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Principles of Clinical Practice with Older Men

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Older men are much less likely to be aware of community services available to them and they are less likely to utilize services generally. This underutilization is affected by the way in which social services are organized and how practitioners function within them. Since there are greater numbers of elderly women and women utilize services more readily, practice tends to be female-centered. It is important that gender-sensitive intervention processes are established that recognize the unique experiences and concerns of older men in order to better serve them. The uniqueness of men's experiences with such issues as loss of a spouse, retirement, caregiving, and victimization warrant particular attention by gerontological practitioners. Male-friendly interventions that take into account traditional male values will foster greater participation and better quality care for older men.

Key words: elderly men, services, interventions, participation

Setting the Context

While it may seem counterintuitive to write about the clinical needs of older men given the advantages afforded them by society over older women, it is essential to note that older men have tended to be underserved as a population and remain largely invisible to social service providers in the community (Thompson, 1994). Social service workers interact with fewer older men in their professional role. In part, this is due to the larger proportion

of older women surviving into later old age. However, it is also noteworthy that older men are less likely to be aware of existing community resources and less likely to seek out such resources even if their existence were known. As Strain and Blandford (1999) found, older male caregivers were less likely than their female counterparts to be aware of community resources available to them. These kinds of service knowledge and utilization patterns are even more pronounced for older men of color who have historically experienced an additional set of barriers to accessing services that are racially derived.

Secondly, the configuration of social services is one that may not necessarily be "male friendly." For example, according to U.S. Department of Labor statistics, the social assistance industry employed 2.8 million people and of those employed in this industry approximately 86 percent were women (U.S. Department of Labor, 2003). Services are often not designed to reach out to older male clients and older men may see seeking out services as admitting personal weakness. Older men, especially older caregivers, tend to be more suspicious of government-run services (Kaye, 2002).

It is against this backdrop, that eight areas of particular concern for working with older men are considered below. It is argued that these areas, in particular, warrant special consideration by clinicians in their daily practice.

Principles of Practice with Older Men

A common theme running throughout this article pertains to the social expectations of the manner in which older men should behave with respect to their roles within communities and their own families. These expectations can help a man feel comfortable in knowing what expected behavior is and how to carry out his role. However, both developmentally normative and non-normative events occur that can contribute to men redefining themselves and the roles they fulfill. As such, practitioners who work with older men need to be cognizant of their own biases and expectations of older men. Intervention strategies need to be informed by research and augmented by the personal experiences of working with older men.

Practitioner bias affects not only whether or not services are delivered but also how effective and helpful those services may be to an older man. A female-centered intervention philosophy within the research community often extends into the service community rendering older men largely invisible and underserved (Thompson, 1994). While women often experience more difficulties associated with the aging experience, this does not in itself guarantee that older men are immune from the concerns and effects of growing old (Kaye, 2000). This is an important concept to keep at the forefront of intervention work. Practitioners need to remain mindful that many older men experience considerable stigma attached to seeking services and depending on their particular circumstances and inclinations, this may have kept them from taking advantage of needed services in the past.

Another consideration running through the topics to be presented is the importance of understanding the unique experiences and concerns of older men. Given that older men often have different outcomes surrounding milestones and changes in roles, when compared to women, it is important to include those considerations in clinical assessment and screening processes. A gender-sensitive screening process would ideally include explicit consideration of men's areas of strength and vulnerability. In addition, screening would also include exploring important roles in a man's life in anticipation for the change in roles that accompany the aging process.

Practitioners who interact with older men should encourage, in particular, that their clients visit a physician on a regular basis for many reasons. First of all, men tend not to visit a physician as often as women throughout adulthood yet they tend to develop more serious life threatening chronic illnesses than their female counterparts, which means many older men are foregoing the benefits of preventative care (Cherry, Burt, & Woodwell, 2003, National Center for Health Statistics, 2002.; Charmaz, 1995). Second, the mental health complaints being presented by male patients often have physical correlates that require attention from a physician. A case in point is the close relationship between depression, alcoholism, stress and physical decline. Additionally, certain physical conditions can mimic the presentation of a mental illness or can produce side effects consistent with the symptoms

of a mental illness (Wolfe, Morrow, & Fredrickson, 1996). Third, many older men of color, have experienced limited access to health care throughout their lives. Older African American men are of special concern because they have higher rates of chronic illness than their white counterparts and are also more likely to receive inadequate treatment for their medical conditions (Staples, 1995).

