Review article / Artykuł przeglądowy

Masculinity and addiction: a narrative review of therapeutic interventions for men with substance-use disorders

Męskość i uzależnienie. Narracyjny przegląd interwencji terapeutycznych skierowanych do mężczyzn z zaburzeniami używania substancji psychoaktywnych

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Abstract

Introduction: Despite men representing the lion's share of substance use disorder (SUD) treatment clients, the detrimental influence of traditional masculinity is rarely addressed in SUD treatment. The aim of this review is to provide an overview of the specific approaches applied in therapeutic work with men and their masculinities in SUD treatment programmes.

Material and methods: A narrative scientific literature review was conducted on the topic of masculinity and its relations with SUD. Two main therapeutic programme models were identified, the first based on traditional understandings of masculinity and the second taking into

Streszczenie

Wprowadzenie: Pomimo że mężczyźni stanowią przeważającą część pacjentów lecznictwa uzależnień, szkodliwy wpływ wzorców zachowania związanych z tradycyjną męskością na proces terapeutyczny jest rzadko przedmiotem uwagi terapeutów. Celem niniejszego przeglądu jest prezentacja konkretnych podejść stosowanych w pracy terapeutycznej z mężczyznami i ich męskością w lecznictwie uzależnień.

Materiał i metody: Przeprowadzono narracyjny przegląd literatury naukowej na temat męskości i jej związków z zaburzeniami wynikającymi z używania substancji psychoaktywnych oraz ich leczeniem. Zidentyfikowano dwa typy programów terapeutycz-

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account men's specific needs and problems arising from gendered cultural expectations. The literature reviewwas supplemented by examples of good therapeutic practice from Switzerland, Germany, Italy, the USA and the UK.

Results: Four key issues were identified as good practice in working with men with SUD: (a) traditional masculinity and the set of characteristics and expectations associated with it, (b) fatherhood and the relationship with the father, (c) the experience of sexual problems and the trauma of sexual abuse and (d) aggressive behaviour and the experience of violence.

Conclusions: SUD treatment could benefit from problematising masculinity and what constitutes it, reflecting on gendered identity traits and developing alternative models of masculinity that include health-promoting behaviours. Framing the barriers associated with masculinity in terms of cultural expectations can help to reduce the burden of guilt experienced by male patients and to increase the reflexivity on cultural norms and stereotypes.

Keywords: Masculinities, Gender-roles, Alcohol use, Alcohol treatment.

nych: pierwszy odwoływał się do tradycyjnych wzorów w rozumieniu męskości, drugi uwzględniał specyficzne potrzeby i problemy mężczyzn wynikające z oczekiwań kulturowych związanych z męskością. Przegląd literatury uzupełniono przykładami dobrych praktyk terapeutycznych ze Szwajcarii, Niemiec, Włoch, USA i Wielkiej Brytanii.

Wyniki: Zidentyfikowano cztery kluczowe zagadnienia poruszane w programach terapeutycznych stanowiących dobrą praktykę w pracy z mężczyznami uzależnionymi od substancji psychoaktywnych: (a) tradycyjna męskość oraz zestaw cech i oczekiwań z nią związanych, (b) ojcostwo i relacja z ojcem, (c) doświadczenie problemów seksualnych i traumy związanej z wykorzystywaniem seksualnym, (d) zachowania agresywne i doświadczenia przemocy.

Wnioski: Leczenie uzależnień ma szansę bardziej adekwatnie odpowiadać na potrzeby pacjentów, jeśli w procesie terapeutycznym znajdzie się przestrzeń na problematyzowanie męskości i tego, co ją stanowi, refleksję nad cechami tożsamości płciowej oraz wzmacnianie alternatywnych modeli męskości, które uwzględniają również zachowania prozdrowotne. Ujęcie barier związanych z męskością w kategoriach oczekiwań kulturowych może pomóc ograniczyć poczucie winy doświadczane przez pacjentów i zwiększyć ich refleksyjność w odniesieniu do norm kulturowych i stereotypów.

Słowa kluczowe: męskość, role płciowe, używanie alkoholu, leczenie alkoholizmu.

