronic mental health problems arising from having been a victim of childhood sexual abuse. Men may be less willing to seek help for these conditions and it may be that public – and sometimes professional – perceptions of sexual abuse tend towards an assumption that the problem is one that only affects women. Services for eating disorders, which are increasingly common in young men, may suffer from the same kinds of problem.

## Discussion and conclusions

The review demonstrates that men often have mental health needs that are distinct from those of women and which are particularly associated with the lived experience of being male. Some of these needs are not being met as effectively as they might. This situation is compounded by the fact that in some circumstances some of the familiar cultural markers of masculinity are also potential symptoms of, or predisposing factors for, poor mental health. Many of these behaviours are so familiar that they seem indisputably “normal” even though it is easy to see that they are sometimes simultaneously damaging.

This poses significant problems. First, it is very difficult to separate out those men who may be struggling to cope from those who are not. Second – and this is the lesson from other areas of health – the expertise to plan and deliver services that men are willing to use may be lacking. Finally, it will be immensely challenging to engage men in a dialogue that encourages them to ask themselves whether they should be seeking help.

The review does not set out to make recommendations but it does identify a series of ideas and principles that should be taken into account when future actions are planned. These ideas



and principles are summarised below:

- A cross-cutting approach is crucial. Improving and maintaining the mental health of men is not just a function of mental health services.
- Simply being male could – and should – be seen as a primary risk factor for several specific mental health problems.
- Depression may be under-diagnosed in men.
- Many men who need help may not say so, and some may come to notice in ways that do not encourage a sympathetic response.
- It is important to find ways of improving boys' educational performance because poor educational outcomes militate against good mental health
- It is important to support and encourage fathers, especially those in the most adverse circumstances.
- Male-specific helpline services may have something to offer.
- Early intervention should be part of the solution. Encouraging boys to become more sensitive to their own emotional needs and the emotional needs of those around them will not solve all the problems but it has the potential to help considerably.
- Boys and men need to be allowed to explore a less narrow version of masculinity. This is not a magic wand but it has the potential to help.
- Poor working practices contribute to poor mental health.
- Many men in prison have had adverse childhood experiences and are suffering from psychological problems. Public safety must remain paramount but there is a strong case for more thoughtful assessment and treatment of some prisoners.
- Several specific forms psychological distress have particular importance for men and need to be considered from a male perspective.



# Preface

Reviews of mental health services and feedback from service users have indicated that mental health services do not always equitably meet the needs of women (DH, 2002). Evidence is becoming clearer that gender based inequalities also exist for men in certain aspects of service experience and outcomes.

The learning gained through better understanding of the mental health needs of women has proved extremely useful in improving the effectiveness of services. The policy and guidance documents on mainstreaming service responses to women's mental health have influenced the planning and development of service provision for women. The improvements that resulted were clearly necessary but in many cases the same attention to specific needs was not given to the provision of services for men. For example, women-only acute wards, in many cases, have been carefully planned and developed without sufficient consideration of the consequence, i.e. that men-only acute wards have emerged without planning.

The review that is reported in this document was commissioned from the Men's Health Forum by the National Mental Health Development Unit (NMH DU) in order to identify and better understand the mental health needs of men. It brings together most relevant evidence and explores the most important issues within the context of what is already known about male attitudes, behaviour and sensibilities.

This work will be used to inform the development of policy and practice so that service providers can respond more effectively to the needs of both male and female service users. In particular, this review will help the NMH DU Equalities Programme plan future work. This review has also been submitted to the New Horizons in Mental Health consultation on the future of mental health services in England.

## **Sue Waterhouse**

National Deputy Programme Lead  
Mental Health Equalities Programme  
National Mental Health Development Unit

# Foreword

This document doesn't make wild generalisations about "all men". It doesn't bleat about the need for equality and diversity beyond what is fair and just. Nor does it attempt to turn boys into girls. Rather, this is a report that proceeds by reason and evidence to argue that men as a sex face specific emotional and mental difficulties that society commonly misunderstands.

The facts are stark. Being male increases your chances of drug and alcohol dependency, school failure, suicide and involvement in crime. Almost three quarters of people who kill themselves are men. Most adults who go missing are men. Most prisoners are men. Most men in prison suffer from at least one mental disorder. Most of the people detained in secure mental institutions are men. Three quarters of rough sleepers are men. Men are responsible for 87% of crimes of violence. Nearly all children permanently excluded from school are male. And boys are performing less well than girls at almost every single level of education.

Some of these problems result from what I described in my 1984 BBC book, *Men, an investigation into the emotional male*, as the "fall of the male chauvinist empire". It has indeed been difficult for 21st century men to adapt to a world where their natural anxieties are no longer masked by the universal subservience of women. Nor have they adjusted well to an economy that ignores brute strength in favour of brains and the utility of emotional intelligence.

As the report concludes, we must urgently look beyond masculine stereotypes to understand the mental health needs of contemporary males. To take just one example, consider the notion of 'depression and self-harm'. Such an image probably conjures up the picture of a teenage girl cutting her arms or suffering from an eating disorder. But if I reflect on 'self-harm' in a different context, I can soon call to mind male public figures who have wound up in prison, lost jobs due to drink problems or forfeited the public's respect as a consequence of risky sexual behaviour. In my opinion these kinds of behaviours often qualify as explicitly 'self-harming' activity.

Most of these formerly respected figures might deny they'd had a mental health problem. All of them have been able to function – with some help – in their respective roles. Yet all have come to grief for reasons which we might conclude are depressive if not depressing. The plausible bottom line is that whereas women tend to confess to feelings of depression, and hence are labelled the "more depressed sex", men routinely deny their problems so you can mainly detect men's symptoms from their self-harming acts, not their testimony.

I believe that the balance of the national depression statistics would be very much altered if we took note of men's greater problems with alcohol, drug dependency, overstress, workaholism and road rage. Otherwise, it surely remains difficult to explain why men are half as likely as women to be diagnosed with depression yet three times more likely to kill themselves because of it.

## Phillip Hodson

Phillip Hodson FRSA

Chief Spokesperson, British Association for Counselling and Psychotherapy

Phillip Hodson is a Fellow of the British Association for Counselling and Psychotherapy [www.bacp.co.uk] and for ten years has been its Chief Spokesperson. He has worked as a psychotherapist and sex and relationship therapist for nearly 30 years specialising in the problems of men and couples. He introduced radio counselling to Britain on LBC radio who then asked him to work seven days a week. He declined. His original book on the problems of men and emotions was almost the first to appear on the subject - and consequently had to be placed in the "Women's" section in Waterstone's.

## Definition of a male health issue

The following definition was used to identify the aspects of male mental health addressed in this review.

**A male health issue is one that fulfils either of the following conditions:**

*It arises from physiological, psychological, social, cultural or environmental factors that have a specific impact on boys or men.*

*It necessitates male-specific actions to achieve improvements in health or well-being at either individual or population level.<sup>1</sup>*

# Introduction

This paper is about the mental health of men and boys. It considers good mental health from a male point of view and explores how that can be achieved and maintained. It also looks the kinds of mental health problems that men and boys experience and asks how services can most effectively respond. It brings together a wide range of the most helpful evidence and concentrates in particular on the relevance of cultural perceptions of masculinity.

The evidence in relation to male mental health has never been reviewed in this way before. Where there has been work that considers the particular needs of men, it has tended to be in relation to physical health. A good starting point therefore is to look very briefly at what can be learned from that evidence base.

On average, men live five years fewer than women. Men are also proportionately more likely at all ages to suffer from almost all the major forms of disease and injury. Most authorities agree that biological differences between men and women account only partially for these gender gaps in health outcome. The most plausible explanation lies in a combination of men's unhealthier lifestyles and their less effective use of health services. Men smoke and drink more than women for example, they also eat a less healthy diet and take more physical risks. Men are less likely to be influenced by health improvement campaigns than women, are known to make less effective use of many health services, and may be more likely to delay seeking help until later in the development of symptoms.

Trying to redress imbalances in health outcome between men and women is undeniably challenging. Clearly it cannot just be assumed all men behave in one way and all women in another. It would be absurd to take such a simplistic view. At the same time (as has long been understood in the commercial world) there are broad but clearly observable differences between men and women in the way they engage with the world. There is increasing recognition that the effectiveness of health services could be improved if greater account was taken of these differences.

There have been some promising developments in relation to male health need in very recent years. Historically however, "gender sensitive services" (to use a shorthand term) have largely been developed to take account of the particular needs of women. This has probably been because the experience in other fields of public provision has been that it is women who have more usually been at a disadvantage. There have also been effective grass roots campaigns by women's organisations calling for better services. This has particularly been the case in relation to maternity services and the female-specific cancers. It has also been so in relation to some aspects of mental health – indeed, it was mental health services that were the subject of the UK's first national gender-specific health policy guidance, *Mainstreaming Gender and Women's Mental Health*, published in 2003.<sup>2</sup>

It is not surprising that it was in the field of mental health that this first policy guidance appeared. The relevance of gender to mental health is crystal clear. Our gender is perhaps the most basic characteristic of our sense of self. It also governs many of society's expectations of us, colours the way we are seen by other people, and helps determine the range of behaviours that are perceived as "normal". Our gender is furthermore a significant factor in many of our formative experiences and a defining element in most of our most important relationships.

For many men, as we shall see, there are often significant tensions between conventional masculine behaviour and the idea of nurturing good mental health. Admitting the need for support with emotional and psychological problems may be a particular challenge for some and may account for some of the more destructive behaviours seen more commonly in men which we will explore in due course.

We will argue that there is a good case for developing services that take account of men's needs "as men". That it is right to do this was noted in the introduction to *Mainstreaming Gender and Women's Mental Health*:

*The underlying theme is that gender differences in women **and men** need to be equally recognised and addressed across policy development, research, planning, commissioning, service organisation and delivery. [present author's emphasis]*

This review aims to provide the information base for achieving this objective. The following section explains why this is important, outlines the background to the review and describes the context in which the information is presented.