Loss of a Spouse

The loss of a spouse at any age is a traumatic, life-altering experience for both men and women. However, later in life, the experience of losing a spouse is often different for men and women. Older women and men use many of the same coping strategies in dealing with loss however the impact of the loss of a spouse and the trajectory of the grief experience varies between older men and women. In highlighting the differences between older men and women, it is also important to keep in mind that most older adults survive the loss of a spouse and adapt in a healthy manner (Hoyer & Roodin, 2003).

Partnering connections in older age The support offered by a spouse may be of particular value to older men compared to support offered by friends. In old age, women tend to have a more varied social support network and often rely on their spouse, friends and family for social support. However, older men have a very different social network and rely less on friends as they get older, spending less time with their friends and seeing friendship as less important (Field & Minkler, 1988). Older men also confide in their spouses more often than women do and as a result, when a spouse dies men often lose a close confidant and a critical companion in his social support network (Robertson & Mosher-Ashley, 2002; Adams, 1994). Given that women tend to live longer than men, Allan and Adams (1989) posit that older women tend to have more support surrounding bereavement because they are likely to have friends who have had similar experiences. Social support during the grieving process facilitates coping and also increases the chances of gaining compensatory support after losing a spouse (Baarsen & Groenou, 2001).

Little research has been done on gay and lesbian couples and the loss of a partner. However, McInnis-Dittrich (2002) points out that life partners are important to gay and lesbian older adults and they play an equally important and valuable role in their lives. As such, the grieving over loss of a partner may be similar for both heterosexual and older gay men. However, for couples who have not openly disclosed their relationship, losing a partner also poses special challenges and many times those individuals may be excluded from being involved in the arrangements that must be made following the death of a partner including both funerary considerations and financial issues (McInnis-Dittrich, 2002).

Grieving and coping strategies While men and women experience similar emotions and affective change during the grieving process, how women and men process the experience of grief can often be a different matter. Women tend to be more *intuitive grievers* and often share their feelings with friends and family members as they move through the grieving process. Men, however, are more instrumental in their grieving which means that following the death of a loved one they may become involved in physical outlets of expression such as hobbies, home projects and problem solving activities. Thus, for men, grief is experienced more intellectually and physically rather than emotionally and becomes more centered on involvement in tangible activities (Martin & Doka, 2000; Gallagher, Lovett, Hanley-Dunn, & Thompson, 1989).

Gass (1989) has found that older men who lose a spouse often utilize different coping mechanisms depending on the type of death that was experienced. For example, older men who have lost a spouse suddenly tend to use more coping strategies than those older men who lose a spouse to a chronic illness. Because loss of a spouse is associated with high levels of distress it is important to recognize avoidant and maladaptive coping strategies in which older men are engaging. Gallagher, Lovett, Hanley-Dunn and Thompson (1989) have found high levels of bereavement stress to be related to use of avoidant strategies such as the use of alcohol and tranquilizers, eating disturbances, and avoiding social contact. Men who experience a loss suddenly also engage in a number of intellectual and physical coping strategies

including becoming problem-focused and engaging in self-blame and wishful thinking. Older men whose wives have died from a longer term illness tend to have more social support available to them as the illness progresses. The opportunity for anticipatory grief may be one that facilitates the grieving process after the spouse has died (Gass, 1989).

The grieving process also varies for men based on their ethnic, racial and cultural backgrounds. Martin and Doka (2000) suggest that culture and ethnic background influence the way one experiences grief and expresses grief. As death rituals vary from culture to culture and religion to religion so too do the coping strategies and norms associated with appropriate grieving. Understanding which institutional, community and familial resources meaningful to each client with regards to their culture will allow practitioners to better serve older adults.

