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MEETING THE NEEDS OF OLDER MEN: CHALLENGES FOR THOSE IN HELPING PROFESSIONS

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The uniqueness of men's lives has not been revealed in the social service literature. Therefore policy makers and practitioners are without the necessary knowledge base and research to create programs and services that will engage men and, in particular, aging men. This article presents an overview of the state of knowledge in general and the specific areas significant to policy and practice development.

Key words: *aging men, men, health problems, unmet needs, community resources*

It has been suggested that professional education and literature may either not include content on men or, when discussed, portray them in a biased manner (Kosberg, 2002; Kosberg & Mangum, 2002). The result can be a distortion in the perception of this population that minimizes their problems. Future practitioners may, thus, be ill-prepared to provide sensitive and effective interventions to assist males, in general, and older men, in particular, facing both normative and unique challenges. This certainly involves men from minority group backgrounds, including immigrants and refugees.

This article emanates out of a belief in the need for an equitable and fair portrayal of older men, no less than for older women. Future professionals need to be adequately educated and trained to work effectively with older men, as well as older women. Finally, it needs to be acknowledged that a focus on the needs of

older men helps not only them but the members of their families as well.

Stereotypes of Older Men

There are several explanations for lack of attention to older males (Kosberg & Mangum, 2002). First of all, older men exist in smaller numbers and proportions than do older women. As such, they represent a minority group among older persons. Whereas older women have taken advantage of the successful advocacy efforts of feminists, older men have not benefited from efforts of those in the men's movement and there are few, if any, groups or organizations that advocate on behalf of their welfare. There are (faulty) assumptions regarding the superior quality of older men's lives, compared to older women. Older men are seen to be powerful, affluent, and dominant in the home and in society. Some are; the majority of them are not. Humor in American society often takes a "poke" at older men. Jokes about the "dirty old man" or movie titles such as "Grumpy Older Men" can be seen to make mockery of them.

There seems to be a bi-modal view of older men as either frail, incompetent, dependent, sedentary, and asexual or privileged without significant problems. The first view results from both stereotypical humor and extrapolations from the fact that some older men are older and more impaired than their wives and that they have shorter life spans. The second view, equally wrong, results from incorrect conclusions from research findings and practice experiences regarding the relatively small proportion of older male clients, patients, and program participants involved in community based programs and services for older persons. Since they do not use resources, it is believed that they do not need them.

Thompson (1994) has pointed out that older men are a homogenized and marginalized (and a faceless) group. Gross generalizations about older men gloss over the fact that they are, as a group, more diverse than they are alike (Kosberg & Kaye, 1997). They vary by social class, education, racial and ethnic background, marital status, and existence of an informal support system. Older

men live in different geographic areas of the country and there are differences between life in urban and rural areas. There are variations by country of origin and level of acculturation for older men who are immigrants or refugees. Although the majority of older men have led and lead normative life styles, there are those who are incarcerated, institutionalized, or lead deviant lives. Finally men, no different than women, vary in their personalities. Thus, the fact that older men would be considered alike and stereotyped is both unfair and wrong, and has negative implications for professional education and practice.

Special Problems of Older Men

As they age, older men face some challenges that are little different from older women. But there are problems that are especially prevalent for older men, and others that result from being a male. This section will discuss physical health problems and psychosocial challenges. Although discussed separately, these topics are often inter-related.

Physical Health Problems

Despite stereotypes regarding the superior quality of their later years, older men face a greater likelihood of acquiring specific health problems. As Courtenay (2003) points out, men are more likely than older women to suffer from cardiovascular diseases, seven of the top 10 infectious diseases, and death from cancer. Men, more so than women, meet the criteria for psychiatric diagnoses, and Courtenay goes on to indicate that men have higher rates of substance related disorders, sexual disorders, and are at greater risk for schizophrenia, and their suicide rate is four to 12 times higher than for females. So, too, men have been found to have memory loss, sexually transmitted diseases, and physiological challenges to their immune functioning (Adler, Patterson, & Grant, 2002). The ultimate measure of the quality of life is mortality, and men's longevity is considerably shorter than women's.

Being male results in particular health concerns and problems in old age. Prostate and testicular cancers, as well as non-gender

specific types, have reached epidemic proportions for males. One in five men develops prostate cancer and, at age 75, males are dying at twice the rate as women. The cancer death rate for African American men is twice that for Caucasian men (*Men's Health Network*, 2000).