## Context for the review

Although generalised ideas of psychotic illness such as schizophrenia and bipolar disorder are known to be an important influence on public perceptions of mental ill health, psychotic illness is in fact, relatively uncommon. Prevalence is believed to be around 0.4% in the population as a whole and is roughly equally distributed between men and women<sup>3</sup> (although the onset of some particular forms of psychosis seems to occur earlier in the lifespan in men).<sup>4,5</sup>

It is the group of conditions collectively known as the “common mental disorders” that comprise the great bulk of disabling mental ill health in the community. Common mental disorders are mostly made up of the various types of depression and anxiety but also include phobia, obsessive compulsive disorder and panic disorder. These conditions affect very large numbers of people and – in a reversal of the pattern seen typically in physical ill health – are more commonly diagnosed in women. The most recent figures suggest that, at any one time, one in five women (19.7%) compared to one in eight men (12.5%)<sup>6</sup> is diagnosed with a common mental disorder.

The key word here is “diagnosed”. Diagnosis requires that the disorder has been seen and recorded by a health professional. As we shall see, it seems at least possible that mental health problems in men are, for a variety of reasons, less likely to come to the attention of those agencies where an appropriate diagnosis could be made.

The rest of this review does not routinely compare men with women but it is useful to consider the two sexes together at the outset in order to set the scene. As we have just seen, the data suggest that common mental disorders are a more pressing issue for women. Certainly there is no dispute that the development of specific policy guidance for women’s mental health is entirely justified. At the same time, common mental disorders are undoubtedly a significant problem for men too. One man in eight is roughly the same, for example, as the proportion of men diagnosed with cardiovascular disease, a major cause of premature death in men.<sup>7</sup> An examination of the bigger picture suggests furthermore, that matters in relation to men are rather more complicated than they seem at first sight. For example:

- Almost three quarters of people who kill themselves are men.<sup>8</sup>
- 73% of adults who “go missing” are men.<sup>9</sup>
- 90% of rough sleepers are men.<sup>10</sup>
- Men are three times more likely than women to become alcohol dependent (6% of men are alcohol dependent compared to 2% of women).<sup>11</sup>
- Men are more than twice as likely to use Class A drugs (4.8% compared to 2% of women)<sup>12</sup> and 79% of drug-related deaths occur in men.<sup>13</sup>
- Men make up 94% of the prison population.<sup>14</sup> 72% of male prisoners suffer from two or more mental disorders.<sup>15</sup>
- More than twice as many male psychiatric inpatients are detained and treated compulsorily.<sup>16</sup>

- Men have measurably lower access to the social support of friends, relatives and community.<sup>17, 18</sup>
- Men commit 87% of violent crime (and are twice as likely to be victims of violent crime).<sup>19</sup>
- Over 80% of children permanently excluded from school are boys.<sup>20</sup>
- Boys are performing less well than girls at all levels of education. For example in 2008 only 60.9 per cent of boys achieved 5 or more grade A\*-C GCSEs compared to 69.9 per cent of girls.<sup>21</sup>

These statistics suggest that male emotional and psychological distress may sometimes emerge in ways that do not fit comfortably within conventional approaches to diagnosis. It can also be seen that men may be more likely to lack some of the known precursors of good mental health, such as a positive engagement with education or the emotional support of friends and family. A sketchy picture begins to emerge of a potentially sizeable group of men who cope less well than they might. These men may fail to recognise or act on warning signs, and may be unable or unwilling to seek help from support services. At the further end of the spectrum they may rely on unwise, unsustainable self-management strategies that are damaging not only to themselves but also to those around them. Such a picture would broadly parallel what is already known about men's poorer physical health.

It should also be added at this point, that men are believed to be more likely to suffer from personality disorders (5.4% of men compared to 3.4% of women).<sup>22</sup> Personality disorders are personality characteristics which "cause regular and long term problems in the way [people] cope with life, interact with other people and the way in which they can respond emotionally."<sup>123</sup> People with personality disorders are more likely than the general population to come into contact with mental health services<sup>24</sup> and are known to be at increased risk of substance misuse, anti-social behaviour and suicide.<sup>25, 26</sup> At the same time, it is believed that many people with personality disorders will never seek or need treatment. Although personality disorders are not generally considered a form of mental illness in themselves, they can be highly disabling.

There is a good case then, to consider the inter-relationship between men, masculinity and mental health, particularly within the context of men's social functioning. This does not mean this review will be attempting to pathologise a group of common behaviours that may or may not form part of a "typical male spectrum". We simply propose that there are potentially some significant benefits in bringing the evidence together in one place and looking at it with an open mind. It seems likely that if men's needs were better understood, then services could be developed that would be more effective and better value for investment.

If we turn briefly again to the field of men's physical health we can see precedents for doing this. Two national policy documents in recent years, the *Cancer Reform Strategy*<sup>27</sup> and *Choosing health through pharmacy*<sup>28</sup> have noted the need to take account of men's poorer use of services and the connection with poorer outcomes. The benefits of concerted action can however most clearly be seen in the National Chlamydia Screening Programme (NCSP). Although chlamydia is known to be equally prevalent in both men and women, uptake of screening by men was very low in the early years of the programme. The NCSP has developed a strategy<sup>29</sup> for engaging men in the programme and is soon to publish a detailed action plan.<sup>30</sup> The consequence has been an increase in male participation in initial screening from only 17% in 2004 – 2005 to 28% in 2007 – 2008.



As we have seen, the field of mental health led the way in the UK in acknowledging the importance of gender as a determinant of health status, with the publication of *Mainstreaming Gender and Women's Mental Health*. Unfortunately, that pioneering document has not led to a routine consideration of gender issues in policy development and service planning – with consideration of male issues particularly lacking. It is probably true to say for example, that current national mental health programmes such as *Improving Access to Psychological Therapies*<sup>31</sup> and the anti-stigma campaign *Time To Change*<sup>32</sup> have not, so far, considered gender issues in any detail. This review is therefore addressing a genuine need for information.

There is now also a legislative imperative in the UK for developing an evidence base that can inform future planning. The Gender Equality Duty, a provision of the Equality Act 2006 requires public service providers to eliminate unlawful sexual discrimination and promote equality of opportunity between the sexes.<sup>33</sup> This means that service providers must actively seek to understand whether and why gender inequalities exist, and must provide services that take account of the different needs of men and women.

The primary function of this review then, is to identify and explore the most important issues in male mental health in order to help develop more effective provision. We have done this by collecting relevant evidence from a wide variety of sources and by asking what that evidence tells us about the particular needs of men and boys. We also explore what has been learned from those few instances where male-specific programmes have been implemented. Limitations of space have meant that we have had to generalise in places but we have tried throughout to recognise the obvious – that “men” are not a homogenous mass but are a diverse group whose identity is also a function of (among other things) their social class, their race, their sexuality and their life experiences.

Limited resources also mean that the review cannot claim to be exhaustive. We have however aimed to make sure that the scope is wide even where the detail has necessarily been constrained. We are confident of having identified most of the most important issues. We hope particularly to have done enough to encourage professional and public debate on this issue, which surely has been in the shadows for too long. Ultimately the question needs to be asked whether there is a need for a national men's mental health strategy and we attempt to move towards a conclusion on that point.

# 1. The “male role” in family and society

## Socialisation and gender roles

It is of course, possible to argue that there is – or should be – no such thing as a male or female role. Nevertheless, and although there might be debate about what defines “a man” or “a woman” in any particular culture, there is no doubt that virtually all cultures do have broadly different expectations of the sexes. These expectations change and shift over time, and vary from individual to individual but it is not possible to explore the relationship between gender and mental health without acknowledging that such expectations exist.

It is often said that “traditional” gender roles are created by socialisation. This explanation holds that families, peer groups, and many public and commercial institutions treat male and female children differently, with the result that boys and girls develop different attitudes and behaviours. This is said to perpetuate particular social constructions of masculinity and femininity, which remain locked into our culture.

Ideas of socialisation are a particularly important factor in relation to the debate about men’s mental health because of the widely held perception that some of the damaging tendencies seen more commonly in men have their roots in the way boys are raised. These tendencies include a relative lack of emotional expressiveness, the propensity to “act out” emotional distress, and a reduced willingness to admit vulnerability and seek help. All of these propositions are examined in more detail later in this review.

Academic opinion about socialisation is equivocal. It suggests that while socialisation is unquestionably a real and influential phenomenon in emotional development, gender differences in mental health depend on a combination of factors that also include biology, personality type and the prevailing culture.<sup>34,35</sup> Mental health is also known to be influenced by social context – that is to say, it may depend both on the circumstances in which people find themselves at the time and the life experiences that they have had.<sup>36</sup> This social context may vary between men and women.

Biological factors are considered by some to be particularly important. Many neuroscientists believe the evidence points to basic structural differences between the male and female brain, acting in conjunction with hormonal differences between men and women. It is suggested that these physical differences make it likely that men and women will tend to group around different psychological attributes (albeit along a broad spectrum that covers both sexes). The resulting behavioural differences are said to be observable from the very first days of life. Baron-Cohen, for example, argues that the difference lies in the “empathising” nature of the female brain and the “systematising” characteristics of the male brain.<sup>37</sup>

Both socio-biology (the study of the biological and genetic basis for social behaviour in animals and humans) and evolutionary psychology (the study of the psychological adaptations of humans to the changing physical and social environment) argue that these kinds of differences are rooted in processes of adaptation and natural selection.<sup>37</sup> In very simplest terms, these disciplines suggest that men and women have developed different behaviour patterns because the behaviours that conferred evolutionary advantage differed between the sexes.