Gass (1989) suggests that intervention strategies with older widowers take into account some of the intellectual coping strategies that are being used and work with those strategies in a way that promotes control and mastery in the grief process. For men engaging in self-blame it may be useful to foster activities that will promote a more adaptive sense of control (i.e. hobbies, classes, work). These activities would promote a sense of control but also these activities are in line with the instrumental grieving in which many men engage. The use of more behavioral strategies in managing grief tend to be used by men most often in the initial months following the death of a spouse (Gallagher, Lovett, Hanley-Dunn, & Thompson, 1989). Gallagher and colleagues (1989) posit that older men may experience an initial grief reaction characterized by suppressing emotional response. As men move through grieving, they tend to utilize more emotional coping strategies (Baarsen & Groenou, 2001). Recognizing a window of opportunity for processing emotional grief may be an essential part of intervention with older men. For men who are relying on instrumental grieving processes, talking about their emotions is not as helpful as talking about "problems" and staying problem focused (Martin & Doka, 2000). Practitioners are cautioned not to ignore the opportunity for an androgynous and holistic approach to grief work. Tapping into intuitive grieving strategies may provide a useful opportunity for men to address the underlying emotional process.

Retirement

Retirement for older men is an issue of particular importance set against the backdrop of societal values that dictate the definition of manhood and masculinity. This dominant societal and often internalized definition of manhood often includes constructing a work-centered identity, one that derives its value from the achievements, accomplishments and power that work brings, or should bring, to a man's life. With retirement comes many losses including the loss of income, social support, and for some the loss of directed and goal-oriented activities (Gradman, 1994). However, retirement can also be a time of reinvestment in new productive and goal-oriented activities and also a time to re-explore activities. As Vaillant (2002) suggests, retirement need not be and often is not a stressful life event in and of itself. However, special situations regarding retirement warrant attention. For example, retirement can have a detrimental impact on social support for men who largely comprised their social network of friends from their place of employment. As many men form friendships based in the workplace, replacing those friends after retirement will often be contingent upon new roles and activities that place them in contact with others (Wright, 1989).

Cultural considerations and retirement The experience of retirement is something that is intimately related to economic, racial and ethnic background. If one's culture dictates a sense of worth tied to the ability to provide for family members, as it often does in the African American community, then retirement is a time of important redefinition (Hines & Boyd-Franklin, 1996). Additionally, for those in lower socioeconomic classes, primarily men who work in manual labor type jobs, retirement may be a forced experience mandated by aging and physical decline. Many older men in lower socioeconomic classes who continue to work do so out of economic necessity (Solomon & Szwabo, 1995).

In addition, because many jobs that people of color hold are not necessarily covered by social security benefits, people of color are more likely than their white counterparts to experience poverty in old age. The racial breakdown of poverty in old age illustrates the connection between race and the experience of poverty in one's later years. African Americans represent 34% of

the older adults who live at or below the poverty level while Hispanics represent 21% of this population as compared older white adults who comprise 11% of all older adults living in poverty (U.S. Census Bureau, 2000). As compared to white retirees, African American men tend to not have access to formal retirement plans, they are less likely to consider themselves retired, and many need to continue to work for financial reasons (Gradman, 1994). Not surprisingly, those men who retire in good health, with adequate financial and social resources and a planned retirement, fare better than those who retire without those resources (Morgan & Kunkel, 2001).

Retirement, like many other life changes, does not necessarily mean stagnation or disruption in life activities. On the contrary, a continuity perspective would suggest that with retirement comes a redefining period and the maintenance of familiar ways of doing things and going about life. Intervention strategies based on continuity constructs tell us that working with older men does not mean that life stops at retirement but instead requires adaptation in how life activities will be carried on when familiar work activities cease. This could mean discovering new ways to carry out former work activities possibly through hobbies, volunteer work and or part-time employment (Morgan & Kunkel, 2001).

Depression and Suicide

While older women are more likely than older men to develop depression, there is some research that indicates that depression for older men may have more devastating effects on mortality. It is estimated that as many as 16% of older adults experience some form of depression and while women make up the bulk of this population, male rates of suicide tend to be higher than female rates of suicide and these rates are rising (Coren & Hewitt, 1999; Department of Health and Human Services, 1999). In addition, there exist disparities between treatment for depression in older men and women. Specifically, clinically depressed older men do not receive treatment as often as older women which makes this topic particularly essential for practitioners to understand and address in older men. In addition, older African Americans and Latinos are also less likely to receive treatment for depression when compared to their white counterparts (Unützer et al.,

2003). Depression may go unnoticed because: 1) older adults, particularly men, may be less likely to talk about psychological distress while tending to more readily discuss physical ailments; 2) physicians who often have the first contact with a depressed adult often focus more on somatic complaints than psychological issues; 3) symptoms of medical conditions are similar to those of depression; and 4) stigma associated with having a mental health diagnosis may inhibit seeking treatment (Moutier, Wetherell, and Zisook, 2003; Wolfe, Morrow, and Fredrickson, 1996).

