

A TREATMENT IMPROVEMENT PROTOCOL

Addressing the Specific Behavioral Health Needs of Men

TIP 56



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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

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Introduction

This chapter discusses how to engage men in the treatment process and addresses factors that can influence men's behaviors and attitudes toward behavioral health services. It reviews screening and assessment instruments and discusses these processes, including assessment of risk-taking, shame, male sexuality, and anger.

Screening and Assessment of Men

Screening and assessment are used to identify a client's strengths and problems. Normally, screening and assessment occur at intake, and both processes should continue throughout the course of treatment. Routine screening and assessment can identify problems that may arise or manifest after initial intake and can help pinpoint a client's strengths—such as strong marriage or family ties, strong motivation to change, or the absence of pressing crises. Routine administration of these processes is imperative, as the counselor's understanding of a client's strengths and problems significantly influences the type and duration of interventions applied as clients enter treatment in various behavioral health settings.

Screening and assessment are often grouped together, but they are distinct processes. Screening is a formal interviewing and/or testing process that identifies areas of a client's life that might need further examination. It evaluates for the possible presence of a problem, but does not diagnose or determine the severity of a disorder. For instance, screening a man for substance abuse might entail asking him a few interview questions about drug use and related problems and using a brief screening scale for substance abuse and/or substance dependence. When positive indicators are found, schedule the individual for an assessment.

Assessment is a more indepth evaluation that confirms the presence of a problem, determines its severity, and specifies treatment options for addressing the problem. It also surveys client strengths and resources for addressing life problems. Assessment typically examines not only possible diagnoses, but also the context in which a disorder manifests. A substance abuse assessment, for example, assesses the severity and nature of the substance use disorder and may also explore the possibility of co-occurring disorders; the client's family, marital, interpersonal, physical, and spiritual life; financial and legal situations; and any other issues that might affect treatment and recovery. Assessment generally involves indepth interviews and the use of various assessment instruments, such as psychological tests.

Although there has been little research into the differences between men's and women's responses to screening and assessment, some literature (e.g., Cochran 2005) suggests that men present unique difficulties. Masculine gender role socialization can lead some men to minimize difficulties or underreport problems—and some problems, such as depression, can manifest differently in men, thus disguising the disorder and leading to underdiagnosis or misdiagnosis (see Chapter 4 for discussion of this and other co-occurring mental disorders). In addition, different screening or assessment settings (e.g., prisons, outpatient programs, primary care offices) influence whether and how men present their struggles. Culture also plays a role; men from some nonmainstream cultures may be reluctant to share information about difficulties or illnesses. Counselors must be sensitive to these nuances and create an environment in which men feel open to sharing their vulnerabilities or perceived shortcomings.

This chapter focuses on screening and assessment processes and instruments specifically

applicable to male clients. Certain well-established physical, mental, and social assessments that are useful regardless of gender are also briefly introduced. When possible, the reader is referred to other Treatment Improvement Protocols (TIPs) that cover screening and assessment activities relevant for both male and female clients.

Comprehensive Screening and Assessment

The Institute of Medicine's (1990) three-step assessment process for problematic alcohol use offers a useful framework for organizing the assessment of men who abuse substances; see also TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (Center for Substance Abuse Treatment [CSAT] 1997a). Comprehensive substance abuse assessment documents detail the nature of the substance use problem and thoroughly describe the person with the problem so that appropriate decisions about intervention can be made.

The three steps in a comprehensive substance abuse assessment are screening, problem assessment, and personal assessment. The process begins with a screening to identify men in need of a problem assessment. Screening can be provided by any behavioral health counselor who has been trained in the screening process. Problem assessment documents patterns of use; signs and symptoms of substance abuse or dependence; and the social, spiritual, psychological, and medical consequences of use. Problem assessment typically occurs in the substance abuse treatment or behavioral health system. Assessment skills for behavioral health service providers include additional training, experience and clinical supervision in understanding the interrelationships between drug use and other facets of the individual's life, exploring an individual's motivation for and any resistance to treatment, and understanding the

scope of treatment services that might be available in the community behavioral health system. When problem assessment indicates the presence of substance abuse or dependence, a comprehensive, gender-aware personal assessment can add psychosocial data important for treatment.