In a study (*Aging Today*, 1991–92) of 300 doctors and 500 men over age 50, it was found that half of the men did not follow-up on the warning signs of prostate or colorectal cancer as a result of their embarrassment, fear, and denial. Citing embarrassment as the main reason, more than half of the men did not discuss their sexual dysfunction or depression with their doctors. As will be discussed, males from minority group backgrounds might be especially reluctant to seek professional advice on their health related concerns. *The New York Times* (February 17, 1999) ran a special section on Men's Health which advised males "Don't Take Your Medicine Like a Man" (Lipsyte, 1999), but do what women do: Inquire about one's health problems. Another article was entitled "Why Men Don't Last: Self-Destruction as a Way of Life" (Angier, 1999) which suggests that men's life styles jeopardize their survival. Courtenay (2003) adds that men respond to physical problems and mental stress by using avoidant coping strategies, increase alcohol consumption, and are less likely to acknowledge that they need help. He goes on to indicate that men are less likely than women to use health care resources, to have a regular physician, and to seek psychological services (although more men than women meet the criteria for psychiatric diagnoses).

Often not thought about are military veterans who are victims of post-traumatic stress disorder (PTSD), including former POWs from World War II and Korean and Vietnam veterans. It has been reported (*Aging Today*, 1991–92) that vets with PTSD are a larger group than generally believed. Events associated with the aging process (e.g., retirement, bereavement) can lead to delayed PTSD. Such problems have not received necessary attention by professionals.

Although females are more likely to utilize psychological services, and thus believed to have higher rates of depression, it is possible that the rates for males are grossly under-reported due to their being reluctant to admit their problems and due to their under-utilization of community-based social and health services.

Psychosocial Challenges

Present cohorts of older men face the possibility of greater relative deprivation than do older women, in that they were more likely to have been employed outside the home and had faced retirement. Wan and Odell (1983) found that the greater the role losses of older men the less likely they would be involved in informal or formal interactions. Thus, it can be concluded that the loss of role, status, and income can, in turn, adversely affect the self-concepts of older men.

Older married men generally believe that they will predecease their wives and when they do not, and become widowers, research has found that they have an increased risk of suicide and overall mortality in the first six months after the loss of a spouse. They are also more likely than women to suffer from depression, mental illness, and physical health problems after the death of a spouse (Fitzpatrick, 1998; Tudiver, Hilditch, & Permaul, 1991). Nieboer, Lindenberg, and Ormel (1999) found that older widowers scored considerably lower on measures of well-being than older widows for two years of bereavement following the death of a spouse. Additionally, there are few bereavement groups for older widowers. As their wives had also been their confidants, the loss of a wife is an event that can result in extreme loneliness.

Males have been found to be more likely than females to be victimized and murdered, to complete suicide attempts, to become substance abusers of alcohol, tobacco, and drugs, to be homeless, to be victims of work-related injuries and illness, to suffer heart attacks, and to have fatal car accidents. The result is that men have shorter life expectancies (Farrell, 1993).

Although males are popularly depicted as abusers (of children and females), there is reason to believe that males are at least as likely as females to be victims of abuse—including elder abuse (Kosberg, 1998). Steinmetz (1977–78) wrote of the “The Battered Husband Syndrome,” Tutty (1999) discussed “Husband Abuse,” and both Brothers (2001) and Pritchard (2001) wrote of the abuse of men. Inattention to the possibility that there are heterosexual and homosexual male victims of domestic violence sustains their portrayal as aggressors and denies them professional assistance and community resources. Koff (1997) discussed older men in

long-term care facilities as being emotionally abused when the majority of residents and staff are women, and activities are female-oriented.

Whether lonely, isolated, depressed, or otherwise faced with consequences of their losses, the coping mechanisms used by older men may seriously challenge the quality of their lives. Older men are more likely, than older women, to be substance abusers. They are more likely to place themselves in dangerous situations in the community or can be taken advantage of by those who would prey upon their loneliness. Although depression among older men has been compared to that of older women without consistent findings, it can be pointed out that depressed men who utilize substances as a coping mechanism may be diagnosed as alcoholic rather than as depressed. Additionally, inasmuch as suicide rates for men increase by age group, it is possible that depressed men turn to suicide and, therefore, are not reported in studies on the prevalence of depression among older populations.