Physical and experiential correlates Depression for older adults can take on a somatic presentation, however it is also important to realize that many times depression is experienced in association with other physical ailments. Because older men may not be as likely to express their feelings, the expression of physical complaints may be the manner in which depression first presents itself. In addition, depression in older adults may manifest itself differently from depression in younger age groups. Older adults with depression may present with symptoms such as irritability, anxiety, agitation, social withdrawal, rapid change in functionality or memory complaints (Moutier, Wetherell, & Zisook, 2003; Wolfe, Morrow, & Fredrickson, 1996). Furthermore, many older men may be experiencing depression due to the physical aging process and not necessarily the outcome of any specific loss in their lives. Research suggests a complicated link between age-related declines in testosterone levels and depression (Shore et al., 2004; Kaneda, 2003, Carnahan & Perry, 2004). While the link between depression and testosterone is in need of further investigation, best practice would dictate that practitioners working with older depressed males enlist a physician to become involved in the treatment plan.

Depression is often linked in a complex manner to adverse life events related to losses that accompany the aging experience. Such losses may include loss of friends, a spouse, decreased physical functioning, declines in health and or loss of professional identity (Moutier, Wetherell, & Zisook, 2003; Zarit & Zarit, 1998; Wolfe, Morrow, & Fredrickson, 1996). However, despite these losses, Moutier and colleagues (2003) warn practitioners that depression should not be viewed as a normal reaction to life events.

In doing so, many practitioners neglect the severity of depression as an illness and also place older men at risk for committing suicide. For many older adults, independence is an important consideration and many older men may be afraid to discuss depression with a counselor or physician out of fear of losing some sense of independence. Zarit and Zarit (1998) suggest that when working with older depressed clients the clinician should focus on developing strategies for the client to cope with threats to independence including allowing these clients to maintain a sense of control within the treatment process. Additionally, because social support can buffer the effects of stress and loss in one's life, clinicians working with older men need to address ways to keep men from becoming socially isolated during times when experiencing loss (Alpass & Neville, 2003; George, 1993)

Suicide The suicide rate among older men is alarming and accounts for approximately 85% of all suicide among older adults (Coren & Hewitt, 1999; Department of Human Services, 1999). According to the Department of Health and Human Services (1999), the highest rates of suicide in the United States are among white men over the age of 85. Older men at particular risk for committing suicide include those who are divorced or widowed, socially isolated or have a history of previous suicide attempts (Department of Health and Human Services, 1999; Osgood & Theilman, 1990).

Depression and suicidal warning signs among older men in particular may go unnoticed. One striking observation is that 70 percent of those older adults who commit suicide had visited their primary care physician within a month of committing suicide (Department of Health and Human Services, 1999). Practitioners working with older men need to be keenly aware of the risks for suicide as well as perform careful mental health assessments in older men. Moutier, Wetherell, and Zisook (2003) suggest that practitioners pay particularly close attention to older adults who may be experiencing symptoms of depression.

Substance Abuse

Older men abuse alcohol at a higher rate than older women and men with substance abuse issues are a population of partic-

ular concern because substance abuse is often co-occurring with other psychosocial issues in one's life (Department of Health and Human Services, 1998). For example, older men who engage in substance abuse are more likely to live alone, be widowed and tend to be more isolated than those who are not engaging in substance abuse. The relationship is complex and often difficult to ascertain whether isolation lends itself to substance abuse or if substance abuse is causing the person to become more isolated (Barusch, 2000; Hanson, 1994; (Department of Health and Human Services, 1998). In addition, late-life alcoholism is related to losses in one's life particularly the loss of a spouse (Barusch, 2000; Martin & Doka, 2000; Perkins & Tice, 1999). Those also at increased risk for experiencing substance abuse include older men who were never married and men who reside in veteran's hospitals and other residential facilities (Butler, Lewis & Sunderland, 1991). Comorbid occurrences including dementia, Alzheimer's disease or a mental health diagnosis may cloud recognition and subsequent treatment of an older adult's substance abuse problem (U.S. Department of Health and Human Services, 1998).