These biological theories of gender difference suggest that men and women may be predisposed to experience different forms of emotional distress and to exhibit different coping strategies. Even so, these theories also allow that life experiences are an important mediator of men's and women's tendencies to act in one way or the other. As Kilmartin, among others, has pointed out, "It has become scientifically indefensible to claim that either biological or social forces are solely responsible for gender behaviour."<sup>39</sup>

On the whole then, the evidence does not support the assumption that socialisation alone is responsible for creating behaviours that might be seen to be crucial to a discussion of men's mental health. At the same time – as we have just seen – biological theories do encompass the idea that the way boys are raised is likely to contribute to the way they experience and cope with emotional distress as adults. It is probably beyond dispute that boys in our culture are often encouraged both to minimise the expression of hurt ("big boys don't cry") and allowed greater leeway in the expression of externalised emotions like physical aggression and anger.<sup>40</sup> These two aspects of male behaviour in particular do recur in different guises in different contexts throughout this review.

## Fathers; and fathers and sons

A very important issue in considering what kinds of upbringing are more conducive to good mental health in men and boys, is the role of fathers – particularly in relation to the upbringing of sons. Families often report that a father's involvement is particularly important for the well-being of boys but in practice little of the evidence in relation to fatherhood looks at the effect on sons and daughters separately.<sup>41</sup>

It is however possible tentatively to extrapolate the potential benefits for boys of a loving and engaged father. Adolescents who have a strong paternal bond are less likely to become involved in petty crime for example.<sup>42</sup> This may be particularly important for sons since most juvenile offenders are male (see section on anti-social behaviour below). Likewise, children who have supportive fathers are more likely to do well in school.<sup>43</sup> This may again be particularly important for sons since boys tend generally do less well in school than girls (see section on boys and school below).

According to research in the USA, in families where fathers have greater involvement with their children, those children tend to display less gender-stereotypical behaviour.<sup>44</sup> As we have seen, greater flexibility in the range of allowable behaviours may have particular benefits for boys. An important survey by the Samaritans in 1999 found that young men who lived apart from their fathers were more likely to show suicidal tendencies in adolescence. Similarly, young men who had symptoms of depression were more likely to report that their fathers did not show an interest in their schoolwork and were less likely to try and talk to them about their worries.<sup>45</sup>

Depression, anxiety and alcoholism in fathers are all associated with an increased risk of behavioural and emotional disorders in their children, particularly during adolescence. There is some evidence that mental ill health in fathers – especially alcoholism – contributes particularly to behavioural disorders in sons.<sup>46</sup> This greater effect of paternal mental illness on sons adds theoretical weight to the idea that fathers are of particular importance in the development of good mental health for boys.

Fathers do not always live with their children of course. One child in four is brought up in a lone parent household, and nine out of ten of such households are headed by the mother.<sup>47</sup>

The break up of the family does not of itself, necessarily prevent fathers from playing a positive and supportive role. Many separated fathers maintain a strong commitment to the welfare of their children and where that happens, the children tend to be more settled and better adjusted.<sup>48</sup> In light of the benefits for mental well-being of boys however, it is potentially a cause for concern that the Millennium Cohort Study suggests as many as four in ten children being brought up by their mothers have no contact at all with their fathers.<sup>49</sup>

In their recent report calling for greater resources for early intervention, Graham Allen MP and Iain Duncan-Smith MP highlight the evidence for the “strength of the correlations between family breakdown and crime, educational failure, economic dependency, debt and addiction and the systemic nature of these social problems where cause and effect interact.” Whilst acknowledging that “it is not totally guaranteed, and protective factors might arise to alter it” they also point out that children who will grow up to be dysfunctional adults can often be identified while they are still toddlers. They go on to suggest that an absence of father involvement is an important contributing factor to these cycles of social problems.<sup>50</sup>

One important proviso that should be inserted here however is that research suggests that where a father exhibits anti-social behaviour, his presence may result in worse behavioural outcomes for his children than his absence.<sup>51</sup>

There is evidence that one under-recognised form of depression in fathers – post-natal depression – also has a damaging effect on sons. A large scale study of fathers who suffered depression in the post-natal period found a clear association with adverse emotional outcomes in children of both sexes at age three and a half, and a “striking” association with behavioural problems specifically in sons (an outcome that has not been consistently observed in studies of postnatal depression in mothers).<sup>52</sup> Post-natal depression in men may in fact be an issue to which not enough attention has been paid. A review in 2003 found few studies and consequently arrived at a very wide variation in reported rates (1% – 26% of all new fathers).<sup>53</sup> Ramchandani in the study cited earlier found an incidence rate of 4% for depression in new fathers, compared to 10% for new mothers.<sup>54</sup>

The proportionate difference in the figures explains why more attention has been paid to post-natal depression in mothers but does not justify an absence of support for men – especially, as we have seen, given the relationship between the mental health of the father and the mental health of his children. It could be argued indeed, that the needs of fathers are inadequately recognised in peri- and post-natal services altogether, and that this constrains service provision for men from the outset. There is good evidence that supporting fathers to take an active role during this period in particular has a range of short and long term psychological benefits for the new baby, the mother and the father himself.<sup>55</sup>

## The benefits of family life for men

As loving fathers are a benefit to children, so loving families are a benefit to men. Evidence from many countries has demonstrated strongly and consistently that a stable, long term relationship is among the most important predisposing factors for good mental health for both men and women, but of more marked benefit for men.<sup>56</sup> This effect applies to marriage more so than cohabitation but both states significantly out-perform the various alternatives.<sup>57</sup>

As one might expect, the converse of this is also true – divorce and separation are common causes of unhappiness and emotional distress.<sup>58</sup> This latter is believed to be somewhat more true for women than men – although a massive unmet need for emotional support for men who have experienced the break up of a family relationship has been demonstrated by

MensLine Australia. This nationwide service – the first of its kind in the world – uses a specifically “male-centred” approach. Its success – it takes over 60,000 calls each year – has suggested that at least some men will seek help during crisis periods, provided that the help is delivered in a way that meets their needs.<sup>59</sup> Data from MensLine callers also bears out the connections between relationship breakdown and poorer mental health; men who are separated from their children are twice as likely as fathers who live with their children to report a serious mental health concern and five times more likely to have attempted suicide.<sup>60</sup>

## Boys and school

We have already seen that boys do less well than girls in school. In 1988 girls overtook boys in passes at GCSE level and gradually in the late 1990s overtook boys in “A” level passes (although boys are still doing relatively well at “A” level in science and maths). Historically, young men had been more likely than young women to go on to higher education (HE) but by 1992, the numbers had equalised. Currently around 32% of young women are in HE at age 19 compared to 25% of young men (figures for those educated at state schools).<sup>61</sup>

These differences between boys and girls undoubtedly represent progress for girls and women that is very much to be welcomed, especially in the context of the long-standing historical imbalance in favour of boys’ education. Ironically in the present context however, the fact that girls now outperform boys in school has been officially cited as representing progress towards “equality between the sexes”.<sup>62</sup>

The specific groups currently doing least well are young white men from poor backgrounds (30% below average attainment at GCSE) and young black men of Caribbean origin from poor backgrounds (33% below).<sup>63</sup> Not surprisingly, these two groups are also the least likely to be represented in HE. In the case of black Caribbean boys, low achievement in school exceeds that which could be accounted for by the economic deprivation experienced by those pupils (measured by eligibility for free school meals).<sup>64</sup>

Boys make up 70% of those identified as having a special educational need (SEN) with 12% of boys overall falling into this category (compared to 5% of girls). Of pupils with an SEN, boys are 9 times more likely to be diagnosed as having autistic spectrum disorder, 2.7 times more likely to have a specific learning difficulty and 2.5 times more likely to have a speech, language or communication problem. Boys are also 4 times more likely to be diagnosed as having a behavioural, emotional or social difficulty (BESD). Boys from black Caribbean and other black backgrounds in particular are more likely to have a BESD.<sup>65</sup>

Boys are also 3 times more likely to be diagnosed with attention deficit hyperactivity disorder (ADHD) and between 6 and 9 times more likely to be referred to child mental health clinics with the condition (probably because they are more likely to present with aggression which is difficult to manage in school).<sup>66</sup> The report of the Government Office for Science’s Foresight Report into the future mental well-being of the British population noted that diagnosed mental disorder in school age children (ages 5 – 15) is markedly more common in boys (11.4% of boys against 7.5% of girls).<sup>67</sup>

As we saw in the introduction, over 80% of excluded pupils are boys, as are 75% of those on fixed period exclusion. The most common reasons for permanent exclusion are “persistent disruptive behaviour” and physical assault of adults or other pupils. Black boys are twice as likely as white boys to be excluded (as a proportion of their own population group) and white boys are twice as likely to be excluded as Asian boys. It should be added however, that permanent exclusions are proportionately relatively uncommon – only 0.21% of white boys were permanently excluded in 2007 for example. There are around 7,000 permanent exclusions of boys per annum and around 275,000 fixed term exclusions.<sup>68</sup>

There are a variety of potential explanations for the greater range and number of problems presented by boys in school. There is no space here to explore them in detail but it is believed that girls find it easier to achieve in school settings; are more likely to enjoy school; place a greater value on homework and the presentation of their work; and care more about the opinion of their teachers.<sup>69</sup> It has been argued that “boys feel compelled to conform to a dominant view of masculinity which conceptualises academic work as ‘feminine’”<sup>70</sup> and that “anti-school subcultures” exist among boys from the most marginalised backgrounds in which “specific forms of masculinity” are “manifested, in particular, by disruptive behaviour in class”.<sup>71</sup>

The difficulty that some boys are having in engaging at school is important because of the potential connection with boys’ ability to engage with wider society as they grow into men. There is also a modest but clear correlation between educational achievement and good mental health in adult life – a correlation may partly be explained by higher educational achievement increasing the chances of obtaining a more satisfying job.<sup>72</sup> The Foresight Report demonstrates the complexity and importance of the relationship between poorer academic performance and the greater likelihood of emotional dysfunction when it observes that the consequences of untreated mental illness in children include:

*... low academic achievement, subsequent psychiatric problems in adult life which may impair relationships and productivity in the workplace, an increased likelihood of unwanted pregnancy and impaired parenting skills, unhealthy lifestyles, and crime...*<sup>73</sup>

Overall, it seems at least probable that educational provision as it is currently structured is not contributing as well as it might to the development of good mental health in boys and men – particularly perhaps, for boys and men from more marginalised population sub-groups.