Literature on males as family caregivers has been increasing. While traditionally it has been females (such as wives or daughters) who have cared for dependent members of the family (i.e., children, specially-challenged relatives, dependent elderly parents), increasingly males—including older men—are taking on such responsibilities (Kramer, 1997; Kramer & Lambert, 1999). There is ample evidence that male caregivers (i.e., husbands, sons) may experience similar levels of burden and depression as found for females; yet, these male caregivers are less likely to seek assistance or admit their adversities (Kaye & Applegate, 1997; Yee & Schultz, 1999). Husbands caring for wives may not admit to the negative consequences of caregiving (such as burden or stress), as a result of their stoic upbringing and a spirit of responsibility for their wives that prevent them from relinquishing their caregiving role. Yet, they have been found to become less happy and more depressed after assuming the caregiving role (Kramer & Lambert, 1999). Older fathers who take on new or additional caregiving responsibilities for a mentally retarded adult child, when his wife becomes incapacitated or dies, have been found to have similar low levels of morale, depressive symptoms, and subjective burdens as mothers who have such caregiving responsibilities (Essex, Seltzer, & Krauss, 2002). Houde (2002) has called for more

careful research on male caregivers that will provide additional knowledge for clinicians and researchers.

Efforts Focusing upon the Needs of Men

There has been a growth in the past decades on literature focusing upon males; much of it emanating from men's studies. Generally, older men have been forgotten. However, some authors have focused their attention directly or indirectly on older men, such as Sheehy (1998) *Understanding Men's Passages*, Levinson (1978) *The Seasons of a Man's Life*, Thompson (1994) *Older Men's Lives*, Kosberg and Kaye (1997) *Older Men: Special Problems & Professionals Challenges*, Moore and Stratton (2002) *Resilient Widowers*, Brothers (2001) *The Abuse of Men*, Lund (2001) *Men Coping with Grief*, Kramer and Thompson (2002) *Men as Caregivers*, Pritchard (2001) *Male Victims of Elder Abuse*, and Diamond (1997) *Male Menopause*.

Psychologists, and their professional organizations, seem to be leading the way in attention to the problems of males. The *Handbook of Counseling and Psychotherapy with Men* edited by Scher, Stevens, Good, and Eichenfield (1987), *A New Psychotherapy for Traditional Men* by Brooks (1998), and *Husband Focused Marital Therapy: An Approach to Dealing with Marital Distress* by Rugel (1997) are among the few texts on professional intervention with men. The American Psychological Association established The Society for the Psychological Study of Men and Masculinity that seeks to challenge restrictive gender roles leading to negative consequences, harmful activities, unhealthy interactions, and oppression of others.

Among the limited social work material is an article on males by Lichtenberg (1995), in *The Encyclopedia of Social Work*, where it is suggested that contemporary males are fearful of intimacy, dependency, and vulnerability. The result can be psychosocial dysfunctioning including mental illness, alcoholism, and criminality. In the same publication, Chestang (1995) discussed the fact that "[Social] changes among men are not being accomplished without significant conflicts and challenges" (p. 1702). While some might respond with anger or denial, he states, "others are beginning to seek professional help in coming to terms with their own fears and

needs, turning to therapists and mentor/coaches, including professionally trained social workers, for assistance in finding more fulfilling and effective lives" (p. 1702). Not addressed is whether there are professionals with appropriate skills, knowledge, and positive attitudes for effective work with males.

Problems Faced by Minority Group Males

Two books that focus on professional practice with African American men are *Social Work Practice with African American Men: The Invisible Presence* by Rasheed and Rasheed (1999) and *Working with African American Males: A Guide to Practice* edited by Davis (1999). These texts present a positive, balanced, and applied approach to the problems of African American males, and underscore that there are special problems facing minority group males, both native and foreign born, and challenges for professionals working with such men.

Older males from minority group backgrounds, no less than such females, may face the frustrations from subtle and overt discrimination that impede their ability to provide for themselves and their families. For members of minority groups, there can be a perception of social prejudice and suspicion of a service system believed to be representative of an unsympathetic and discriminatory society. For example, "Black clients may be uncommunicative, not because they cannot deal with their feelings, but because the context involves a representative of a traditional 'White' institution that they never had reason to trust" (McGoldrick & Giordano, 1996, p. 21).