■ Introduction

Gender differences in alcohol use are universal, with higher frequency and quantity of alcohol consumption among men and higher abstinence rates among women [1, 2]. The concept of masculinity in public health allows us to better understand how gender roles, and in particular the set of characteristics associated with traditional masculinity, influence men's exposure to risk behaviours, their health behaviours and/or use of the health care system, including the addiction-treatment system. The Australian sociologist Raewyn Connell points out that different forms of masculinity, understood as a set of characteristics, behaviours and social roles associated with boys and men, coexist in every culture, but only hegemonic masculinity is the culturally dominant set [3, 4]. Traditional masculinity, which is a set of traits including courage, endurance and resilience, self-control, independence and self-reliance, willingness to fight and compete, striving for power and dominance, rationality and efficiency, heterosexuality, a tendency to engage in risk-taking behaviour and aggression, is dominant in our culture [5-7]. Importantly, traditional masculinity is not the most common form of masculinity; on the contrary, most contemporary men do not conform to the stereotypical image of the traditional male. The dominance of traditional masculinity lies in its organisational and overriding importance over all other gendered behaviours and roles assumed by men [3, 4]. Similarly, the majority of research refers specifically to masculinity in its traditional form [5]. The review

by Connor and colleagues [8] is a promising inductive approach that analyses how men, rather than researchers, view masculinity themselves. The review identified 'inclusivity/acceptance of different sexualities', 'emotional intimacy, e.g. emotional bonding', 'physicality/intentional physical contact' and 'resistance/rejection of traditional masculine norm' as four 'global concepts'. The discourse on masculinities evolves with changes in society and culture. This thematic analysis again empirically illustrates the multidimensionality of the concept, combining rejection of traditional values and new masculinity norms using Inclusive Masculinity Theory as a framework [9, 10]. At the same time, it remains an open question how gender measures like gender norms, gender discrimination and violence and gender (in)equality relate to masculinity measures [11, 12].

Masculinity and alcohol use

Researchers emphasise that alcohol use is associated with traditionally understood masculinity, regardless of respondents' age or even geography, with similar relationships described across continents [1, 6, 13-15]. Traditionally understood masculinity is socially constructed through the shared use of alcohol and sharing of drinking stories, even among adolescents and young men, including tales about the ability to consume large amounts of alcohol [1, 4, 16]. This raises questions about the impact of abstinence on self-perception and gender identity. Traditional masculinity and the social pressures associated with it like the presence of alcohol in cultural rituals associated with the celebration of important life events, may be an important barrier to maintaining positive treatment outcomes [1, 13].

Masculinity and depression

Studies show that the risk of depressive disorders is twice as high in women as in men, although there is an inverse relationship for the number of committed suicides; in Poland, the male suicide rate is six times higher than for women [17]. One hypothesis that attempts to explain these discrepancies is that depression in most men has a non-specific clinical picture and that the prevalence and intensity of its symptoms are related to traditional norms and roles ascribed to men and are not included in standard diagnostic criteria. Symptoms of male depression include suppression of emotions, self-destructive behaviour and tendency to engage in risky behaviour, alcohol and drug use and, manifestations of irritability, anger and aggression [7, 17-19].

When men experience severe stress, psychological distress or humiliation, they do not disclose it, are often unable to recognise these symptoms and do not seek help. They tend to cope by abusing psychoactive substances, which can lead to the development of a substance-use disorder (SUD) [17, 18]. Men are much more likely to attempt suicide while under the influence of alcohol or drugs, and a failed suicide attempt may be seen (through the lens of traditional masculinity) as a source of shame [17].

Men and help-seeking

Men are more likely than women to consider themselves healthy, to report less need for health care, and to try to manage their problems for longer on their own. They are more likely to seek medical advice for somatic rather than for mental or emotional problems [1]. The root is societal perceptions of gender roles and the characteristics traditionally associated with masculinity; from childhood, boys are taught to be independent and active, assured of their strength and unlimited possibilities, and are discouraged from expressing helplessness, weakness or emotionality [1, 14, 15, 17, 20].

According to an American study, men with co-occurring mental disorders were less likely than women to be referred to psychiatric care, but are more likely to be referred to addiction treatment [20]. SUD can conceal other mental health problems, particularly symptoms of 'masculine depression', which may go undiagnosed, worsening outcomes in addiction treatment and increasing the risk of relapse and suicide [7].

The importance of alcohol use in men's daily routines and rituals, and the (false) hope that the problems experienced are temporary, are barriers to seeking help in addiction treatment. Research also suggests that men tend to minimise their symptoms and not report them if they risk exclusion from an important social group or loss of reputation [17, 21]. Paradoxically, the decision to seek treatment may also be justified by the manifestations of traditional masculinity like the need to regain sexual prowess, to be a good father, to improve one's financial situation, to return to the labour market, to find a partner and start a family or to regain one's driving licence [6, 22].

Despite men representing the lion's share of patients in addiction treatment services, the detrimental influence of traditional masculinity is rarely addressed in therapy. The aim of this review is to systematise knowledge of specific therapeutic approaches and techniques used in therapeutic work with men and their masculinity through a review of the literature and good practice in current treatment interventions in different countries.