Finally, for obvious reasons being a victim of bullying at school is strongly associated with potential damage to mental health. By and large, victims of bullying are evenly distributed between the sexes, as are perpetrators of bullying.<sup>74</sup> Boys are however more likely to be subject to physical bullying (24% of boys compared to 12% of girls have experienced violence from others for example). Girls are more likely to experience psychological bullying (19% of girls report having been excluded from friendship groups compared to 5% of boys).<sup>75</sup>

One group of boys is particularly vulnerable to bullying; half of all gay men report having experienced homophobic attitudes in school – from staff as well as fellow students – and almost half (45%) were victims of bullying directly related to their sexuality. In all, 65% report experiencing problems of one kind or another at school in association with their sexuality – problems which show a direct correlation with poorer mental health.<sup>76</sup>

## Men and work

As is widely known, despite the major social changes of the past few decades in relation to gender roles, and despite a range of employment equality legislation, men continue to earn more than women (18% – 40% more on average) and are more often represented at higher levels in management structures.<sup>77</sup> The perhaps inevitable corollary of this is that men remain very much more likely than women to work full time; during the last quarter of 2008 for example, 13.9 million men were in full time work compared to 7.8 million women.<sup>78</sup> This suggests that in the majority of traditional family situations (70% of children are brought up by a male/female couple) the man may remain the primary breadwinner, even where the woman’s income is equally important to the household budget. By extension, this necessitates for many men a predominant commitment to work.



The statistics relating to comparative income and employment status are often, quite rightly, cited as evidence of the continued disadvantage experienced in the workplace by women. It is however, possible simultaneously to understand them as directly bearing on the mental health of men. Work and “providing” are, on several familiar levels, an established cultural delineator of masculinity and the “male role”. For many men, this means that work confers significant benefits in terms of emotional satisfaction, personal status, self esteem and income. But that does not necessarily mean that work predisposes all men to good mental health. Work and our cultural perception of who should be doing it, can also be a trap.

There are various reasons for this. First of all, the very centrality of work in men’s lives has the effect for many, of making their mental health a function of their experience at work. For some this is a very good thing. An important meta analysis of the relationship between job satisfaction and mental health has established that job satisfaction is significantly correlated with positive mental health.<sup>79</sup> The same study suggests however, that the failure of a job to provide satisfaction may predispose the individual to anxiety and depression.

Moreover, even the most satisfying job can become burdensome if the demands exceed the worker’s capacity to cope. The association between stress at work and loss of mental well-being is an obvious one, to the extent that “work-related stress” is itself a commonly accepted mental ill health diagnosis. Estimates vary but it is accepted that around half a million people may be suffering from psychological problems associated with their work at any one time. A major study commissioned by the Health and Safety Executive in 2004 suggested that men were significantly more likely than women to experience most of the factors associated with predisposing workers to work-related stress, such as lower levels of support from peers and manager; higher levels of demand; and lack of understanding of their role.<sup>80</sup> Work-related stress is also comprehensively associated with numerous chronic physical health problems, doubling the risk in men, for example, of heart disease and diabetes.<sup>81</sup> This may be especially true when work-related stress combines with relationship problems.<sup>82</sup> Chronic ill health is, in turn, itself associated with poorer mental health. American research has also suggested that men are more likely than women to rely on less constructive means of coping with work-related stress:

*Men in particular reported a greater use of maladaptive coping behaviors in response to work-related stress in the form of excessive drinking, excessive consumption of a range of foodstuffs and/or cigarettes, and avoidance or denial of stressful work situations.<sup>83</sup>*

It should be further noted that men in the UK work the longest hours in Europe. The most recent figures suggest that 27% of men with full-time jobs in the UK work more than 45 hours a week (compared to 9.7% of women).<sup>84</sup> 11% of men are believed to work more than 60 hours a week.<sup>85</sup> These hours are not always paid. The TUC estimates that 5 million people work over seven hours unpaid overtime every week. Because so many more men work full time, the majority of these people are likely to be men. In the NHS alone for example, 53% of staff report working regular unpaid overtime (unsurprisingly, 33% of NHS staff report having suffered from work-related stress in the preceding 12 months).<sup>86</sup> Unpaid overtime is often worked unwillingly. Studies conducted by the TUC suggest that almost half the UK workforce would like to work fewer hours, with 10% willing to accept a reduction in pay to do so.<sup>87</sup>

Apart from the obvious link with reduced job satisfaction and work-related stress, long working hours also militate against relationships between fathers and their children, which (as we have seen) are extremely important for the mental health of future generations of men. In this context it is interesting to note that fathers implementing their right to request flexible working patterns under the 2002 Employment Act are more likely than mothers to have their requests turned down by their employer (14% against 10%) and more likely to have their



cases fail on appeal to an Employment Tribunal (only 27% of cases are brought by men but men account for 45% of cases that fail).<sup>88</sup> This suggests at least the possibility that an institutionalised traditional view of gender roles may be causing discrimination against men.

The reverse of long working hours – unemployment – is also a well known predisposing factor for potential mental ill health. The Health Development Agency's review of the evidence concluded that:

*... there is a strong association between unemployment and psychological and psychiatric morbidity.... Upon re-employment, there appears to be a reversal of these effects.*<sup>89</sup>

The strong connection between work and masculine status that has already been described, also means that the loss of employment affects men's sense of well-being more damagingly than it does that of women.<sup>90,91</sup> The same is true of continuing job insecurity.<sup>92</sup> It is believed that as many as one in seven men may develop depression within 6 months of being made redundant.<sup>93</sup> The reduction in income consequent upon unemployment increases the risk of debt which in turn is associated with an increased likelihood of experiencing poorer mental health. Although cause and effect are difficult to separate, it is known that people with mental health problems are three times more likely to be in problematic debt.<sup>94</sup>

This is a particularly pressing problem at the moment because of the high rate of redundancies caused by the present recession – even more so because proportionately more men are losing their jobs. During the first quarter of 2009, 183,000 men were made redundant compared to 103,000 women. The employment rate for men during this period was 1.7 percentage points lower than that during first quarter of 2008; the comparative rate change for women was 0.8 percentage points.<sup>95</sup>

## Community engagement and supportive relationships

The phrase "social capital" is often employed to encapsulate the extent to which any given society demonstrates the capacity for social "connectedness" among its citizens, and engagement between its citizens and civic processes.<sup>96</sup> It is broadly accepted that the greater the level of social capital in society, the lower the likelihood of social dysfunction and the greater the likelihood of better physical and mental health for its citizens. Although much of the early research underpinning the theory of social capital was undertaken in the US and Italy, the ideas are widely accepted to be relevant for most countries in the developed world.

There has been a great deal of interest in recent years in understanding social capital in the UK context – indeed, the tenth *Health Survey for England* in 2000 made an examination of social capital one of its central objectives. An analysis of that survey's findings concluded that for two of the seven measures of social capital that it investigated – "perceived social support" and levels of trust in other people – there was a significant correlation with both "self-assessed health" and objective measures of mental health.<sup>97</sup> In other words, the lower the level of social support and/or the lower the level of trust in other people, the greater the likelihood that the subject will report feeling in poor health and/or will experience poor mental health.

This relationship between measures of social capital and health held equally true for both men and women. It is notable however that, while men and women tended to score equally on five of the seven measures of social capital, men were markedly more likely to score lower than women on the other two – "contact with family" and "levels of social support".

"Social support" in this context was indicated by the level of physical and emotional engagement between the survey respondent and his or her family and friends, measured

using an established scale. 67% of women reported that they felt fully supported and encouraged in this way, against only 55% of men. At the other end of the scale, 17% of men reported a severe lack of social support, compared to 11% of women. This is a particularly important finding because – as explained above – lack of social support was one of the clear correlates of risk for poorer mental health.

This rather dispiriting situation in regard to men’s “ownership” of social capital is borne out by other research. A study commissioned by the Health Development Agency and based on an analysis of different data (the British Household Panel Survey) also concluded that there are significant connections between some measures of social capital and mental and physical health. This study noted that while men appeared more likely to be active in community organisations, they are, by comparison with women:

*... more likely to have low contact with friends, low neighbourhood attachment and low social support.*<sup>98</sup>

A third study concluded:

*... it seems that women have more social capital than men in all key dimensions.*<sup>99</sup>

Why men appear to have lower levels of social capital, has not been specifically explored and it seems probable that the reasons are complex and multi-factorial. To take one example, it may be that the reasons vary by social class.<sup>100</sup> Levels of social capital are also known to vary significantly at whole population level by ethnic group.<sup>101</sup> There is no space here to explore the matter of men’s poorer social connectedness in detail but earlier research has typically suggested the broad “catch-all” possibility that men tend to exhibit a lower capacity for intimacy in relationships than women. This idea, summarised below, maintains widespread acceptance among academics – and indeed, the general public:

*Disclosure and “really knowing” each other is more characteristic of women’s friendships, while doing things together is more characteristic of men’s friendships.*<sup>102</sup>

In 2000 an American study tried to narrow down the potential explanations for this perceived lack of intimacy between men, taking into account that both women and men report valuing and desiring intimacy in friendships.<sup>103</sup> Using established scales, the study found men much less likely than women to report intimate best friendships (23.5% of female friendships scored very highly on the scale, compared to only 7.5% of male friendships). Two possibilities from a range of six appeared to have measurable explanatory value in understanding the lack of intimacy in male friendships; emotional restraint in individual men and fear of being perceived as gay. The study nevertheless – and perhaps inevitably – leaves unanswered questions about the origins of these two behaviour patterns in men.