Recognition that substance abuse is occurring can be difficult for many reasons. First of all, many practitioners working with older adults hold faulty beliefs that substance abuse does not occur in older adults. However, quite contrary to this, older men drink for many of the same reasons that younger men drink. Second, the effects of alcohol in older adults often present themselves in a way that is similar to changes occurring as a result of the aging process including confusion, changes in memory, or unsteady gait (Perkins & Tice, 1999).

Medications and substance abuse While alcohol is widely mentioned in the geriatric literature on substance abuse, the abuse of prescription medications by older adults is another area of growing concern. Older adults are using prescription drugs at a rate three times that of the general population. Many older adults do not intend to abuse their prescription drugs. Instead, it is a combination of factors that influence the abuse and misuse of prescription drugs. For example, older adults have poorer compliance rates with medications and tend to use prescribed medications for longer periods of time and for more chronic

medical conditions than their younger counterparts. Additionally, poorly informed prescribing practices by physicians put older adults at risk. Unknown to some medical professionals, age-related changes in metabolism can result in older adults needing smaller amounts of a prescription drugs to elicit the desired affect. Furthermore, some physicians may misdiagnose presenting problems because they fail to recognize the impact that the aging process can have on symptom manifestation (National Institute on Drug Abuse, 2001; Department of Health and Human Services, 1998).

While there may be some bias against the ability of an older adult to alter his life with respect to problem drinking and substance abuse, research suggests something quite to the contrary. In fact, those older men who do seek outpatient treatment tend to experience advantageous outcomes in treatment and in some cases these outcomes, including compliance and attendance rates, are superior to those experienced by their younger counterparts (Brennan, Nichol, & Moos, 2003). Treatment goals for older adults are very similar to those used for treating younger clients and may include stabilizing or reducing alcohol consumption, treating any coexisting psychological conditions and strengthening the patient's social supports (Schonfeld and Dupree, 1999).

Physical Health Changes

For many older men, coping with physical changes may be difficult and challenging. For those who work in manual labor professions, loss of health can equate with not only loss of independence but also loss of income and work-related identity. Concern about one's health status and concern about access to healthcare has been linked to suicide among older adults (Osgood & Theilman, 1990). In addition, populations who are institutionalized due to poor health have higher rates of depression (Zarit & Zarit, 1998). For these reasons, physical health concerns cannot be left out of the treatment picture for older adults.

The leading causes of death among older men, in some cases, are preventable given timely access to quality health care. The top three causes of death for white, African American, Asian and Pacific Islander, and Hispanic older men are, in order of rank, heart disease, cancer and stroke. For American Indian and

Native Alaskan older men the top ranking diseases are heart disease, cancer and diabetes (Federal Intraagency Forum on Aging Statistics, 2000). However, research pertaining to utilizing health care services points to not necessarily a problem with seeking medical care but rather gender differences in behaviors that are destructive to health. So, even though women do use medical services more often than men this has been found to not be related to increase mortality in men. Instead, biological and behavioral factors are most likely to account for differences in health in old age. Behaviors that extend over one's lifetime may contribute, in particular, to health status in old age. For example, more men than women smoke and drink heavily and men tend to have occupations throughout life which require more physical labor and the possibility for physical harm (Waldron, 1995). In terms of access to health care, many older adults of color are at risk of not receiving critical health care. According to the Federal Intraagency Forum on Aging Statistics (2000), as many as seven percent of Hispanic older adults who qualified for Medicare and nearly 10 percent of non-Hispanic African American older adults reported that they delayed obtaining medical care because of the medical costs compared to five percent of non-Hispanic whites.

The loss of physical health is a challenge to traditional formulations of masculinity. Thus, as a response to losses in function and health, older men begin to redefine who they are and how they perceive their own masculinity. For example, Gerschick and Miller (1995) found that men with disabilities often redefined their own masculinity and independence into a more congruent perspective in accordance with their own abilities and strengths. In coping with illness and disability many men redefine themselves and their lives in a way that reconciles differences in their past and present selves. Many older men aim to decrease the visibility and impact that disease is having on their lives. All of these strategies work to maintain the past self as well as facilitate a new reality that is as close to their prior functional lives as possible (Charmaz, 1995).