■ Material and methods

We conducted a narrative review of the literature by searching the *Web of Science* database for articles that included the topic of masculinity in addiction, including specific areas like the co-occurrence of addiction and other psychiatric disorders. traumatic experiences and aggressive, violent and law-breaking behaviour. We used a combination of keywords like *addiction, masculinity, treatment, substance use, men, treatment needs, gender-specific, male, male-centred, intervention, health, treatment service, trauma and barriers*. We selected 37 articles (best matching keywords and titles) but discarded 29 after reading the full article (if available).

Due to the small number of scientific articles, the literature review was supplemented with examples of good therapeutic practice. We sought information about treatment interventions that address masculinity issues from addiction researchers and practitioners, using both personal contacts and research social networks (*ResearchGate*; the communication platform of *the Kettil Bruun Society for Social and Epidemiological Research on Alcohol*). We received information from Italy, Germany, Switzerland, the United Kingdom and the United States of America.

The selected articles have been carefully analysed and the information consolidated and presented under the thematic headings (a) therapeutic programmes based on traditional notions of masculinity and (b) therapeutic programmes that take into account men's specific needs and problems arising from gender-based cultural expectations. In addition, information on (c) good practice is presented separately in the results section.

■ Results

Men's health behaviours, experiences, problems and barriers have become the focus of academic debate in recent years, including in the context of male gender identities; however this has not yet translated into a response from health systems. While men represent the vast majority of patients in addiction treatment worldwide [6, 23], specific masculinity-oriented programmes in addiction treatment are rare, and there are even fewer publications describing them.

Treatment programmes based on traditional masculinity

Ezzell [24] describes an American therapeutic programme for men based on the community method, using confrontational-type 'games' to channel aggression and frustration. The programme was conducted over two years, and the community included 370 voluntary male members, mostly as a result of a choice of therapy over incarceration. The author analysed the techniques used by the men to compensate for their sense of masculinity as traditionally understood and as oppressed by a lost sense of control. The four main groups of compensatory techniques identified in the study were expressing masculinity through verbal aggression, expressing masculinity through humiliating women and men who do not conform to the 'macho' stereotype, provoking other members of the community to prove that 'they are men', and keeping emotions in check or not giving in to provocation [24]. The author suggests that the aim of the therapy, which was to 'destroy the old identity in order to build a new one', appeared to be only partially realised, as the therapy focused on destroying the 'old identity' and the 'games' were used to vent frustration and aggression. However, the destructive behaviours associated with the compensatory reconstruction of male hegemonic identities have been identified [24].

Similarly, Lozano-Verduzco and colleagues [13] describe a confrontational therapeutic community programme for men in Mexico, characterised by a high dose of verbal violence and an aggressively demonstrated traditional form of masculinity that was not problematised in therapy. According to the authors, this is not a recommended way of working with people with SUD and the programme had negligible therapeutic success [13].

Søgaard and colleagues [25] describe a Danish programme for young men who experience problems related to their cannabis use including

legal problems. The authors point out that both criminal activity and drug use are behaviours within the traditional model of masculinity. The programme described used a reverse narrative and reframing; cessation of criminal activity and drug use were framed as positive behaviours for a man manifesting traditional masculinity. Abstaining from psychoactive substances and illegal activities was reframed as a 'masculine' choice, a manifestation of self-control, strong will, perseverance and responsibility [25]. Similarly during therapy, young men learned that there are two different ways to make money: 'easy money' from criminal activities and 'honourable money' from honest work, which is one of the characteristics of a new, mature form of masculinity. The therapeutic programme was also combined with boxing training. While the idea of addressing traditional masculinity seems attractive for motivating young men who have had difficulty fitting in with other therapeutic formulas, researchers stress that this kind of reframed narrative is risky as it may turn out that some young men cannot cope with the challenges. For example, while 'street culture' values autonomy and independence, the labour market, with its hierarchy and classism, tends to enforce the worker's subordination to the employer [25].

Wilton and colleagues [23] describe residential therapeutic facilities where men participate in all domestic activities like cleaning, cooking and ironing. In this way, according to the authors, a new masculinity that supports these activities is formed. However, the sustainability of these changes is unknown, especially if they are not followed by an increased awareness of the limitations of gender roles, built up during therapy. At the same time, men who are often separated or divorced because of addiction, learn the new practical skills required for living alone. On the other hand, some may resist these tasks and drop out. Dropping out of therapy is usually interpreted as a lack of readiness for treatment, but it may be a lack of openness to the transformation from traditional masculinity to its alternative manifestations [23].