Interestingly, a study by the Mental Health Foundation in 2006 which explored the idea that, for many people, the use of alcohol may function as “self medication” for “low-lying mental health or mood problems”, found men markedly more likely than women to use alcohol in order to be able to “fit in socially”.<sup>104</sup> This potentially suggests that – whatever the reason – men do find membership of a social community more difficult to achieve than women.

This issue of closeness in friendships is not a peripheral one. It is important because of the potential role of emotionally engaged friends in providing support at times of crisis and in encouraging help-seeking behaviour. Mind’s survey of over 2000 people in 2009 for its campaign week on male mental health<sup>105</sup> found that only 29% of men compared to 53% of women would talk to friends about their feelings if they were unhappy. Men were also less likely to talk to family members (31% of men compared to 47% of women). More than half of men on the other hand (52%) would talk to their partner. This is consistent with other findings,

highlighted earlier, that men in stable long term relationships tend to enjoy better mental health than their single counterparts; Mind points out however, that men aged under 45 are three times as likely as women to live alone, so this kind of support is not available to every man – even if he were willing to seek it.

Because there is an established correlation between loneliness in older age and the likelihood of suffering depression, social support is a particularly important for the mental health of older men. Studies have consistently shown older men living alone to be more likely than women to report loneliness, with older men who have never had a partner being particularly likely to do so. Women are known to be more likely to have several emotionally supportive friends, and to maintain more family and friendship contacts into older age than men. As we have just seen, a man is more likely to rely to a greater extent on his “closest person” or “primary attachment” (often his partner).<sup>106, 107, 108</sup> This may make a man more vulnerable to isolation if he becomes widowed.

## 2. Men's mental health and anti-social behaviour

### Male violence

Violent behaviour of all kinds is very much more common in men. Analysis of the data from the Office for National Statistics' (ONS) national survey of over 8,000 adults, *Psychiatric morbidity among adults living in private households*, found that among the population as a whole men were three times more likely than women to have committed a violent act against another person in the preceding five years (18% of men compared to 6% of women). Men were also 4.5 times more likely to have been involved in a fight and more than 6 times as likely to have used a weapon in a fight (3% compared to 0.4%).<sup>109</sup>

As we noted in the introduction to this review, men are also the perpetrators in the great majority of cases of reported violent crime. The British Crime Survey 2006 (BCS) reported that men commit 79% of woundings, 77% of domestic violence, 79% of violence against strangers and 86% of muggings.<sup>110</sup> Between 1995 and 1999, 89% of homicides were committed by men (59% of all homicides had both male perpetrators and male victims).<sup>111</sup> Low level non-violent anti-social behaviour is also more common in men. 26% of young men compared to 18% of young women report behaviour such as "being noisy or rude in a public place so that people complained or the individual got into trouble with the police".<sup>112</sup>

Men – young men in particular – are also much more likely to be victims of most violence; the BCS found the risk of being a victim of violence was 13.4% among men aged 16 – 24 (compared to 6.4% for women aged 16 – 24, and 1% for men aged over 65). The exceptions are sexual violence and domestic violence where the victims are of course, much more likely to be women; 0.6% of women reported domestic violence to the BCS, compared to 0.2% of men (n.b. the BCS is based on face-to-face interviews; self-report surveys tend to elicit very much higher reporting of domestic violence).<sup>113</sup>

Knife crime has been a form of violence of particular public concern in recent years and a "sharp instrument" was used in 28% of the 765 homicides in England and Wales in 2005 – 2006.<sup>114</sup> The statistics on the use of knives as weapons have been the subject of a good deal of contention. The Offending, Crime and Justice Survey (OCJS) which interviewed over 4500 young people aged 10 – 25 found that 5% of young men compared to 2% of young women had carried a knife with them at least once over the previous 12 months; the great majority (85%) claiming to have done so for "protection".<sup>115</sup>

An amalgamation of data from various sources suggests that the proportion carrying knives is very much higher when limited to the younger age range, with almost a third (32%) of upper school age children claiming to have done so at least once in the 12 months prior to survey. When a narrower range of potentially more dangerous knives is considered however (i.e. once penknives are excluded), the proportion falls significantly. 9% of children in school claim to have carried a flick knife for example although – significantly – this figure rises to 30% of those excluded from school.<sup>116</sup> These latter data are not broken down by gender but it is safe to assume that the majority of the knife carriers will be male.

It is clear then that men – particularly young men – are greatly more likely to exhibit behaviours that threaten and disquiet others, and have the potential in some circumstances to cause very serious harm. The analysis of ONS data cited earlier in this section noted that

in addition to the primary risk factor of being male, risk factors for the commission of violence also included being of lower socio-economic status and being single, separated or divorced (this latter observation incidentally, parallels the greater likelihood of poor mental health in men without a partner highlighted earlier in this report). Violent behaviour declined with age and was less prevalent among the Asian population than among white people and black people.<sup>117</sup>

The more complex question is to what extent and under what circumstances violent behaviour might be indicative of poor mental health. The propensity for violence in adulthood has been connected in numerous studies with a dysfunctional upbringing and adverse childhood experiences which, as we have already seen, are also connected with greater risk of poorer mental health.<sup>118</sup> It is not clear however why a propensity for violence should be a more common outcome in men than women as a consequence of these circumstances.

The data further suggest that violent behaviour is generally higher among people with mental disorders – although not greatly so in the case of neurotic disorders and psychosis where these occur alone. The association is much stronger in relation to personality disorders and substance misuse (and where these two disorders occur in conjunction with neurotic disorders or psychosis). Alcohol dependence in particular doubles the risk of violent conduct, and hazardous drinking is associated with 56% of all violent incidents.<sup>119</sup> As we have already noted, personality disorders, alcohol dependence and drug dependence are all markedly more common in men.

In support of their case for early intervention, Allen and Duncan-Smith point out that the potential propensity for violence needs to be resolved in childhood. They suggest that “Social and emotional capabilities, especially for empathy, are a significant antidote to anti-social behaviour, including violence”.<sup>120</sup> We return to the question of the relationship between violence and male mental health in later sections of this review.

## Mental health and male prisoners

As we saw in the introduction, 94% of the 80,000+ adult prisoners currently in British jails are men.<sup>121</sup> Offences of violence are the single most common reason for their being there; 22% of male prisoners are serving sentences for “violence against the person”, compared to 17% who are serving sentences for burglary and 16% for drug offences (the next highest categories).<sup>122</sup> Many other offences for which prisoners have been sentenced are also likely to contain elements of violence.

It is estimated that up to 90% of prisoners may have a mental health problem of some kind<sup>123</sup> and male prisoners are five times more likely than men in the general population to kill themselves – despite living in a setting where suicide is expressly guarded against.<sup>124</sup> There is furthermore, a clear association between the likelihood of a man ending up in prison and his having experienced some of the life experiences listed elsewhere in this document as being damaging to mental health:

*Compared with the general population, prisoners are thirteen times more likely to have been in care as a child, thirteen times more likely to have been unemployed, ten times more likely to have been a regular truant... six times as likely to have been a young father...*<sup>125</sup>

Black and minority ethnic men make up 19 per cent of the male prison population (between two and three times the proportion in the general population). It is believed that one of the explanations for this is that men from these population groups are proportionately more likely

to experience the kinds of social exclusion highlighted above.<sup>126</sup> Black men are also more likely to come to the notice of mental health services via the criminal justice system (see specific section on the mental health of BME men).

It may also be that alternatives to custodial sentences for convicted offenders with mental health problems are under-used. In particular, there have proved to be a number of practical difficulties to making the most effective use of mental health treatment requirements in Suspended Sentence Orders and Community Orders.<sup>127</sup>

There tends to be consensus among mental health specialist organisations that the criminal justice service in general and the prison service in particular, are not well equipped to deal well with mental health problems. Consequently mental health assessment and treatment services for prisoners fall well below those for the rest of the population. Constraints of space again prohibit more detailed exploration of this matter but it is worth noting that one of the most respected research and development organisations in the field, The Sainsbury Centre for Mental Health, in outlining its (ideal) *Vision for 2015* offers the following:

*Offenders with mental health conditions will, where appropriate, be diverted from prison; and those who are in prisons will be offered equivalent care to that which is offered outside, or transferred promptly to an appropriate NHS secure bed.*<sup>128</sup>

The Bradley Report<sup>129</sup> on the needs of people with mental health problems in the criminal justice system, was published while the present review was in preparation. It does not discuss the relationship between masculinity, mental health and offending and is very largely written in “gender neutral” terms. It does acknowledge the value of gender-specific services, although only in relation to the needs of women offenders – perhaps assuming that because most offenders are male, the existing services must have evolved to meet the needs of men well.

Most of the issues raised in this section (and some raised elsewhere in this report) are considered in the Bradley Report in very much more detail than we are able to examine them here. The Bradley Report makes a number of recommendations with which we strongly concur and which are supported, in relation to men, by the evidence in this review. These recommendations include those in favour of early intervention; those concerned with enhanced training in mental health for people working in the criminal justice system; those calling for better identification of mental health problems among offenders; and those calling for the greater availability of mental health services for offenders.

## Alcohol misuse in men

Men are more likely to drink to damaging levels within all three of the categories of alcohol use disorder (“hazardous drinking”, “harmful drinking” and “dependent drinking”). Overall, men are more than twice as likely to suffer from an alcohol use disorder (38% of men compared to 16% of women) and three times as likely to be in the most severe category of alcohol dependence (6% of men compared to 2% of women). Around 800,000 men may be alcohol dependent.<sup>130</sup>

Alcohol consumption by boys is also high. The most recent annual national *Health Related Behaviour Questionnaire* found that school-age boys were more likely to report drinking alcohol at all ages than school-age girls. 9% of Year 10 boys (14 – 15 year-olds) reported drinking on three or more days in the week prior to survey for example, compared to 5% of girls – although girls were slightly more likely to report having been drunk on at least one occasion in the preceding week (23% against 20%).<sup>131</sup> The average amount of alcohol



consumed by both boys and girls has increased significantly in recent years. Methods of data collection have changed over the period, making exact comparisons difficult but it is believed that both sexes are now regularly drinking twice the amount they were in 1990.<sup>132</sup>

*The Alcohol Harm Reduction Strategy for England*<sup>133</sup> articulated a concern that alcohol misuse levels are unacceptably high and highlighted a range of negative consequences for both individuals and society. In addition to the well known chronic physical health disorders and greater risk of injury (at peak times 70 per cent of all admissions to accident and emergency departments are related to alcohol misuse), alcohol misuse is also – and not surprisingly – associated with a greater risk of relationship problems. Relationship problems, as we have already seen, are a common cause of emotional distress in men. Also as we have already seen, alcohol is also very strongly linked to male violence, anti-social behaviour and crime.