Sexuality Changes/Challenges

Age-related changes in sexuality also challenge traditional notions of masculinity and for some older men their sexual identities

adapt and change throughout old age. In discussing changes in sexuality it is important to recognize that individual changes in sexuality take place against the backdrop of a society that stigmatizes and pathologizes older adult sexuality. Mayers and McBride (1998) discuss the stereotypes that are prevalent in society surrounding older adult sexuality. Many older men are viewed as either asexual or intensely sexual such as the "dirty old man" stereotype. Prevalent messages that exist portray that sexuality is only for the young and that older adults are not interested in sex. Of special concern are those older adults who are living within institutions. Those older men who exhibit sexual behavior, especially those with a mental health diagnosis, may be labeled and stigmatized by staff members as being "perverted" or "disgusting" because of their sexuality or desire to continue to engage in sexual expression with other residents (Mayers & McBride, 1998). Fortunately, in response to federal policy regarding sexual expression in institutional settings, these conditions are changing and development of staff education and training surrounding these issues continue to develop as well (Schiavi, 1999).

The impact of aging related changes in sexuality, much like other changes mentioned here in this chapter, can often be mediated by a loving relationship with a spouse or partner. Changes in sexual functioning that come gradually and in the context of a relationship characterized by sharing and mutuality may stave off negative experiences related to sexuality (Marsiglio & Greer, 1994). In fact, sexuality can be heightened for older adults by refocusing on caressing and caring touch. Tender connections with a partner, for heterosexual as well as gay and lesbian couples, can enhance sexuality (Papalia, Sterns, Feldmen, & Camp, 2002). Such touch often challenges conceptions of the sexual relationship that one should have with a partner.

Older Gay Men Research regarding the well-being of older gay men suggests that they do not tend to be more depressed or alienated from the gay culture of youth and vitality. In contrast, older gay men tend to draw much support from friends and networks developed within the gay community as opposed to family members and this must also be kept at the forefront of intervention strategies with older gay men (Schiavi, 1999). Older gay men face

special challenges when in need of health care services. Due to the prevalence of homophobia, some gay men may be forced to hide their sexual orientation from those who provide care for them. Specifically, institution or home care staff may interact differently with gay individuals depending on personal bias and prior training related to older adult sexuality. Adverse reactions to an older adults' sexuality may have an impact on the health and well being of an older adult. Older gay men risk becoming isolated, depressed, and suicidal when faced with homophobia from health care staff and residents (Sales, 2002). Homophobia in home health care and residential facilities affects well-being by robbing the resident or consumer of the ability to state their needs with regards to care and also restricts the involvement of a partner in that person's care. Practitioners working with older gay men are encouraged to seek out appropriate training with regards to gay male sexuality including best practice methods for addressing the needs of clients in a way that is characterized by acceptance and warmth and without judgment. It should be further advised that exploration of relationships that are important to an older man should be carried out in an unobtrusive manner and with great respect for confidentiality (Sales, 2002).

Older Men as Caregivers

Caregiving for men is a topic of special concern because male caregivers have historically been left unrecognized within the caregiver literature. When men take on the caregiving role they often have less support in doing so and also face the challenges of a changing role within their relationship with the care receiver particularly if that person is their spouse. Additionally, caregiving responsibilities can have adverse impacts on the well-being of older men compounded by lack of support and recognition in this role. Consequently, many men are at risk of stress-related effects and decline in psychological well-being and emotional support (Kramer, 2002). In particular, those who are providing care for another person, especially those providing care for someone with dementia, are at increased risk for developing a depressive disorder. Being a caregiver is stressful and being a caregiver for someone who is in the later stages of dementia is particularly taxing (Wolfe, Morrow, and Fredrickson, 1996).

Male caregivers often are confronted with a period of adjustment when they first take on caregiving responsibilities. Kramer (2000) suggests that this adaptation period may level off as older men begin to become more comfortable in their role as a caregiver. In fact, when compared to older men who had spouses in an institution, male caregivers tended to fair better in terms of their psychological well-being. These findings suggest that once men adapt to their new roles that there may be a need to explore other care options and alternatives that will help them maintain their roles as caregivers rather than turn to an institution to assume the full responsibility of care.