The nature of one's upbringing (including family and culture) has profound implications on the quality and length of one's life. African American or Hispanic males are over-represented in prisons, detention centers, in probation and parole systems, and are more likely to face violent death (Cose, 1995). Minority group males may be high risk for other adversities, such as prostate cancer, diabetes, violence, homelessness, and incarceration (Davis, 1999). Compared to White males, minority group males may receive less intensive and poorer-quality medical care for a broad range of conditions (Williams, 2003). Gornick (2003) concludes from her study of Medicare utilization by men that "analyses

of health care utilization point to the profound effects of race, ethnicity, and SES on access to and use of health care services, even among individuals with health insurance coverage" (p. 758).

Professionals working with persons from culturally diverse groups have known that a professional's age and racial, religious, or ethnic background can influence the utilization, continuation, and effectiveness of interventions (Matsuoka & Sorenson, 1991). So, too, might the gender of the professional have an impact (Kosberg & Morano, 2000). To be sure, the professional's competence is more important than gender; yet, gender is a consideration. For example, Baptiste, Hardy, and Lewis (1996) have suggested that inasmuch as Caribbean societies are patriarchal, males coming from Caribbean countries are often uncomfortable with female professionals, regardless of their skills and experience. On the other hand, Brice-Baker (1996) suggests that "since the domain of females is considered to be the emotional well-being of the family, a female therapist could be accepted and have validity" (p. 94). Accordingly, disclosure by a male client or patient to male professional could result in a "loss of face."

In a study undertaken in a group treatment program for substance abusers that included males and females from diverse racial, ethnic, and religious backgrounds, it was found that males were inactive in the group and had high drop out rates (Kosberg & Dobson, 1993). Based upon limitations in speaking and understanding English, a lack of desire or inability to articulate feelings, and shyness around females, some minority group males were especially reluctant to join or participate in the program that was dominated by females. Additionally, research is needed to explore if the characteristics of a group leader (including gender) can influence the rate of male participation in the program, especially those males from racial or ethnic minority groups.

The introductory chapter of the book, *Social Work Practice with African American Males*, by Rasheed and Rasheed (1999), presented a summary of social statistics that beg for professional concern and social action. Indeed, Allen-Meares and Burman (1995) sounded an appeal for widespread social work action on behalf of "endangered" African American men. These realities are not necessarily a result of one's race or ethnicity, but rather are due to poverty, discrimination, and societal inequities in educational,

social, and health care systems. Those in helping professions need to focus upon both causes and consequences of such issues that "victimize" males (as they do females) from different minority group backgrounds, if not all from economically disadvantaged backgrounds.

Immigrant males face unique problems. Gil and Vega (1996) have written about the acculturation stress within Cuban and Nicaraguan families involving conflicts between different generations of male relatives. The problems of Caribbean male immigrants in the Miami Area have been discussed (Albertini, Kosberg, & Frederick, 1999) as resulting from a difficulty, or reluctance, to change one's gender-role attitudes and behavior from those found in traditional Caribbean cultures to those that emphasize gender equity in the U.S. Additionally, often such males encounter racial prejudice and poor employment opportunities, and can become dependent upon the females in their family. Consequences have been found to include marital and relationship problems (i.e., abuse, divorce), addictive behavior, criminality, and mental illness (Farrell, 1993). Finally, it needs to be pointed out that as a result of workplace preferences often given to women and minority group members (of both sexes) in the name of "political correctness," and the growing proportion of racial and ethnic groups of males, heterosexual non-Hispanic White males are increasingly becoming members of a new minority group. This will certainly be true for older men.

Reaching Out to Older Men

The research findings and practice experiences in working with and for older men has increasingly produced, both directly and indirectly, a better understanding of the reasons for the underutilization of needed community resources by older men. They are less likely to admit having problems, seek professional assistance, actively participate in interactive therapies, and remain in treatment programs (Baptiste, Hardy, & Lewis, 1996; Courtenay, 2003). Referring to medical counseling, Courtenay (2001) suggests that men and women differ in their perceptions of their health, and he advocates for gender-specific interventions that meet the

particular gender needs of individuals. Corney (1990) indicates that women have more confidants than men and more contacts with social agencies, and find it easier to confide in others about social or psychological problems. Moreover, older men who are married have been found to be involved in health and social services more so than those who have never married (or are widowers or divorced).