Therapeutic programmes that address needs and problems associated with gender roles

Ferkul [26] suggests that most men only become fully aware of the destructive values and expectations associated with traditional masculine identity during the therapeutic process when their masculinity is transformed and they have the opportunity to transform trauma and suffering into enriching experiences. Thus, therapy is based on problematising masculinity and the set of expectations that constitute it through a reflective look at the characteristics of gendered identity [26]. During therapy, the hierarchy of masculinities shifts as the self-conscious, reflective, emotional self becomes the desired masculine identity [5, 23]. Similarly, the masculinity manifested by excessive alcohol or drug use is problematised and replaced by an alternative that embraces health-promoting behaviours [23]. Every man is an individual, just as substance-use related problems are heterogeneous; however, researchers and practitioners identified a set of especially important themes when working with men with SUD [26]. These include traditional masculinity and characteristics and expectations ascribed to it like fatherhood and the relationship with one's father, the experience of sexual problems and the trauma of sexual abuse and experiences of violence.

Being a traditional man

Traditional masculinity is usually expressed through silence and dominance. The very act of speaking, of sharing emotions with other men, is fraught with guilt and shame. Similarly, the ability to maintain self-control when using alcohol or drugs is part of the repertoire of traits associated with traditional masculinity, with the loss of this control associated with shame and a sense of failure [23, 24]. Cultural barriers are even expressed in terms of 'boys don't cry' language that shames men for showing emotion. In treatment, men receive conflicting messages about how to talk and whether to talk at all [26]. Treatment programmes often use the method of group therapy where patients open up in confidential conversation, describing not only their behaviour but also revealing painful or shameful life experiences and expressing the emotions, thoughts and attitudes making up their identity. Exposing one's 'Achilles' heel' to other men in the safe space of the therapy room encourages openness and trust in the face of cultural expectations associated with traditional forms of masculinity.

Framing these barriers in terms of cultural expectations can help remove the burden of guilt and to reflect on cultural norms and stereotypes. Gender

identity work can help patients redefine their thinking about what it means to be a man in less destructive ways. However, this process takes time [26].

Different forms of masculinity come together in the therapy room. For men with identities constructed according to the patterns of 'street masculinity' [27] (i.e. as a result of experiences of gang involvement or imprisonment), learning new ways of interacting with other people, with other men, in a therapeutic programme is an enormous challenge, and it is not clear to what extent the identity changes achieved in therapy are later maintained. At the same time, for men whose identity corresponds to the specific vulnerability of the middle class, the challenge in therapy is the proximity of more aggressive forms of masculinity. These factors allow us to better understand the very real difficulties men face in the therapeutic process [23].

This is not a problem unique to our culture. Research conducted in Thailand points to the stereotypical, traditional view of masculine norms that contributes to the reinforcement of risky and destructive behaviour. Thai patients in addiction treatment programmes see alcohol use as one of the behaviours embedded in cultural expectations of masculinity, including in the context of professional interactions. Offering alcohol at work or after work is a sign of generosity and respect. Men feared losing control of their drinking and entering treatment because of the stigma associated with it. These men entered treatment reporting mainly somatic problems and withdrawal symptoms and felt that the treatment on offer was not appropriate to their needs. Abstinence was not an attractive therapeutic goal as they hoped to be able to continue drinking in a less risky way after leaving treatment; they described the therapeutic process as incomprehensible, the therapists as incompetent and the treatment as boring [1].

Being a father

Being a father is both an identity and an act, a social role and a life experience. How we understand being a man is very much related to how we understand the cultural and social expectations of fatherhood. Meanwhile, addiction researchers have addressed the issue of being a parent and a person with SUD almost exclusively in relation to female patients, reinforcing the stereotype of substance-dependent fathers as irresponsible and even dangerous. The few studies conducted among men with SUD who have entered treatment show that being a father is more important to them than is usually acknowledged, accompanied by feelings of guilt, shame and uncertainty about how to manage (and repair) relationships with children after treatment. Many men felt that it was their addiction that made them 'absent or poor fathers'. Others added that they had been 'absent fathers' themselves. They felt the need to take responsibility for the past and the future. However, fatherhood was rarely addressed in the treatment process as therapists felt that these issues should wait until patients had resolved their substance use problems first [28].

Klingemann and Gomez [6] conducted a study in two large alcohol treatment clinics in Switzerland. They found that 58% of the men (n = 115) were fathers, including 27% who had lived with their children prior to treatment. For almost all respondents, children were either extremely important (76%) or important (16%), and 41% of respondents hoped to improve their relationship with their children. Respondents were also asked whether the difficulties and hopes associated with fatherhood were explored in their therapy. This survey shows that fatherhood is rarely or extremely rarely addressed in both individual (72%) and group (82%) therapy. Furthermore, it appears to be one of the most sensitive topics, as only 5% of respondents expressed a willingness to discuss these issues in group therapy. The study also found that 35% of the men had an addicted father and 9% had an addicted mother, which probably placed an additional burden on the patients in their attempts to be a 'good father' [6].

