Executive Summary

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The state of men's physical, mental, and social health in the Commonwealth of Massachusetts is cause for concern, particularly given our current economic climate of high unemployment, a climate that tends to exacerbate these already highly problematic issues for men. This briefing report features three essays by experts – James Mahalik, Michael Addis, and Emily Douglas – who focus on each of these three aspects of men's health.

Although this report treats these issues separately, they are very much intertwined. Research demonstrates that mental and physical health have a reciprocal relationship with each other, with poor mental health influencing poor physical health and vice versa. Moreover, they both are intertwined with men's social health, in that men who are divorced or separated, in comparison to their married counterparts, have poorer physical health, eat fewer fruits and vegetables, drink and smoke more, and are at greater risk of committing suicide.

Gender is the strongest and most consistent predictor of health and longevity. Men die earlier than women, with women's average age at death in the U.S. at 83 and men's at 78. Men die at higher rates from 14 of the 15 leading causes of death, except for Alzheimer's disease; 3 out of every 4 persons under the age of 65 who die of heart disease are men, and men have a 1 in 2 lifetime risk of developing cancer, compared to 1 in 3 for women.

The majority of these gender differences in health are due to lifestyle differences that are modifiable. Hundreds of empirical studies show that men are more likely than women to engage in almost every health risk behavior that increases their risk of disease, injury, and death. These risks include not getting preventive care or delaying seeking healthcare when symptoms arise.

All too often, we accept men's shorter lives as inevitable, natural, or inherent. However, policymakers in Massachusetts need to be concerned about men's shorter life span, more severe disease states, and riskier health behaviors because they cost hundreds of billions of dollars per year in lost productivity and health care costs. Thus, governments end up absorbing the enormous costs that the premature death and disability of men incurs, including the costs of caring for dependents who were left behind.

What causes men's poorer health? James Mahalik's research shows three prominent themes: (1) the way we socialize men to be men is antithetical to health-promoting behaviors, and men's adherence to traditional masculine norms is a consistent predictor of health-risk behaviors; (2) men's beliefs about other men's health behaviors is that it is normal for men to engage in health-risk behaviors, and when men perceive that other men are engaging in health-risk behaviors, they are more likely to report engaging in health-risk behaviors as well; and (3) society is full of barriers to men engaging in health-promoting behaviors; for example, missing work, or not being able to leave work to make physician's appointments that are typically scheduled from 9 to 5, are prominently identified as barriers for men.

Michael Addis then introduces us to some disturbing statistics regarding men's mental health, including that men commit suicide at four times the rate of women; that clinical depression is under-diagnosed in men; that men have higher rates of alcohol and substance abuse than women; and that despite these figures, men are far less likely than women to utilize available mental health services.

Dr. Addis' work shows that we are taught from a young age that men are expected to be tough, strong and stoic at all times. Consequently, when men struggle with real mental health problems, they are met by social stigma and a lack of support. This harsh reality has led many men to hide their mental health problems and suffer alone. As a result, men dealing with a mental health issue often experience an escalation of distress and pathology that can leave them out of work, detached from loved-ones, addicted to alcohol or other drugs, and on the brink of committing suicide.

Researchers have also demonstrated that individuals who avoid seeking mental health care end up using a greater amount of health services than those who receive treatment early on. This results in greater social and financial costs to the individual, family, and society.

Unemployment, which is currently a state for many Massachusetts men during this "Man-cession", only exacerbates these issues. Men are especially vulnerable to mental health issues when facing unemployment, including suicide, alcohol and substance abuse, and depression. In fact, in comparison to women, men have been shown to suffer more psychological problems from unemployment.

These undiagnosed and untreated mental health problems for men are associated with excessive burdens to the state and families. For example: (1) untreated and mistreated mental illness in the United States results in $150 billion in lost productivity and $8 billion in crime and welfare costs every year; (2) if businesses and government increased spending on mental health treatment by 5.5%, these costs could be reduced by 50%; and (3) people living with major mental illness die 25 years earlier on average than other Americans.

In addition to these burdensome physical and mental health issues, the family health of men is also in peril, as discussed by Emily Douglas. Divorce and loss of child custody are issues faced by up to 50% of men. In Massachusetts, the divorce rate is 2.3 per 1,000 persons, and most men do not retain physical or residential custody of their children after divorce. Moreover, contrary to popular belief, men's social health often suffers after divorce or family disruption, and such distress includes lower incomes, increased financial burdens, depression and emotional pain, alcohol abuse, feeling shut out of their children's lives, and not being able to be a father in the way they had once been.

Men's adjustment to post-divorce life is closely tied to their relationships with their children and former partners. Research documents that, unless there is evidence of maltreatment or violence, children and fathers are better off when they have regular and frequent access with each other. Moreover, fathers who are involved with their children are also more likely pay child support and to emotionally support their former partners.

Somewhat linked to the issues of divorce and child custody is the issue of domestic violence (DV), and what most policymakers do not know is that men are often the victims of domestic violence as well. In fact, current estimates are that over 800,000 men per year are the victims of domestic violence in the U.S., yet because of many of the reasons discussed about accessing physical and mental health care, men do not readily admit to or seek help for this issue.

Nonetheless, men's domestic violence victimization has been shown to result in physical injuries, mental health problems, and poorer physical health. What is particularly troublesome is that their efforts at seeking help often exacerbate their mental health issues. Often, men report being turned away from DV agencies and hotlines because the agencies say that they only help women; others report that agency staff ridicule them for being "wimps" and "letting" their partners abuse them. Overall, the majority of men who do seek help from first responders – DV agencies, DV hotlines, and the police – report these agencies to be not at all helpful.

What can Massachusetts do to improve the physical, mental, and social health of men? Several suggestions and policy options are forwarded in these three reports, and they all focus on a multi-level and multi-pronged approach to dealing with this hidden crisis. A few of the more consistent suggestions will be summarized here.

Massachusetts is a leader in providing high quality physical and mental health services in this country; however, more effort is needed to get men to utilize these existing services. Massachusetts is also a leader in providing high quality domestic violence victim services, but these services need to consistently be made available to men.

One overarching recommendation is the creation of a Men's Health Commission for Massachusetts. We have a Men's Health Partnership, under the direction of the Department of Public Health, but it is limited in its scope. Men's Health Commissions have been established in a few states, and their goals could encompass the men's health issues raised in this report.

Public education campaigns would be a powerful tool. Our nation and the Commonwealth have tackled important health and social conditions through the use of public education about a variety of topics, including the health risks of smoking, violence against women, shaken baby syndrome, Sudden Infant Death Syndrome and the "Back-to-Sleep" campaign, and child sexual abuse prevention. Similar campaigns can be undertaken to promote men's physical, mental, and social health.

As our experts recommend, such campaigns need address men as men, and consider the ways that we have socialized men, normative beliefs about men's behavior, and the public's perceptions of men. Thus, campaigns should strive to have both high-profile and everyday men discussing their struggles with health, mental health, divorce, and domestic violence victimization, and that it is manly to get help for these problems.

Another prominent suggestion is to begin education on these issues early, since many of these beliefs and behaviors start when men are boys. If we can socialize boys early on about the manliness of being healthy and seeking help when necessary – for example, through health-promotion classes in schools – the health of men in this country would improve greatly, and the costs for Massachusetts and the families living here would decrease substantially.