Influenced by culture of upbringing, traditional male values often emphasize stoicism, independence, self-reliance, and strength, and males often believe that they should not admit to having problems, show fear or sadness, or seek out assistance from others. Accordingly, there are significant challenges facing professionals who wish to assist older men with their problems. Males can be reluctant to open their inner most feelings in front of females, while others are resistant to verbalizing their concerns in front of other males. All these issues need to be considered in the helping process that pertains to older men's help-seeking behavior and utilization of services, and the effectiveness of various forms of intervention.

Problem Definitions

There is some suggestion that older males, especially those from minority group backgrounds, are less likely to recognize and label nonspecific feelings of distress as problematic. Men are less likely to seek help for problems as diverse as depression, substance abuse, physical disabilities, and stressful life events. Additionally, some conditions (i.e., homosexuality, sexual dysfunction) are met by denial or embarrassment. There are indications that present problems resulting from one's past life style or deviancy are denied or suppressed. For example, this can include failure to seek help for breathing difficulties caused by long term smoking or malnutrition as a consequence of heavy drinking.

Although research findings vary, there is some suggestion of differences in coping mechanisms between males and females (Courtenay, 2003). Such mechanisms can include rational problem-solving, emotional reactions, use of relationships, spirituality, denial, and stoicism, among others. The denial of health

problems by males has been written about with regard to sexual dysfunction and depression. Lipsyte (1999) indicated that men deny their problems and advocated that they need to acknowledge their problems and consult health care professionals.

Help Seeking Behavior.

Even though acknowledging their problems, older men are still less likely to seek help for problems such as depression, substance abuse, physical disabilities, and challenges associated with daily living. Among explanations for the inability of men to seek and use assistance are those that pertain to the stereotypes that men must be independent, stoic, in control, and self-reliant, often taught as part of masculine gender-role socialization. This is especially characteristic of males from certain socioeconomic, ethnic, and racial groups.

The concept of the "normativeness" of a problem has been discussed related to men's desire to seek needed social or medical attention (Addis & Mahalik, 2003). Senator Bob Dole's disclosure of his erectile dysfunction and Mile Wallace's public declaration (or that of Tony Soprano's) about seeking professional help for depression has done much to "normalize" such problems for males, leading them to seek needed assistance.

Other explanations for the lack of help-seeking behavior are related to the importance of one's kinship or friendship systems, the perception of prejudice in the service system, impoverishment, and immigration status. While such considerations are true for females as well as males, prideful self-reliance and strong views of masculinity might make older men especially non-responsive to using traditional community-based service systems.

Tudiver and Talbot (1999) undertook a study of 18 physicians' perceptions of men's help seeking behavior. The doctors saw the importance of the female partner who urged the men to seek medical help. Male patients demonstrated their concerns in indirect rather than direct ways and it seemed as if they were hoping that the physician would ask pointed questions about the reason for the appointment. Men were more likely to seek help if a close friend had recently become ill. The physicians also believed that male patients had difficulty relinquishing control.

Research has documented the qualitative differences between men who are married (or otherwise are in long-term relationships) and those who are not (Hooyman & Kiyak, 2005). The married group benefits from the surveillance by their partners of their physical and emotional conditions. Female partners encourage the males to seek professional assessment or professional assistance. Indeed, unmarried males more so than those married, and males more so than females, have been found to be unfamiliar with community resources and the methods by which to utilize them. Further, males have been found to have smaller informal support systems which have been found instrumental in the use of community resources by older persons.

Interventions.

"There continues to be conflicting findings in terms of the extent to which male caregivers utilize community services to ease the burden associated with maintaining informal supports in the community" (Kaye, 1997, p. 237). Yet, there is a growing body of knowledge regarding methods for better meeting the needs of older men. Some of the knowledge is based upon empirical research findings or on cumulative practice experiences that has either included older men or has been extrapolated from work on younger male populations to older men. In his article on counseling men in medical settings, Courtenay (2001) provides guidelines for the treatment of men that is based upon his extensive review of bio-psychosocial research findings related to men and health. The guidelines include attention to (1) validating or normalizing health problems and concerns, (2) educating men about their health and the need for screening, (3) helping men to perceive risks in their health behavior, (4) identifying formal and informal support systems, (5) customizing plans for the future, and (6) highlighting the strengths of the individual.