Experiencing sexual problems

Research shows that men are more willing than women to give up unhealthy habits in order to improve their sexual performance. For 32% of men, sexual health is one of the most important components of their wellbeing and they also feel that the healthcare system does not adequately address these needs. The vast majority of men seek medical help for problems such as sexually transmitted diseases (98%), irritation or genital infections (93%), with a much smaller group of men seeking medical help for problems such as pain during intercourse (68%), erectile problems (62%) or lack of libido (54%) [29].

In a study by Klingemann and Gomez [6], men with SUD who were patients in two large alcohol treatment clinics in Switzerland reported a range of traumatic experiences related to sex like being touched in a sexual way against their will (17%), being forced to watch or participate in sexual acts (14%), having sex under threat of violence (6%) and being sexually abused as a child (9%). In addition, patients experienced sexual problems like lack of libido (37% and 23% an excess), erectile problems (26%) and problems reaching orgasm (20%). 59% of the men admitted that alcohol worsened their sexual performance. The researchers point out that these percentages could be higher due to the sensitive nature of these problems. Unfortunately, this issue was largely ignored in both group (79%) and individual (66%) therapy. However, 44% of patients expressed a willingness to talk about it in individual therapy (2% in group therapy) [6].

Experiencing violence

Men are both the most common perpetrators and victims of violence. The World Health Organization report shows that male violence against women is more prevalent when violence between men is normalised in society. In addition, people who have experienced violence in childhood are more likely to be both perpetrators and victims of violence in adulthood. According to the World Health Organization, improving gender equality is the only strategy to effectively reduce violence in society [14, 15].

The use of psychoactive substances, particularly alcohol, is one of the main factors associated with intimate partner violence against women [30, 31]. One possible explanation for this association is the disinhibition theory, which suggests a role for the pharmacological effects of alcohol in reducing the capacity to inhibit or control impulsive aggressive and violent behaviour [31]. Another explanation is learned disinhibition theory, which suggests that a violent perpetrator engages in aggression while under the influence of alcohol because intoxication 'allows' him or her to take no responsibility for the acts committed under its influence and thus avoid social sanction [31].

The study by Thomas and colleagues compared male perpetrators of violence with and without alcohol-use disorder (AUD). Male perpetrators with AUD were more likely to commit acts of psychological and physical violence, and these acts were more severe. They were also more likely to have experienced traumatic and violent events in the past, to have a borderline-personality type, and to display higher levels of anger. In addition, men with AUD were four times more likely to be under the influence of alcohol during a violent act than the other group [31].

Researchers therefore suggest there is a need for more therapeutic work with anger, especially as perpetrators of violence have experienced traumatic events themselves. Therapeutic work that addresses a wide range of psychological and emotional problems can not only significantly help perpetrators, but also prevent further acts of violence [31].

Good practice: addiction treatment interventions that address gender role barriers and needs

This section of the review describes specific therapeutic methods and techniques used in addiction treatment programmes for men that address gender role barriers and needs. Information on good practice is drawn from addiction researchers and practitioners in Switzerland, Germany, Italy, the USA and the UK.

Switzerland. The Swiss Federal Office of Public Health published recommendations for therapeutic work with men in 2012. The topics of the recommended sessions include issues like:

- relationships with other men,
- love and sexuality,
- committing acts of and experiencing violence,
- work and career,
- fatherhood.

The recommendations also include specific not only verbal, but also non-verbal and non-threatening techniques for working and establishing a therapeutic relationship. According to the recommendations, therapists of both sexes are suitable for this work as long as they are aware of the specific pitfalls of interaction. Therapists can benefit from general training on masculinity issues offered in Switzerland by *the Swiss Institute for Men's and Gender Issues*. The organisation's mission is to raise awareness of gender issues and the constructive transformation of gender roles in therapeutic work with boys, men and fathers. Switzerland also has a national programme called MenCare Switzerland, which is part of the global MenCare campaign.

Man(n)agement mit Kopf, Herz und Leidenschaft (... with head, heart and passion) is an example of a group therapy programme exclusively for men with SUD run by Blue Cross in Switzerland. The programme consists of 11 evening group sessions (18:30-20:30) held every two weeks. The groups have around 10 participants, who are referred from other agencies, but are also encouraged by advertisements in the media. Session topics include:

- Who am I?
- My work – passion or torture?
- My body an expression of my masculinity?
- My father – role model,
- Relationships – easy or hard?
- Love, tenderness, sexuality – desire and frustration,
- Aggression, violence and constructive power,
- Friends, family, loneliness – sources and outlets of energy,
- Being and not being a father,
- Spirituality, emotions – unknown dimensions,
- Theme proposed and chosen by the group.