Comprehensive assessment of men with substance use disorders should be carried out by a behavioral health specialist with a clear understanding of how male gender role socialization broadly influences the psychosocial adaptation, substance use, and help-seeking behavior of men. Behavioral health clinicians performing assessments should understand how chronic substance use affects the biopsychosocial adaptation of men and should be aware of the other social, psychological, and medical problems common among this population.

The screening and assessment instruments presented in this chapter serve to inform readers of current work in different clinical and research settings. The decision to pursue a specialized assessment (e.g., of a client's comfort level with gender roles or history of childhood abuse or neglect) must be made on a case-by-case basis that considers the appropriateness of the assessment, the skill and resources of behavioral health service providers in pursuing such an assessment, and the wishes and interests of the client. Treatment programs need to determine how best to use available resources when assessing clients. When a program is unable to conduct an assessment that providers believe is necessary—a mental health evaluation, for example—it should be able to refer the client to another provider for that assessment.

Assessors should show sensitivity to the values, attitudes, and behavioral dispositions that men share, as well as differences related to age, ethnicity, socioeconomic status, geographic location, disability status, and sexual orientation.

That is, while considering ways in which men are alike because of their gender, clinicians must also account for other characteristics that make them different from one another. See the planned TIP, *Improving Cultural Competence* (Substance Abuse and Mental Health Services Administration [SAMHSA] planned c) for more information on assessing cultural identity and acculturation.

Screening Men for Substance Abuse

The primary goal of screening is to identify men who need a comprehensive problem assessment. In a screening intake, the behavioral health clinician gathers facts by asking simple questions that evaluate whether a person requires further assessment. For screening, clients often fill out self-reports prior to a clinical interview. In such cases, the screener should be sensitive to possible language or literacy barriers by asking clients if they want assistance with forms or if they prefer to fill them out by themselves.

A client with a drug- or alcohol-related driving offense will likely have been screened in the criminal justice system and sent for further assessment and treatment. The clinician can thus move on to problem assessment using the justice system report but should go over it with the client, seeking input with questions, such as “Do you think this report is substantially accurate?” or “What other information would you add?” TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System* (CSAT 2005b), discusses treating clients in the criminal justice system, and TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* (CSAT 1998b), addresses treatment for clients transitioning from the criminal justice system to community-based treatment.

For listings of substance use disorder screening instruments, see TIP 16, *Alcohol and Other Drug Screening of Hospitalized Trauma Patients* (CSAT 1995a), and TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005c). TIP 24 (CSAT 1997a) addresses conceptual, procedural, and legal issues associated with screening for alcohol and drug abuse. TIP 24 and Alcohol Alert No. 56, *Screening for Alcohol Problems: An Update* (National Institute on Alcohol Abuse and Alcoholism [NIAAA] 2002), also contain lists of proven screening instruments. The Center for Social Work Research at The University of Texas–Austin (<http://www.utexas.edu/research/cswr/nida/instrumentListing.html>) and the University of Washington Alcohol and Drug Abuse Institute (<http://lib.adai.washington.edu/instruments/>) offer comprehensive lists of screening and assessment instruments online.

Clients can be screened by behavioral health service providers in a variety of settings for current or recent substance use using a variety of testing methods (e.g., urine, oral fluid, or hair for drug tests; breath analysis for alcohol). For more on these testing methods, the reliability of testing, specimen collection, and responding to test results, see Chapter 9 of TIP 43, *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* (CSAT 2005a), and Appendix B of TIP 47, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* (CSAT 2006c). Providers interested in laboratory tests for alcohol used in ambulatory medical settings can refer to Alcohol Alert No. 56 (NIAAA 2002).