Kiselica (2001) wrote about a "male friendly therapeutic process with boys" that might have implications for older men. Based upon the author's experience with White, African American, and Hispanic male clients from rural and urban areas, Kiselica suggested that the "fifty-minute hour" might be too short or too long a time period. At the start of therapy, the time might be too long for the male who is unaccustomed to the formality of a set time period

and who is not ready to engage in meaningful dialogue with the therapist. The formal office setting may be problematic for males who are most accustomed to informality. Other conclusions reached by the author for more effectively working with males involve the use of humor, self-disclosure, issue-specific discussions, and respect for the client's autonomy.

In an article that discusses men, their masculine identity, and help seeking behavior, Addis and Mahalik (2003) identify social psychological processes for developing ways to foster adaptive male help seeking behavior. If a problem is considered "normal" there will be a greater likelihood of seeking help. On the other hand, if a problem is perceived to be "ego central" (that is, related to one's personal masculine norms); a man will be less likely to seek help. Men who believe that they can reciprocate with help to the agency (i.e., financial donations, volunteering) will be more willing to accept assistance. Men who believe that they will be perceived negatively by other men from seeking professional assistance will be reluctant to get such help. Avoiding dependence and maintaining power and control are important to men. The authors conclude by suggesting that service providers need to consider the congruity between the program and the social psychology of men.

Discussing principles for therapeutic work with caregiving men, Femiano and Coonerty-Femiano (2002) include such imperatives as the need for validation, strength building and control, recognizing unexpressed feelings, fostering emotional and social support, and assisting with practical concerns and future planning. Coe and Neufeld (1999) studied the use of formal support services by men providing care to relatives with cognitive impairments and they found acceptance of help took four phases. The first phase, *Resistance*, involves the role of men's personal values and beliefs that prevent them from seeking needed assistance in their caregiving. The second phase, *Giving In*, involves the need to overcome reluctance to seek help from an agency. The third phase, *Opening the Door*, involves identifying and contacting an appropriate professional or agency. The fourth phase, *Making the Match*, involves the ongoing use of formal services and an assessment of the effectiveness.

Organizational Barriers

Once there is a decision made to seek assistance, males can be influenced by the organizational characteristics of social and health service systems. In a study of physicians' perceptions of male patients, it was found that there was a belief that systematic barriers existed in delivery of primary health care that precluded male patients getting proper medical care (Tudiver & Talbot, 1999). Such deterrents included long waiting periods, limited hours of operation, and having to disclose the reason for the visit to a receptionist or assistant. Xu and Borders (2003) found that "waiting times of 30 minutes or longer in a physician's office sharply reduced the likelihood of a man's having visited a doctor" (p. 1077). There is no reason to believe that this would not be true in an office of a psychologist, social worker, or nurse.

Systematic barriers to both social and health services can include attention to organizational availability, accessibility, and acceptability. Damon-Rodriguez, Wallace, and Kington (1994) address appropriateness, accessibility, and acceptability of community resources for culturally diverse groups of older persons, but do not address the importance of gender. This author identifies four elements to organizational use.

1. *Appropriateness* refers to the existence of needed community resources by level of care, intensity, and length of service, and equally pertains to men and women.

2. *Availability* refers to the location, hours, and days of week that a community resource is available to older persons. Inasmuch most adult sons work during the day, they may be unable to take an older parent to a community resource that sees clients or patients from 8 am to 5 pm during the work week. Older males have been found less involved with their families, and have fewer friends; individuals who can provide men linkages with community resources, inform them of community resources, and assist them in getting to the program or service.

3. *Accessibility* refers to knowing about resources, having the necessary finances and insurance, or meeting eligibility criteria to use needed social, physical, nutritional, or mental health services.

Publicity about the existence of community resources (especially if written) in the dominant English language can discriminate against minority and immigrant groups who are either illiterate or do not speak or understand English. Not all males have their own transportation or can afford public transportation.

4. *Acceptability* pertains to the perceived appropriateness of community resources by older men. While this concept has been often used with regard to cultural values and traditions, the fact that some social and health service programs are often dominated by female clients, patients, program participants, and staff, can deter some men from using a resource. In addition, the name or focus of a program has been found to have potential social or personal stigma attached (i.e., alcohol treatment, mental health, marital problems) for some who will be reluctant to be seen entering such agency settings. The auspices of some services (i.e., Catholic Charities, Public Welfare, Salvation Army) can deter some especially prideful older men from taking advantage of resources. Female-dominated long-term care facilities may be unacceptable to some men. It is not only the predominance of female service users that can dissuade use by men, but also the female-oriented activities of the program.