The pilot version of the project was evaluated in 2009 and the programme has since become part of the therapeutic offer in the city of Sankt Gallen canton.

Meanwhile, the Casa Fidelio programme, in existence since 1993, is the only therapeutic community for men with SUD in Switzerland. It is abstinence-oriented, but patients can receive substitution treatment. The patients are men with various types of SUD, often in conflict with the law. Problems with aggression and violence are reported. The facility employs 15 therapists, including men. During therapy, the explored topics include:

- being in a masculine group and problematising the classic demands of the role (protecting and impressing women – a therapeutic relationship reminiscent of that with the mother),
- relationships with women (sense of control, emotional distance, objectification of women) or men (homosexuality),
- not showing fear and anxiety, showing affection and tenderness,
- divorce, fatherlessness, father-child relationship,
- vulnerability to injury, experiencing abuse and violence,
- managing expectations and resolving conflicts, breaking the law [32].

Germany. Cultural gender role expectations and their impact on SUD treatment have been addressed in Germany for several years as SUD treatment programmes sensitive to gender-role issues have been introduced. Therapists receive a three-day training based on the manual "Masculinity and Addiction: a handbook for practitioners" (Praxishandbuch "Männlichkeiten und Sucht", 2017), which is the result of a research project carried out several years earlier. This manual, based on 11 thematic therapeutic modules, allows each treatment centre to use its content in a flexible way and seems to be an example of good practice in this field. Another example is programmes that address the needs of homosexual men with SUD like the chemsex group at the Salus clinic.

Italy. Information about programmes in Italy was provided by Dr Fasoli, Director of the Addiction Unit at ASL Brescia (ASL = Local Health Service). When asked about the implementation of a gender-sensitive approach to cultural expectations in the treatment of male addicts in Italy, Dr Fasoli wrote: *There are no facilities exclusively for men with SUD in Italy, but there are a large number of private and public treatment groups aimed at women or men. Some of these groups have been created for men who are perpetrators of violence, many of whom have SUDs.*

Dr Fasoli emphasises that Italian services try to respond to the range of patients' needs and problems. In practice, this means that patients' resources, problems and needs are identified at the very beginning of treatment (a checklist of resources and needs). This creates an initial barrier for men with SUD, as they find it difficult to disclose problems such as sexual abuse, harassment or concerns about sexual health at the very beginning of therapy. They also tend to avoid answering direct questions and downplay the seriousness of the problems they report. In fact, men often first describe their financial or legal problems as the reason for seeking help. Dr Fasoli gives the example of her patient who was asked to name the three most vexing problems in his life. *The businessman with serious family and health problems answered this question: China, unions and banks. Meanwhile, in my (limited) experience, the most serious problems were (a) jeopardising one's role in the family and society due to work problems or unemployment, (b) sexual problems and (c) shyness. Shyness seems to be a common trait, but it is rarely recognised, as men are even more ashamed of it than women. Meanwhile, it can lead to alienation,*

depression, loneliness, outbursts of aggression and even suicide.

Dr Fasoli also points out that men often expect short-term programmes that focus only on their addiction. However, other problems tend to surface after the programme has ended. According to Dr Fasoli, short-term addiction treatment programmes should be linked to other programmes that address 'hidden' problems. Dr Fasoli's patients often did not want to join an all-male treatment group, but preferred to work in so-called 'duos'. In the duos, two socio-culturally different patients with similar 'male' problems were paired up in order to make it easier to identify the specific difficulties that the patients had to overcome in the therapy process.

One example is the therapy of a very formal director of a large company together with a relaxed Italian DJ. Both in their fifties, both with a heroin addiction from which they managed to abstain for long periods, usually linked to changes in their lives (change of country, job, new relationship). Both had been in substitution programmes for many years and had received psychotherapy on several occasions. Both were abused as children, had experienced bereavement, had chronic pain and both had had successful careers. Their duo consisted of behavioural-cognitive sessions in which the patients chose the topic of the session. They talked about the fear of living alone, even if their relationships with women were dysfunctional, the feeling of a wasted career, the lack of authentic interpersonal relationships and the lack of a home. As a result, the patients stopped using heroin and remained friends even after the end of the therapy.

United States of America. We came into contact with an American researcher and therapist, who is the author of a concept for therapeutic programmes focused on working with traumatic experiences. Persons with SUD often experience psychological trauma during their lives, which can make it difficult for them to function and overcome their substance use. The TREM model (*Trauma Recovery and Empowerment Model*) [33] was developed with women in mind, and in subsequent years an M-TREM model focusing on emotions and relationships – areas where men have particular difficulty – was also developed.