Screening in other settings

Because substance abuse, especially involving alcohol, is the most frequent behavioral health issue among men in the general population (Kessler et al. 1994), healthcare, legal, educational, occupational, and social service organizations should always carefully screen men for

substance use when they present (see TIP 16 [CSAT 1995a]). Chronic substance abuse often contributes to legal, family, employment, housing, mental health, and medical problems; men with substance use disorders (particularly those reluctant to seek help for their substance abuse problem) may first seek help for related problems outside the behavioral health treatment system. When performed using proven methods, screening need not be expensive or burdensome. In fact, as noted in TIP 16 (CSAT 1995a), effective screening of men who abuse substances can prevent unnecessary expenditure of resources and promote more effective referral of men to the service delivery systems that can best meet their needs.

Often, the presenting problem indicates a need for problem assessment. For example, men warrant referral for further assessment when they present in the legal system after driving under the influence, in the emergency room after being injured while under the influence, or in a primary care practice with medical problems directly related to substance abuse. Service systems can integrate simple, structured screenings with clear markers of need for further assessment into their admission procedures (see TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* [CSAT 1994b]).

Substance Abuse Assessment Procedures for Men

When screening suggests the presence of a substance use disorder, problem assessment will help better define the nature of the client's problems. In many ways, assessment procedures for men and women do not differ significantly. Nevertheless, at each stage of the assessment process, providers should consider how gender may have affected a male client's past behaviors and how it may affect current

treatment. Assessment for substance abuse or dependence should focus on:

- Historical and situational factors contributing to the onset of the substance use.
- Patterns of use.
- Common signs and symptoms of a substance use problem.
- Consequences of use.

Comprehensive assessment also investigates other factors related to the client's substance abuse; these factors are discussed in this chapter under the heading "Gender-Aware Personal Assessment."

A variety of standardized approaches can be used in problem assessment. Retrospective methods using timeline follow-back procedures (Fals-Stewart et al. 2000*b*) define the nature and consequences of substance use during a circumscribed period of time. Because some men are more comfortable analyzing visual information, visually representing substance use and consequences of substance use along a timeline or on a calendar may be a better method of collecting and displaying information for male clients. Laboratory studies may also be used to document recent use, obtain markers of chronic use, and document medical consequences of chronic use.

Most standardized assessment instruments were developed largely with male client populations, and most are normed for men. Readers are referred to resource guides developed by NIAAA (Allen and Columbus 2003) and the National Institute on Drug Abuse (1994), which contain listings of clinical and research tools that can be used during problem assessment. The Center for Social Work Research at The University of Texas at Austin has also assembled a valuable list of screening and assessment instruments (<http://www.utexas.edu/research/cswr/nida/instrumentListing.html>).

Gender-Aware Personal Assessment

Once the nature of the substance abuse problem has been clearly established, the assessment process moves to the personal assessment phase. A comprehensive personal assessment routinely includes a complete physical examination, an exploration of significant events in the client's life that could affect treatment and recovery, the client's history of mental health or developmental problems, and an evaluation of his close relationships. In each of these areas, client strengths should also be assessed. Personal assessment aims to distinguish values, attitudes, and behavioral dispositions that the individual may share with other men or that make him different from other men. The first step should be a broad-based, gender-aware screening to identify substantive areas in need of more detailed assessment, such as those described in the following paragraphs.

Employment status and work history: Employment before and during treatment has been associated with better retention and improved treatment outcomes (Platt 1995; Sterling et al. 2001), especially for men (Arndt et al. 2004). Chapter 3 of TIP 38, *Integrating Substance Abuse Treatment and Vocational Services* (CSAT 2000*a*), discusses the assessment of vocational goals and training needs. Providers should also talk with clients about current and past employment and education to get a better understanding of what roles these factors may have played in the clients' substance abuse as well as how they might be used in promoting recovery.

Housing status and needs: A significant number of clients entering substance abuse treatment lack adequate housing or are at risk of losing housing. TIP 55, *Behavioral Health Services for People Who Are Homeless* (SAMHSA 2013), discusses issues relevant to the assessment of men who are homeless.

Criminal justice involvement and legal issues:

Providers should understand what outstanding legal problems clients face, any past history of involvement with the criminal justice system, and the roles these issues have played in their clients' lives. Counselors should also ask if a client is currently on probation or being monitored in the criminal justice system, how often the client is required to report to probation or parole officers, and the conditions under which the counselor might be required to report the client's progress to the criminal justice system. During assessment, inform the client of what information you are required to provide to representatives of the criminal justice system (e.g., probation officers), such as the results of positive urine drug screens or threats to self or others. Chapter 4 discusses how to address these issues in treatment.