Although estimates of prevalence vary, studies consistently report that “binge drinking” (single episodes of heavy drinking) is also much more common in men, particularly in those aged 16 – 24 (it should be added that the incidence of binge drinking among young women is known to be rising rapidly). Evidence suggests that drinking of this kind can often be ascribed to cultural perceptions among men that drinking in large quantity is a marker of masculinity.<sup>134</sup> In the recent Mind survey mentioned earlier, men were twice as likely as women to report using alcohol as a coping strategy when they were feeling low or worried (16% of men compared to 8% of women).<sup>135</sup>

Given this markedly higher prevalence of all forms of alcohol misuse among men, it is surprising that women appear almost twice as likely (1.7 times) to use specialist alcohol treatment services.<sup>136</sup> It is not clear whether this difference is accounted for by better identification of female alcohol misusers by referring agencies or is somehow attributable to the way in which services are designed.<sup>137</sup> It seems clear however, that large numbers of men may not get the help that they need and, given the common cultural acceptability of alcohol use, it is probable that many men do not even realise that their drinking may be manifestation of emotional distress. Further, provision of alcohol treatment and dual diagnosis services is acknowledged to be patchy around the country and it may be that some men with more severe problems are trapped in a cycle of alcohol dependence, housing and employment problems, and involvement with the criminal justice system.

## Drug misuse in men

The UK has the highest prevalence of illicit drug use in Europe.<sup>138</sup> Illicit drug use is more common in younger people and much more common in men than women. 26% of men aged 16 – 24 report using cannabis in the previous twelve months compared to 16% of women for example. The same pattern is true for amphetamine use (5% / 2%); use of ecstasy (7% / 3%); and cocaine use (8% / 5%). Young men are more than twice as likely (11% / 6%) as young women to have used any class A drug (cocaine, ecstasy, heroin or LSD). Among adults aged 16 – 59, the reported use of any illicit drug was 13% for men and 7% for women.<sup>139</sup>

During 2006 – 2007, 140,000 men used drug treatment services compared to 55,000 women. 61% of treatments were for the use of heroin.<sup>140</sup> Drug-related deaths are also greatly more common in men. Men made up 79% of the 1573 drug-related deaths in 2008, including 180 intentional (or undetermined) self-poisonings, compared to 107 in women. Male suicide is dealt with later in this review.



The use of illicit drugs is associated with a range of mental health problems. 16% of men with a neurotic disorder report drug use within the past month compared to 8% of men without a neurotic disorder. Men with a neurotic disorder are more than twice as likely to have a cannabis dependency and more than five times as likely to have a dependency on any illicit drug (including cannabis). There is also a clear association between drug misuse and anti-social personality disorder which, as we have seen, is more common in men. The detail is complex because some behaviours are associated with both states but it seems probable that around one in three people with anti-social personality disorder had used an illicit drug within the past month, which is considerably higher than the background rate in the general population.<sup>141</sup>

The use of illicit drugs is strongly linked to criminal behaviour, although there is “no clear picture of either the extent of the linkage, whether it is associative or even casual”. A Home Office funded research programme established that recent drug use was very high among a sample of people arrested for any crime in five English cities (61% of those arrested tested positive for at least one drug).<sup>142</sup> These data were not reported by gender but it is of course likely that the great majority of these arrestees were male.

## 3. Specific groups and conditions

### Suicide in men

Suicide by men – and particularly suicide by young men – is perhaps the most widely acknowledged of male mental health problems. In recent years the issue has attracted public debate and coverage in the popular media. Each individual suicide is of course, a tragedy for the individual man concerned and for his family and friends. At the broader level however, it is worth remembering that, in most cases, suicide is actually an outcome of a complex web of experiences and circumstances, rather than a self-contained event. In this very important sense, suicide can also be understood as the visible representation of a much greater reservoir of emotional distress that may affect far more men than the relatively small number who will ultimately take their own lives.

The *National Suicide Prevention Strategy for England*, published in 2002, is one of very few national policy documents in any area of health to draw attention to the specific needs of men.<sup>143</sup> Encouragingly, suicide rates have shown a marked downward trend in recent years. Nevertheless, in 2007 there were still 5,377 deaths by suicide in the UK, the majority of which were in men.<sup>144</sup> On average, men are three times more likely to end their own lives than women, with the peak relative difference occurring between ages 30 – 39 when men are four times more likely to end their own lives.<sup>145</sup> There is a steep socio-economic gradient in male suicide with men from the most deprived population groups more than twice as likely to take their own lives than men in the least deprived areas.<sup>146</sup>

The reasons why men are more likely than women to die at their own hand are complex. Men more often choose a means of suicide that leaves less chance of a change of heart, or of being found and given assistance; for example half of male suicides are by hanging or suffocation compared with one third of female suicides (the most common form of female suicide attempt is a drug overdose).<sup>147</sup> As we have seen, for a variety of reasons, men are also less likely to have access to informal or professional support at times of emotional distress and may consequently be more likely to feel that there is no alternative to the most drastic solution.

Suicide is also very strongly associated with a number of other adverse personal circumstances, almost all of which we have seen either to be more common in men or to be more damaging for men. There is space here to highlight only some of them. Alcohol intoxication for example, very greatly increases the immediate likelihood of a suicide attempt and increases the probability of choosing a more lethal method, as does a personal tendency towards aggression.<sup>148</sup> A longer term history of alcohol misuse also increases the likelihood of suicide, as does a history of drug misuse.<sup>149</sup> Male prisoners are five times more likely than men in the general population to kill themselves<sup>150</sup> (and, as we have seen, 94% of prisoners are male). Single, divorced and widowed men are three times more likely than their married counterparts to take their own lives.<sup>151</sup> As we suggest in the section below, it is also possible that depression is under-diagnosed in men, with the consequence that men may be less likely than women to get the help that they need.

Finally, and very importantly in the present climate, a recent *BMJ* editorial has highlighted the historical evidence which suggests that male suicide rates frequently increase at times of economic difficulty.<sup>152</sup> Other researchers have observed that the suicide rate in those under retirement age rises by around 0.7% for each 1% rise in unemployment.<sup>153</sup> The Australian national men's health policy mentioned earlier has also suggested that male suicide may be

linked with the fact that “men are particularly ill-equipped to cope with the sense of failure that may come from the loss of property or job.”<sup>154</sup> We have already noted the link between redundancy and depression

## The possibility of under-diagnosis of depression in men

It is a paradox that men are three times more likely than women to take their own lives but only half as likely to be diagnosed with depression. It is possible that – for reasons we have already seen – this may be partly explained by the fact that some men living with depression may never present themselves to a health professional who could diagnose them.

Some observers have also speculated however, that the internationally recognised symptomatology for depression inclines towards a view of the disease that emphasises a more “typically female” form of presentation i.e. one in which the patient is tearful, withdrawn, and lacking in motivation and energy. This proposition holds that men may exhibit different symptoms of depression from those seen in women. The most important is that “acting out” in general and “anger attacks” in particular are more common in men. It is suggested that not only are these more “typically male” symptoms often not recognised as symptoms of depression, they may also militate against a sympathetic response from health professionals and other agencies – or even from family and friends. Indeed, these symptoms have the potential actively to prevent the individual getting any help at all (for example if they mean that a man’s behaviour brings him in the first instance to the attention of the police rather than to a health professional).

The Mind report on men’s mental health takes up this point and suggests that it is:

*... essential that health professionals recognise when aggressive or violent behaviour is a potential indicator of mental distress and that this is reflected in the principles of diagnosis. This should help men get the right treatment at the right time instead of allowing mental health problems to deteriorate through not being treated.*<sup>155</sup>

The problem of under-diagnosis may be exacerbated by depressed men’s greater likelihood of appearing in a clinical setting (if they appear in such a setting at all) with an ostensible “physical” problem, while women may be more likely to directly identify emotional distress as the concern for which they are seeking help.<sup>156, 157</sup>

It is also considered possible that symptoms of depression in men are more likely to be masked in men by self-medication with alcohol or illicit drugs. In 1999, the Samaritans attempted to identify depressed and potentially suicidal young men within a survey group of 1344 young male respondents. Among other important findings, this survey suggested that a third of the potentially suicidal groups would “smash something” if they were worried or upset compared to only around 9% of those youngsters who were not depressed. The depressed young men were also 10 times more likely to say that they would turn to drugs as a means of coping with distress.<sup>158</sup>

Of course, not all men are alike and it is possible that the differences between groups of men are as relevant to this matter as the differences between men and women. The sense of being “trapped” by the incongruity of experiencing depression and vulnerability within a masculine identity may be a particular problem.<sup>159</sup> Research has suggested for example, that some men concur with a version of masculine self-belief that sees emotional help-seeking as a fundamental indicator of weakness:

*It was apparent that to many participants to (be seen to) endure pain and to be “strong and silent” about ‘trivial’ symptoms, and especially about mental health or emotional problems, was a key practice of masculinity.*<sup>160</sup>