The Helping Men Recover (HMR) programme is based on this model. The programme was developed in 2011 for community and for judicial programmes (probation, community alternatives to prison and prison programmes). It is based on a therapist's manual, exercises for the patient and consists of 18 two-hour sessions covering topics like:

- identity and masculinity,
- healing,
- feelings,
- relationships with other people,
- family and being a parent,
- communication and intimacy,
- sexuality and sexual health,
- spirituality.

Another programme, Exploring Trauma (ET), is a brief intervention programme that focuses on traumatic experiences and abuse with SUD being one of the issues addressed. The programme consists of six sessions and can be delivered both in prisons and in community treatment programmes. The sessions use a range of techniques including discussion, role play, interactive projects and relaxation exercises.

United Kingdom. Slightly modified versions of the HMR and ET programmes described above are used in the UK. Exploring Trauma (ET) is a relatively new programme introduced in 17 male prisons in the UK (correspondence with Dr Covington). According to the director of one of the UK programmes:

HMR is a difficult programme to implement in our institution as it lasts 16 weeks and the average stay with us is about 12 weeks. However, participants in its abbreviated version, 'Building resilience: a workbook for exploring trauma' (BR), usually find it to be one of the most important elements of their therapeutic programme. Some of them ask to take part again, pointing out that there was not enough time to build trust at the beginning of the programme. The traumatic experiences of the group participants were common and had an impact, not only in childhood but also in adult life. (Correspondence with Ian Day, Programme Manager).

■ Discussion

Using the concept of masculinity in the treatment of male clients in SUD allows us to better understand how gender roles, and in particular the set of characteristics associated with traditionally understood masculinity, are related to men's risk-taking behaviour, how men manage their emotions, how and where they seek help and whether, and to

what extent, they engage in SUD treatment. Recognising the limitations of male gender roles by both patients and therapists is therefore an important part of the therapeutic process.

Therapeutic programmes that do not include gender-identity problematising work on some of the values or characteristics associated with a traditional view of masculinity contribute significantly to the perpetuation of health-risk behaviours that make individuals vulnerable to substance use. Therefore the idea of programmes for men that are based on values associated with traditional masculinity and use confrontational methods of therapeutic work is not part of the set of good practices in this area. Therapy that is sensitive to the roles implied by gender identities, the specific characteristics associated with these roles and the health consequences of identifying with them can be offered to anyone regardless of gender [23].

Substance use and risk-taking behaviours are part of the repertoire of characteristics of traditional masculinity. For this reason, SUD treatment should problematise masculinity and what constitutes it by reflecting on gendered identity traits and developing alternative models of masculinity that include health-promoting behaviours in their repertoire. This is in line with the World Health Organization's recent recommendations for a treatment approach that takes into account knowledge and understanding of cultural expectations of men's roles and the resulting barriers and inequalities in access to health. The World Health Organization highlights that in countries where there is gender equality, men live longer, are healthier and enjoy a higher quality of life. They also suffer less from depression and are less likely to commit suicide [14, 15].

Limitations. The results of this review must be interpreted in the context of several methodological limitations. Firstly, this is a narrative and not a systematic review so there may be a degree of subjectivity in the selection and interpretation of the data presented. Secondly, this article presents examples of men's addiction treatment programmes and methods that address gender-role barriers and needs. These examples were identified through snowball sampling of experts in different countries. However, this is neither a complete picture nor a representative sample. We have provided a specific set of good practices that largely respond to the barriers and problems identified in the literature on men's experiences of SUD. Some treatment groups for men are formed when SUD is associated with homelessness, violence or crime (prison populations). However, regardless of the type of programme, the content and issues addressed seem to be similar and correspond to the issues identified in the literature.

In addition, the recognition of the interplay between addiction and masculinities in the therapeutic process is relatively new, so there are very few studies on this topic. There is still not enough evidence of the effectiveness of the programmes or strategies that have been presented. To the best of the authors' knowledge, there are no comprehensive evaluation studies of therapies that focus on masculinity. This is partly due to conceptual problems in defining the outcomes of therapy in quantitative terms. Scales measuring traditional masculinity (TM) have focused either on how restrictive rules negatively limit men's ability to lead balanced lives [34] or on the potential strengths of TM as a starting point for therapy [35]. As Kaplan and colleagues [5] state: *Despite growing awareness to the ideological nature of masculinity, and thus the potential multiplicity of such ideologies, quantitative researchers shy away from investigating masculinity ideologies beyond TM* [5: 418]. As potential outcome/success measures, TM scales would be insufficient. *Demonstrating that men reject traditional norms tells us little about what they endorse* [5: 396]. The development of the New Masculinity Inventory, with its 17 items covering the domains of 'holistic attentiveness', 'challenging male norms', 'authenticity', 'domesticity & nurturing' and 'sensitivity to male privilege' [5: 421], addresses this gap and paves the way for future comprehensive, more valid, study outcomes. At the same time, this broader perspective also informs practice; a review of how masculinity is operationalised in the context of gender-transformative health interventions still shows the dominance of the limited concept of hegemonic masculinities [36].