Health status/physical health: Because chronic substance abuse is associated with poor physical health, comprehensive substance abuse assessment *must* include a complete physical examination (and is required for admission to most healthcare facilities). Ideally, the examination will include laboratory studies to screen for health problems associated with the use of specific substances (e.g., hepatitis C and HIV/AIDS for men who use injection drugs, cirrhosis and pancreatitis for men who abuse alcohol) and those health problems most common among men. If the male client is being seen in a hospital or residential setting, a physical examination with laboratory studies will undoubtedly be part of the routine admission process. In ambulatory settings, the initial interview should include questions about health history, general nutrition, sleep patterns, weight changes, last physical examination, and last dental examination. Men who have access to primary health care should be referred to their primary care physician upon admission to an ambulatory setting. Otherwise, programs should work with clients to help them access

needed care through other channels, such as public health clinics. One health-related area that can pose particular problems for clients in substance abuse treatment is chronic pain, the assessment of which is discussed in TIP 54, *Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders* (SAMHSA 2011b).

Functional limitations: Assessment should determine if the client has any functional limitations due to co-occurring physical and/or cognitive disabilities (Schrimsher et al. 2007). The behavioral health service provider must be able to accommodate a client with special needs. For example, a provider can accommodate a client who has lower back pain (which may not necessarily be described as a disability by the client) that is exacerbated by sitting for extended periods by giving the client permission to stretch or stand during long group therapy sessions. Similarly, a person with limited skills in reading or writing English may require modified versions of written client material. TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998e), offers more information on screening individuals for functional limitations.

Co-occurring mental disorders: Rates of co-occurring mental disorders among substance abuse treatment clients (both male and female) are high, and these clients often require special behavioral health services for effective treatment (see TIP 42 [CSAT 2005c]). Details on the assessment of mental disorders and co-occurring disorders are available in Chapter 4 of TIP 42. Additionally, TIP 50, *Addressing Suicidal Thoughts and Behaviors With Clients in Substance Abuse Treatment* (CSAT 2009a), presents information on screening potentially suicidal clients, and TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (CSAT 2008b), discusses

screening specifically for depressive symptoms. Chapter 4 of TIP 48 also discusses rates of specific co-occurring disorders among men and provides some insight into assessing and treating specific disorders in this population.

Trauma histories: Men with substance use disorders often have experienced multiple traumatic events during their lives. Men are more likely than women to be exposed to trauma, and substance abuse may increase the risk of trauma exposure (Breslau 2002). Even if past traumas have not resulted in a mental disorder, such as posttraumatic stress disorder, traumatic events can have lasting effects. Behavioral health service providers should be aware of a client’s trauma history to better understand his substance abuse and better aid him in recovery. The planned TIP, *Trauma-Informed Care in Behavioral Health Services*, includes a chapter on assessing trauma histories (SAMHSA planned g). The assessment of childhood trauma, specifically, is discussed later in this TIP as well as in TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000b).

Motivation to change: A client’s motivation to seek and comply with treatment is a key factor in predicting a successful outcome. TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999b), includes valuable information on a variety of assessment instruments that evaluate a client’s level of motivation and readiness for treatment.

Relapse risk and recovery support: Although it may be left to later stages of treatment, an assessment that evaluates a client’s risk factors for relapse and supports for recovery can reduce relapse risk and promote long-term recovery. The planned TIP, *Recovery in Behavioral Health Services* (SAMHSA planned e), focuses on this important topic.