The ostensibly straightforward option of simply asking for help may in reality, therefore, be fraught with varying degrees of difficulty for many men and irredeemably so for some (particularly perhaps for the most disadvantaged groups). This may increase the likelihood that the pressure of the distress will build up until it boils over in some way. A descriptive model has been developed which proposes that men who do not seek timely help may instead find themselves progressing through a predictable series of attempted coping strategies, each doomed to failure and each more destructive than the one before. In this model, men may begin with attempts to “numb” the pain (through alcohol or drugs for example) before trying to find a means of “escape” and ultimately reaching the point where they are in danger of physically harming themselves or other people.<sup>161</sup>

This is by no means a straightforward issue. A paper which analysed the various theories that attempt to explain whether depression is indeed under-diagnosed in men and, if it is, why that is so, observed that:

*The existing clinical and research literature on depression in men has provided widely varying answers to these questions, and it is safe to say that there is currently no unifying conceptual framework guiding clinical research or practice. Nor have the assumptions underlying different theoretical frameworks been outlined in detail.*<sup>162</sup>

One important and emerging lesson may be the pressing need to find ways of both identifying and treating depression that take account of culturally familiar ideas of masculinity. A recent study based on detailed interviews with men diagnosed with depression has summarised the issue in regard to treatment thus:

*... it is important for men with depression to reconstruct a valued sense of themselves and their own masculinity as part of their recovery... For example rather than seeing depression as making one powerless, some men conceptualised it as an heroic struggle from which they emerged a stronger person.*<sup>163</sup>

## The mental health of men from BME communities

The mental health of men from black and minority (BME) communities has been a controversial subject in recent years. The range of concerns is complex and the issue continues to be extensively debated both professionally and politically. There is inadequate space here to revisit the matter in detail but it is clear enough that this group has had a particularly negative experience of mental health services. The Department of Health's report, *Inside Outside*, acknowledged that:

*There does not appear to be a single area of mental health care in this country in which black and minority ethnic groups fare as well as, or better than, the majority white community.*<sup>164</sup>

The troubled relationship between mental health service providers and the BME community, was also explicitly conceded to have been an important factor in the death of David Bennett, a black psychiatric in-patient who died while being restrained in 1998. The inquiry recognised that:

*... institutional racism has been present in the mental health services, both NHS and private for many years.*<sup>165</sup>

Since 2005 there has been, on a specific single day each year, a national census of inpatients receiving care in publicly funded mental health facilities in England & Wales. This census programme, known as *Count Me In*, will continue until 2010. Its purpose is to provide robust

baseline that will enable future planning of services to take proper account of equality issues.<sup>166</sup> The 2008 census found that 23% of inpatients belonged to BME groups and noted that:

*Men from the White British, Indian and Chinese ethnic groups had lower admission rates than average, by 16%, 18% and 32% respectively. Admission rates were higher than average for men among all other ethnic groups. As in previous censuses, they were particularly high for men from the Black and White/Black Mixed groups, with rates three or more times higher than average. Also, as in previous years, the rate was highest among men from the Other Black group – 13 times higher than average.*<sup>167</sup>

Black men were 24% – 33% more likely to have been compulsorily detained and treated under the Mental Health Act, and 31% – 70% more likely to have been among the group (9%) referred to mental health services via the criminal justice system. Black men were also significantly more likely to have been among the 4% of inpatients who had been placed in seclusion at some point during the preceding year.<sup>168</sup>

Estimates vary, but black men born in Britain are very much more likely to be given a diagnosis of schizophrenia than the general population.<sup>169</sup> This high incidence of psychotic illness is not mirrored among men in the Caribbean, which suggests that there may be some specific aspect of the black British male experience that contributes either to higher incidence or inappropriate diagnosis, or both.<sup>170</sup> There is furthermore, some evidence that the incidence of schizophrenia in all BME communities (i.e. not only black communities) increases in direct proportion to the imbalance between white and non-white residents. In other words, the smaller the local BME community, the higher the incidence of schizophrenia in that community<sup>171</sup> – a finding incidentally, which also suggests the potential protective effect of social relationships which we covered earlier in this review.

It should be noted that other minority communities, including those where data is more sparse, may be at higher risk of poorer mental health. It is not possible to examine all such communities here but gypsy and traveller communities for example, are believed to have rates of anxiety and depression many times greater than the population average and may have higher suicide rates.<sup>172</sup>

## The mental health of gay men

For various reasons the most recent *Count Me In* census was able to identify the sexuality of only 56% of participants. Of these, only 1% of men and women described themselves as gay or lesbian – a considerably smaller proportion than the estimated 5% – 7% of the population as a whole who are believed to be homosexual. The reasons for this discrepancy are not clear and it is not safe to assume that it indicates a lower prevalence of serious mental illness among gay men.

Research has consistently suggested an increased risk of poorer mental health among gay men. A survey of young gay men in Northern Ireland found that over a third of respondents had been diagnosed with a mental illness at some point in their lives (typically depression and anxiety), and that a similar proportion potentially had a current problem (using the “GH12 score” – an established measure of mental health). 27% of respondents had previously attempted suicide and 30% had self-harmed.<sup>173</sup> These are much higher proportions than among men in the population as a whole. The study attributed these indicators of poor mental health to:

*The impact of negativity when coming out, isolation, difficulties in school and work related to sexual orientation and homophobia in society...*

Interestingly in light of our previous discussion of the protective effect of social relationships, this study identified the “key factor” as “the absence of someone to talk to”.

Several other studies have noted a higher prevalence of suicidal thoughts and suicide attempts among gay men. An American study using data from a sub-set of over 3500 men who had participated in the National Health and Nutrition Examination Survey suggested that the risk of completed suicide may be up to five times greater among gay men than among heterosexual men, with the greatest risk concentrated on younger men.<sup>174</sup> This study also identified a somewhat greater prevalence of depression among young gay men than among the population as a whole and concluded that analysis of the data had provided “further evidence that adolescence may be a particularly difficult time for young gay men.”

A UK study produced similar results with 44% of gay men scoring above the threshold for a common mental disorder compared with 35% of heterosexual men (for unexplained reasons, levels of mental disorder were much higher in this study than the background levels in the population as whole). This study also noted higher levels of illicit drug use among gay men; greater use of mental health services regardless of present state of mental health; and a higher risk of self harm, which it noted “would seem to have less to do with confusion about sexuality than confusion about how to express it openly in society.”<sup>175</sup> Eating disorders, which are covered briefly later in this review, are also known to be very much more common in gay men than heterosexual men.<sup>176</sup>

Finally it is worth noting that socialisation, which we discussed earlier, commonly assumes that boys are likely to grow up to be heterosexual – a popular notion that inevitably makes life more difficult for boys who become aware that they are gay. This is also important because this tendency to assume heterosexuality also limits the range of “gender appropriate” behaviours, roles and relationships that men of any sexual orientation are comfortably able to express in adulthood.<sup>177</sup> It is interesting to note that in a series of interviews with men (of all sexual orientations) diagnosed with depression in adulthood, several recalled that showing vulnerability in adolescence resulted in them being called “‘sissies’, ‘poofs’ or ‘gays’”.<sup>178</sup>

## PTSD and the mental health of ex-servicemen

Post-traumatic stress disorder (PTSD) occurs in some people who have had suffered an overwhelmingly traumatic experience. It has a range of symptoms which may include depression and withdrawal; vivid and frightening flashbacks; and irritability aggression and violence. For obvious reasons, PTSD is much more common among ex-services personnel who have had frontline experiences, the great majority of whom are men.

The UK’s only specialist organisation for ex-services personnel suffering from PTSD, Combat Stress, has reported a 53 per cent increase in referrals during the past three years, including 1,160 new cases during 2008 and over 2500 admitted for treatment during the same period.<sup>179</sup> This increase is attributed to the recent conflicts in Afghanistan and Iraq which, in addition to causing many new psychological casualties, are believed also to have encouraged men still suffering distress from earlier conflicts to seek help.

In February 2009, Lance Corporal Johnson Beharry the only currently serving soldier to have been awarded the Victoria Cross, took the unusual step of giving a national newspaper interview in which he described his own “nightmares, mood swings and irrational rages” before calling for better services for ex-services personnel who have been psychologically damaged by their experiences.<sup>180</sup> In August 2009, the same newspaper carried a personal dispatch from an un-named officer in the Welsh Guards who wrote about the problems of dealing with grief and distress at the frontline in Afghanistan:



*With each death I think each of us experiences a feeling of total shock, powerlessness and impotence... there is no refuge, no private corner to go to, to deal with your grief... So the event of each death is placed zipped up in a mental body bag, back in the recesses of your mind... quite possibly to come out and be re-opened, once you return home and have the chance to think about each death, each injury, each friend gone.*<sup>181</sup>

During the first three months of 2008, the Ministry of Defence reported 862 serving armed forces personnel as having been diagnosed with a mental health disorder, just over half of whom (489) had seen service in Afghanistan or Iraq. This suggests an incidence rate of 4 per 1000 personnel for men (less than half the rate for servicewomen). 44 of these 862 were diagnosed as suffering from PTSD, which was described as a "rare condition".<sup>182</sup>

It is believed that ex-servicemen are over-represented among the homeless population. Estimates of the proportion of rough sleepers who are ex-services personnel (very largely men) are variable but figures from 9% to 25% have been suggested. Data from a small random sample of ex-servicemen found that 30% had been homeless at some point since leaving the forces, and 8% had had the experience of sleeping rough.<sup>183</sup>

A pilot study of ex-servicemen who were sleeping rough at the time of survey found broadly similar high levels of mental illness, alcohol dependence, drug misuse, criminality and adverse childhood experiences as within a comparison group of civilian rough sleepers. 15% of the ex-servicemen indicated that they spent had their very first night after discharge sleeping rough (although it should be noted that some older rough sleepers will have left the armed forces before the introduction of improved resettlement support). 60% of the survey group had seen active service.<sup>184</sup>

Young ex-servicemen (those aged under 24) are between two and three times more likely than young men in the population as a whole to end their lives by suicide. It is not clear however whether this is linked to their service experiences or to their pre-service background placing them at higher risk of suicide (for example because of lower socio-economic status – see earlier section on suicide in men). Older ex-servicemen are not at greater risk of suicide; indeed, it may be that a service career (like other secure and satisfying employment) is protective of mental health in that suicide rates for servicemen aged 30 – 49 are lower than those in the general population.<sup>185</sup>

## Specific forms of mental ill health

The limited scope of this review precludes detailed exploration of some of the more specific forms of mental ill health or psychological distress but there are two that should be mentioned, both of which are believed to be under-recognised in men because they are more often encountered in women.