■ Practical implications

While every patient is an individual and SUDs are heterogeneous, it is possible to identify a number of issues that should be addressed when working with men with SUDs. These include (a) traditional masculinity and the set of characteristics and

expectations associated with it, (b) fatherhood and the relationship with the father, (c) the experience of sexual problems and the trauma of sexual abuse and (d) aggressive behaviour and the experience of violence.

In addition, the relationship between SUD and non-specific symptoms of depression should be considered, as failure to recognise this can significantly reduce the effectiveness of treatment and increase the risk of relapse and even suicide.

SUD treatment should (a) provide a sense of autonomy and agency through a therapeutic relationship based on partnership and a solution-focused approach, (b) promote a sense of control and increase motivation by working on short-term goals, coupled with an explanation of what the therapy is about, how long it will take, what effects will be achieved and how progress will be recognised (c) work with shame, stigma, weakness and (d) work with beliefs about what it means to be a man and make patients aware of the destructive role of hegemonic masculinity in their lives, while pointing out the variety of ways masculinity can be expressed and helping them to create their own unique masculinity. Some patients will need more time than others to achieve this. Framing the barriers associated with masculinity in terms of cultural expectations can help to remove the burden of guilt and to reflect on cultural norms and stereotypes. Working with gender identity can help patients to redefine a more constructive way of thinking about what it means to be a man.

Different forms of masculinity meet in the therapy room. For men who have constructed their identity according to the unspoken rules of 'street masculinity' [27], therapy is a major challenge, while for those whose identity corresponds to a specific middle-class sensibility, the challenge in therapy is the proximity of forms of masculinity that manifest themselves in more aggressive ways. Men also struggle with certain elements of therapy as (a) some need more time to establish a therapeutic relationship based on trust, (b) some find it difficult to accept specific therapeutic jargon (it is therefore useful to look for vocabulary that is action-oriented, specific, direct and concise), (c) others find it difficult to accept purely talk-based therapy (in favour of action-based approaches or other innovations), (d) still others find it easier to talk while walking or sitting at a table than on the floor in a therapy room and (e) some will not accept any abstinence-based approach (but will thrive in reduced-risk drinking programmes).

The research literature suggests focusing on positive masculine qualities like coping skills, courage (expressing feelings is brave), problem-solving skills, work ethic and leadership (effective ways of dealing with emotional difficulties). To increase motivation, one could emphasise the possibility of regaining qualities that are an important part of masculine identity like regaining control over one's life, regaining sexual prowess, being a good father, improving one's financial situation, re-entering the labour market, finding a partner, starting a family and even getting one's driving licence back.

Conclusions

The usefulness of setting up 'masculine' programmes based on the values associated with traditional masculinity and using confrontational methods of therapeutic work is not supported by either the literature or therapeutic practice. Programmes should include working with gender identity and problematising some of the values or characteristics associated with a traditional view of masculinity. At the same time, recognising that alcohol use is a manifestation of masculinity in the traditional sense raises the question of the impact of abstinence on self-perception and gender identity. Perhaps the traditional understanding of masculinity and the social pressures associated with it is what makes maintaining positive treatment outcomes so difficult. It would seem it is important that the health care system, including the SUD treatment system, takes into account the specificity of needs related to male gender identity. Raising awareness of these issues and the barriers to accessing health associated with traditional masculinity can help to overcome many of the barriers to treatment and therapeutic support [14, 15].

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Conflict of interest/Konflikt interesów

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Ethics/Etyka

The work described in this article has been carried out in accordance with the Code of Ethics of the World Medical Association (Declaration of Helsinki) on medical research involving human subjects, Uniform Requirements for manuscripts submitted to biomedical journals and the ethical principles defined in the Farmington Consensus of 1997.

Treści przedstawione w pracy są zgodne z zasadami Deklaracji Helsińskiej odnoszącymi się do badań z udziałem ludzi, ujednoliconymi wymaganiami dla czasopism biomedycznych oraz z zasadami etycznymi określonymi w Porozumieniu z Farmington w 1997 roku.

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