Many male caregivers are not able to access services that would help them to continue to provide care to their spouses. This is especially true for older men of color who are caregivers seeking services. Barriers to service utilization by men of color include differences in spiritual beliefs between the caregiver and those within the service system, lack of knowledge of resources available, and mistrust in the system (Kaye, 2002).

For many older persons of color, issues relevant to the relationship with direct service providers may impact their ability to seek out follow through in the service utilization process. Such factors include characteristics of the service provider that may discourage interaction such as the clinical dynamics in particular treatment settings, and lack of worker knowledge or sensitivity to cultural, ethnic, racial, or socioeconomic issues. Barriers to services, as discussed above, may also be similar for older gay men who are caregivers. Issues such as discrimination or lack of sensitivity to the gay man's experience may also create barriers to accessing services (Kaye, 2002).

Older Men and Victimization

Elder abuse and victimization is becoming a topic of increased attention among researchers. However, most of the research is focused on the victimization of older women. While women are more likely to experience a majority of the types of abuse, older men are disproportionately represented among those older adults experiencing abandonment (Mouton, et al, 2001). Violence against persons over the age of 50 makes up approximately 14 percent of the violent crime in the United States (Bureau of Justice Statistics,

2002). According to the Bureau of Justice Statistics (2002), men experience more violent victimization than women. While women are more likely to experience violence at the hands of someone they know, men are more likely to experience violence, particularly assault, by someone they have never met before. Persons of color, particularly African American and Hispanic men are at greater risk of experiencing violence than their white counterparts (Bureau of Justice Statistics, 2002). These data indicate the need for intervention on the personal level and utilization of strategies that emphasize a systems approach. Practitioners who have contact with older men, particularly African American and Hispanic men, are encouraged to engage in discussion surrounding safety with their clients.

Working with men who have been victims of violence also means discussing how this violence has shaped their lives. In a study conducted by D'Augelli and Grossman (2001), 65% of older gay, lesbian and bisexual older adults report experiencing some type of victimization, ranging from threats to assault, in their lives. Older gay and bisexual men were more likely to have experienced physical violence in their lives than older lesbian and bisexual women. D'Augelli and Grossman (2001) also found past victimization to be related to current mental health and well-being. As such, any work, including life review (discussed below) performed with GLBT clients should be attuned to exploring the possibility of such victimization. As recommended by D'Augelli and Grossman (2001), this should be done in an environment that is sensitive to GLBT issues and non-judgmental. Additionally, exploring past abuse and victimization may be an opportunity for older men to discuss any current victimization they may be experiencing.

Principles of Practice with Older Men

Life Review

From a developmental perspective, working with older men often involves understanding how their lives change and they adapt to new situations. This process is often informed by various developmental perspectives including Erikson's theory of adult development. According to Erikson (1968), older adults enter

into a period of *ego integrity* versus *despair* which occurs when they look back on their lives and evaluate what their life's work has been in either a positive or negative light. This "life review" as coined by Butler (1963), is the central tenet of the common therapeutic intervention of life review therapy. Many gerontological practitioners use this method of treatment to facilitate introspection into one's life and facilitate positive reminiscence of one's life work.

Peck (2001) outlines the process as one that increases well-being through reviewing life's events and reconciling with past events as well as tackling discrepancies in perceptions of oneself in relation to past and present life events. The life review may entail facilitating that evaluation process and focusing on ways an older man can create meaning and value in his life through appraisal of past events. This could mean exploring new roles or ways to make old roles more valuable and meaningful in the lives of your clients and resolution of past life conflicts (Butler, 1963). Modifying the life review process for older men might usefully entail examining the impact of the eight areas of vulnerability. In fact, Knight (1996) suggests that life review may be appropriate for those seeking to redefine themselves much like men who are facing changes in marital or partner status, those facing health related decline, and those experiencing changing roles due to caregiving and retirement. Life review techniques can also be altered to accommodate the needs of gay men to include exploration of topics related to health, spirituality, myths surrounding homosexuality, disclosing sexual orientation and family issues (Galassi, 2001). Caution should be used when attempting this intervention especially for those older men who have experienced traumatic events in their past (Galassi, 2001).