We acknowledge that both these issues of very great importance to those who suffer from them. They are addressed in brief here only because of limitations of space. This brevity should not be taken as suggesting that these matters are regarded as of lower importance. We draw attention in the recommendations below to the need to look at these issues, and others like them, in more detail in the longer run

**Sexual abuse** in childhood and adolescence is often viewed as having long term damaging effects primarily for adult women. Precise figures about the prevalence of having been a victim of child sexual abuse are difficult to obtain. Under-reporting is believed to be common because some people (perhaps especially men) prefer not to recall these events. Further, there are significant difficulties with definitions, which may vary from one study to another. Canadian research has however estimated that anything up to one third of men may have



experienced some form of sexual abuse in childhood and that men may make up anything from 10% – 50% of all victims.<sup>186</sup>

Having been a victim of sexual abuse in childhood is very strongly associated with an increased risk of mental ill health in both childhood and adulthood. A 2004 British study noted that a history of sexual abuse is associated with twentyfold increased risk of conduct disorders in childhood, and an eightfold increased risk of personality disorder and a fivefold increased risk of anxiety and acute stress disorders in adulthood.<sup>187</sup> The authors of the study also observed that:

*... although subtle differences may exist in the responses to child sexual abuse between the genders, male victims show associations to most adverse mental health outcomes that are just as strong as those shown in females.*

**Eating disorders** are often exclusively associated with women, particularly young women. In fact, 10% of diagnosed cases of eating disorder occur in young men and the Eating Disorders Association (EDA) believes that the real proportion may be higher still. The EDA suggests that male eating disorders may be under-diagnosed because doctors tend not to look for the condition in men and because young men are less likely than young women to seek help.<sup>188</sup> It is acknowledged that there are often problems for men who do seek help because specialist services tend to be strongly geared towards meeting the needs of women.<sup>189</sup> It is also possible that eating disorders in young men are on the increase because of growing pressure on men to conform to an “ideal” body shape. This pressure is also believed to be associated with an apparent increase in body dysmorphic disorders (excessive concern that parts of one’s body are “not good enough”) in young men, and in particular with “muscle dysmorphia” (the idea that the body is not muscular or athletic enough).<sup>190, 191</sup>

## Discussion

This review has demonstrated that men often have mental health needs that are distinct from those of women and which are particularly associated with the lived experience of being male. Some of these needs are not being met as effectively as they might.

The evidence from service provision in relation to physical health is that men tend, in general terms, to be less knowledgeable about health than women and to take less care of their personal health. Some groups of men are known to delay seeking help even when they have recognisable symptoms. This inevitably means that health services are sometimes less effective in delivering good outcomes for men. In some cases, it may even mean that services have inadvertently developed in such a way that they have become less well equipped to meet the needs of men. This review suggests that – perhaps not unexpectedly – these kinds of problems also exist in mental health services.

What emerges most strongly however, is that these underlying difficulties are significantly compounded by a factor that is peculiar to mental health. This is that some of the accepted cultural markers of masculinity – for example (and among others): the willingness to “soldier on” when under emotional stress; the consumption of large amounts of alcohol; the greater propensity to physical aggression; the greater tendency of boys to misbehave in school – are also potential symptoms of, or predisposing factors for, poor mental health. Many of these behaviours are so familiar that they seem indisputably “normal” even though it is easy to see that they are sometimes simultaneously damaging.

Further, some potentially damaging choices apparently made willingly by men – for example to work long hours or to prioritise career over family – may in fact be forced on them by circumstances.

Of course, this does not mean that all men who exhibit these characteristics, or find themselves in these circumstances, are suffering psychological distress to the point of requiring treatment. To suggest this would be absurd and – as we said at the outset – it is not the intention of this review to pathologise maleness. At the same time, the review suggests that there is a good case to try for a better understanding of the relationship between some of these behaviours and poor mental health in men, where that occurs.

This poses significant problems. First, it is very difficult to separate out those men who may be struggling to cope from those who are not. Second – and this is the lesson from other areas of health – the expertise to plan and deliver services that men are willing to use may be lacking. Finally, it will be immensely challenging to engage men in a dialogue that encourages them to *ask themselves* whether they should be seeking help.

It should also be said that not all the most important issues are concentrated within the framework outlined above. The ongoing problems experienced by men in the black community, the poorer services experienced by mentally disordered prisoners, the increase in eating disorders among boys and so on are all examples of issues that are to some extent self-contained and which perhaps need to be tackled within that context.

## Conclusions

We have seen that there are numerous mental health concerns that meet the definition of a male health issue with which we began; that is to say, they arise from factors that are specific to men and/or they would benefit being addressed in a male-specific way. It was not part of our brief to make formal recommendations for future action. We do however urge consideration of an approach that takes account of the particular needs of men, in parallel of course with an approach that takes account of the particular needs of women. We believe the evidence in this review supports such an approach.

There have been calls (from the Men's Health Forum in 2006 and Mind in 2009)<sup>192, 193</sup> for a national strategy for men's mental health. There are good arguments in favour of such a course of action. The more important issue however is simply to ensure that the knowledge in this review is widely disseminated and used to inform future practice. The process for doing that needs to fit with the wider policy context but the precise means by which progress should be made is rather less important than that progress should happen.

The change that is needed is to make sure that the specific needs of men are properly considered in the development, planning and delivery of mental health services. In its call for a national strategy Mind pointed out that the ongoing *New Horizons* review of the future of mental health services offers the ideal opportunity to make the necessary commitment. Putting aside for now the debate about whether or not there should be a national strategy, *New Horizons* is undoubtedly a wholly appropriate starting point for taking a more concentrated approach to men's mental health. We very much hope the opportunity will be seized – not least because, again as we have already seen, there is now a legislative duty on service-providers to ensure that services meet the needs of both sexes fairly and appropriately.

Finally, we believe that this review provides good evidence for taking the following ideas and principles into account when future actions are planned:

- **A cross-cutting approach.** Improving and maintaining the mental health of men is not just a function of mental health services. To take just two examples highlighted in this review, education provision and employment legislation both have a crucial part to play.
- **Simply being male could – and should – be seen as a primary risk factor for several specific mental health problems.** These include alcohol dependence; drug dependence; suicide; aggressive or criminal behaviour where that is associated with underlying emotional distress; and behavioural problems in school. Consideration should be given to developing more male-specific approaches to prevention and treatment.
- **Depression may be under-diagnosed in men.** This idea needs further investigation and may require both diagnostic and treatment services to become more flexible.
- **Many men who need help may not say so, and some may come to notice in ways that do not encourage a sympathetic response.** Tackling these problems will need more flexible services and perhaps increased "outreach", backed up with the development of a research base into the most effective types of response.

- **Boys are falling behind in education.** A poor experience of school militates against good mental health in a variety of ways. It is important to find ways of improving boys' educational performance.
- **It is important to support and encourage fathers, especially those in the most adverse circumstances.** This has important potential to improve the psychological health of adult men in the longer term as well as improving the self esteem of fathers themselves.
- **Male-specific helpline services may have something to offer.** It should be acknowledged that men are thought to be more reluctant than women to use health-related helplines.<sup>194</sup> At the same time, the Australian Mensline has shown that men will use helpline services that are appropriately designed and targeted. CALM has achieved similar success in the UK in relation to young men in particular.<sup>195</sup> It is at least possible that a dedicated helpline service could offer a first step to men who find difficulty in making the leap to seeking help in person.
- **Early intervention.** Encouraging boys to become more sensitive to their own emotional needs and the emotional needs of those around them will not solve all the problems but it has the potential to help considerably. The Marmot Review of Health Inequalities has recently pointed out that "Economists now argue that investment in early childhood is one of the most powerful investments a country can make, with returns over the life-course many times the amount of the original investment".<sup>196</sup>
- **A cultural shift is needed that will allow boys and men to explore a less restricted version of masculinity.** Similar to the point about early intervention above, this is not a magic wand but it has the potential to help. Role models and public information programmes may be important here – as could be the "reclaiming" of some positive, traditionally masculine, attributes.
- **Poor working practices contribute to poor mental health.** Employers should not routinely expect people to work long hours, especially without pay. Good employers and good employment practice can improve the mental health of men.
- **Many men in prison have had adverse childhood experiences and are suffering from psychological problems.** Public safety must remain paramount but there is a strong case for more thoughtful assessment and treatment of some prisoners. If implemented as intended, the recommendations of the Bradley Report have the potential to make a significant difference to the way mentally disordered offenders are identified and treated.
- **Several specific forms of psychological distress have particular importance for men and need to be considered from a male perspective.** Two examples – eating disorders and having been a victim of sexual abuse in childhood – are given in the text (four, if PTSD in ex-servicemen and male post-natal depression are added to this category). It seems certain that there are others.

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Prior to joining the Men's Health Forum (MHF) in 2002, **David Wilkins** worked in the NHS for 11 years; initially as a community health worker, subsequently as a health promotion specialist and finally, on a joint academic appointment, as a lecturer/practitioner. Both in the NHS and for the Men's Health Forum, he has managed projects intended to improve men's health, including important Department of Health funded projects in the fields of sexual health and cancer prevention. He has written and spoken extensively on men's health issues and is responsible for the MHF's on-going series of policy papers on different aspects of men's physical and mental health. In 2008, he edited *The Gender and Access to Health Services Study* for the Department of Health and in 2009, he jointly edited *Men's health around the world: a review of policy and practice in 11 countries* for the European Men's Health Forum.





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