An International Longevity Center report (2004) discussed the appearance of the clinical setting and its congruity with the interests of males. "Accoutrements such as magazines in the waiting room should be male-oriented as well as female-oriented. Artwork and furniture should create a setting that is comfortable for men as well as women" (p. 6). The report further suggests that there should be male as well as female employees to avoid the appearance of an "all female" environment.

The concept "portent of embarrassment" has been used to describe the perception that one is inappropriate for a particular social or health service. In general, this term has been used with regard to chronological age or socioeconomic status. While in some cases a perception of being inappropriate is a figment of one's imagination, there are situations where the majority of clients, patients, or program participants do not welcome certain individuals. Given the fact that many community services are female dominated, it is reasonable to believe that some men may believe themselves to be inappropriate, or may—in fact—be

unwanted (i.e., support groups for recently divorced or widowed; therapeutic treatment groups for abuse victims or for substance abusers).

Professional Biases

It has been found that men may not be attracted to certain types of treatment modalities, such as psychotherapy, support groups, and other forms of interaction that require the articulation of feelings in the presence of others. There is some disagreement whether the likelihood of male involvement is less likely if others in treatment are females or males. The cultural background of males can influence their willingness to articulate feelings in the presence of other males or in the presence of females.

Further, congruity in the characteristics of professional practitioners in relation to the gender of their clients or patients has not been fully explored with regard to the helping process. This is to suggest that congruity in gender might be as important as age, race, religion, and socio-economic status, among others, in the acceptance of professional assistance. Here, too, the cultural background of the male client or patient may have an impact. For example, a young female Anglo professional may be treated with disregard, embarrassment, condescension, or as a daughter or granddaughter (and not taken seriously) by an older Hispanic client or patient.

There is some suggestion of bias against older men by those in the helping professions, and the possibility of sexism (against males) and ageism (against older persons) is not inconceivable. Williams (2003) reports that in emergency rooms, men with depressive symptoms are more likely than women to be hospitalized, and that women with antisocial behavior or substance abuse problems are more likely to be hospitalized than men with similar symptoms. Williams goes on to suggest that health care professionals spend less time with male patients than female patients, provide men with fewer services and health information, and offer less advice on changing health behavior.

Wisch and Mahalik (1999) introduce the possibility of bias against male clients and patients by male professionals, suggesting that a male therapist's diagnosis and prognosis are related

to the empathy and comfort he has with a male client. This willingness to work with the male client is, in turn, related to the client's sexual orientation and emotional expressiveness, and the therapist's gender role conflict. The authors conclude that there is a need to incorporate female therapists and clients to broaden the exploration of gender role issues between clients and patients and professional helpers. Brooks (1998) discusses the nuances of both female and male therapists with men, and concludes that while there are differences, both need empathy and a sense of responsibility and commitment. Heppner and Gonzales (1987) have addressed practice issues when men counsel men and Carlson (1987) has written about women therapists with male clients.

It is possible that males are relatively unfamiliar with community services, especially more in-depth therapeutic interventions. Confusion and apprehension about professional interventions add other stumbling blocks to the admission of a problem and desire to seek help. Peer groups have become increasingly popular in the U.S. for those with certain personal and/or social problems, or for those who care for such persons, but males have generally been unresponsive to such interventions (Barusch & Peak, 1997). Research has found that peer group-type interventions have generally reached and served a biased segment of the population: Those who are better-educated and affluent English-speaking Whites. Yet, even such males have been found reluctant to seek such assistance (Davies, Priddy, & Tinklenberg, 1986).

Implications

This article advocates for increased attention to the needs of older men and the methods by which formal services and programs attempt to reach and serve them. As stated earlier, such a concern emanates not out of a "male power" perspective, but from the concern about the overlooked needs of a particular group. In addition to advocating for an awareness of the problems of older men, the author suggests that there are many considerations for professional practitioners, educators, researchers, and students, to better understand, reach, and serve such populations. Greater attention to the needs of all males in society, including

those from minority groups, can be seen as an investment in the reduction of societal problems.

The preponderance of male suicides, and their overall shorter lifespan, results in prodigious consequences for their children, spouses or partners, and has economic consequences for society. The extent of their alcoholism, drug use, depression, and other emotional problems also impede their interpersonal functioning and can result in adversities of omission and commission against others. Professionals should realize that preventive, as well as interventive, efforts will not only assist males, but their children, spouses, parents, and significant others as well.

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