Group Strategies

Research indicates that men, like their female counterparts, can benefit from group intervention strategies. Kaye and Applegate (1990) report that male caregivers who took part in support groups reported that they felt their caregiving stress was reduced by participating in the group and the majority of those participating said they felt comfortable sharing their experiences in a group setting. Additionally, Leszcz, Feigenbaum, Sadavoy and Robin-

son (1985) have found that elements of life review can be successfully integrated into group psychotherapy with older men. The group method of psychotherapy may be beneficial in not only improving emotional and mental health well-being but also in combating social isolation. This method seems to be especially effective when utilizing co-facilitators (Leszcz, Feigenbaum, and Sadavoy, 1985).

However, Kaye and Applegate (1990) also suggest that many men may be initially resistant to making use of support group programming. This resistance was attributed to traditional male values that dictate independence and reluctance to share personal experiences. Interestingly enough, those men who do attend such groups, do so on a regular basis. It is key to engage men through targeting methods using customized outreach efforts specifically aimed at men, focusing on providing concrete and practical information and utilizing male group members to recruit others to the group (Jacobs, 1989).

Male-Friendly Interventions

Characteristics of male-friendly intervention strategies include services that take into account traditional male values that may exist and how they have affected men's lives. While female-oriented interventions include opportunities to discuss feelings and connect socially, men prefer opportunities to problem-solve and gather information about a topic as well as serve as an "expert" to other men. In this respect, group strategies may work best for some men. Groups that are offered can best be promoted as educational as well as an opportunity to share information about a given experience in a way that will help participants problem-solve. In addition, Barusch (2000) points out that many older men are not comfortable with spontaneous and open sharing of emotions in a group setting. For this reason, intervention strategies should incorporate expressions of emotion that are somewhat ritualized and comfortable. These ritualized expressions of emotion may include a hand shake or hug at introduction or closing and will allow older men to feel safe in expressing such emotion without judgment. Intervention strategies should also incorporate a means of setting and attaining goals (Barusch, 2000).

Many interventions are established as process-oriented events

tending to reflect traditional affective, relational exchanges. Instead, men tend to work from a task-oriented approach. Strategies that incorporate this orientation will allow men to feel comfortable and will be more beneficial than sharing feelings in a less structured environment. Goal setting and goal attainment will allow men the chance to feel more involved in the intervention and also allow them to master any feelings of loss of control or helplessness that may come with asking for outside help (Barusch, 2000).

Fostering Mental Engagement

According to research by Bar-Tur, Levy-Shiff, and Burns (1998), mental engagements for older men mediate losses within an older man's life. Having both mental engagements and emotional engagements with others is associated with well-being in older age. However, it is mental engagements, the engagement in hobbies, past-times, reading, volunteering or any activities with which one becomes absorbed mentally. Encouraging older men to seek out and make a list of activities that engage them, especially during times of great loss may not only help to buffer that loss but also help some older men more readily redefine their roles. For example, loss of role due to retirement or health decline can be redefined through investment in engaging activities such as volunteer opportunities, part-time work or even education classes. For men who are struggling with changes in their lives, helping them to reconnect with mentally stimulating and absorbing activities may be quite beneficial to them.

Cultural Considerations

As with any intervention, working with older men requires not only sensitivity to gender issues but also knowledge of customs and cultural background of each person. For example, African American older adults often rely greatly on social support offered through the church community and extended kinship networks (Hines & Boyd-Franklin, 1996). For older African American men fostering connections between informal networks and formal service agencies may be the key to helping older men obtain services (Spence & Atherton, 2001). As mentioned above, older gay men tend to draw strong social support from friends

in the gay and lesbian community (Schiavi, 1999). Older men of Latino descent may rely on strong familial ties for support and place great importance on familial roles with respect to honor and unity (Garcia-Preto, 1996). In addition, Latino men tend to have very distinct gender roles to which they are expected to adhere than their counterparts of different ethnic background (Garcia-Preto, 1996). Men of Anglo American, Armenian, Cuban and Iranian decent tend also to hold high regard for individualism (McGill & Pearce, 1996; Dagirmanjian, 1996; Bernal & Shapiro, 1996; Jalali, 1996). Becoming acquainted with the needs and values of a person as well as the social institutions that make up the constellation of that person's culture and life are important for any practitioner to consider. These institutions can include church, family, and work. Ultimately, the roles that older men play within each institution will impact how they face the eight areas of consideration presented herein.

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