Spirituality: At minimum, spiritual assessment should determine the client’s denomination, beliefs, and spiritual practices, if any, and should identify how these might affect his treatment or pose barriers to participation in mutual-help groups or other treatment practices (e.g., meditation). Specific questioning about how spirituality has helped a client through difficult times can elicit spiritual strengths that might positively influence substance abuse treatment. Clinicians can ask clients such questions as, “Who or what provides you with strength and hope? How do you access your sense of ‘higher power’? Is a belief in a higher power important in your life? Has it ever been?” (Joint Commission on Accreditation of Healthcare Organizations 2004). Gorsuch and Miller (1999) provide valuable insights into assessing spirituality in a mental health or substance abuse treatment setting. The Spirituality Competency Resource Center outlines a spiritual assessment that behavioral health counselors may find useful in discussing spirituality with clients (<http://www.spiritualcompetency.com/recovery/lesson7.html>).

Other assessment areas include beliefs about masculinity, family history, sexuality, and shame. These call for male-specific assessment and are thus discussed separately in this TIP.

All assessment should be ongoing with periodic reassessment throughout treatment, but the initial personal assessment can occur over a longer period of time than an initial problem assessment for substance abuse and dependence. Circumstances could require a personal assessment to be deferred. For example, if problem assessment shows alcohol dependence with the need for detoxification, then medically supervised detoxification in a hospital or residential setting should be pursued immediately—personal assessment should be deferred until the individual returns to an

ambulatory setting. Similarly, if a problem assessment done in a medical, behavioral health, legal, occupational, or social service setting shows a need for substance abuse treatment, personal assessment should be deferred to the substance abuse treatment setting. A client's sensitivity to some of the topics discussed in the following sections might also lead to deferral of in-depth exploration until the therapeutic alliance is sufficient to allow the client to be comfortable talking about such issues. In exploring gender and sexuality, clinicians should be sensitive to the degree of discomfort clients might experience. However, if a client shows that these issues are meaningful for him, further exploration enables the clinician to solidify the relationship with the client while also letting him discuss issues of likely importance for his recovery.

Some programs evaluate readiness for treatment in all men but reserve resources for detailed assessment of childhood trauma, cognitive impairment, personality disturbance, and other domains of psychosocial functioning for men who demonstrate a clear and convincing need for such assessments. However, a detailed assessment of personal definitions of masculinity and the relationship among these definitions, their substance use, and their attitudes toward help-seeking will aid treatment planning.

Assessing Personal Definitions of Masculinity

Behavioral health clinicians can examine a client's personal definitions of masculinity during a clinical interview to better address his unique problems and challenges. Using the traditional concepts, roles, and norms of masculinity described in Chapter 1 as a guide, clinicians can determine which roles a client identifies with (if any) and to what extent. For example, if the client pursues success at all costs at his office, does that behavior also carry

over into other aspects of his life— into his relationships with friends and family? Does he expect others to act similarly?

Once the clinician understands the client's personal definitions of masculinity, he or she can then explore the positive function these roles serve for the client. Is the client unusually aggressive so others do not bully him? Is he especially strong and independent so that he feels he does not have to rely on others? The clinician should also examine with the client the possible costs of such behaviors. Are the behaviors hurting the client's life and relationships with others, and, if so, how? Keeping these basic precepts in mind during the clinical interview will help both clinician and client better understand what changes need to be made. They will also help motivate the client to make those changes, thus enabling the clinician and client to develop a more effective treatment plan (Mahalik et al. 2003*a*; Pollack 2001).

A number of rating scales can quantify personal endorsement of traditional concepts of masculinity. In general, these instruments document individual differences in attitudes, beliefs, behavioral dispositions, and internal conflicts commonly associated with traditional concepts of masculinity. Thompson and Pleck (1995) compiled a list of these instruments with comments on the content and potential utility of each. The Male Role Norms Scale (Thompson and Pleck 1986), Gender Role Conflict Scale (O'Neil et al. 1995), and Masculine Gender Role Stress Scale (Eisler 1995) are among the briefer and more widely used measures. The Brannon Masculinity Scale (Brannon and Juni 1984) and the Male Role Norms Inventory (Levant et al. 1992) are longer measures that also quantify personal endorsement of traditional concepts of masculinity. Mahalik and colleagues (2003*b*) describe the Conformity to Masculine Norms

Inventory, a comprehensive measure that documents personal endorsement of the emotional, attitudinal, and behavioral dimensions of traditional concepts of masculinity, which may also prove useful.

Unfortunately, no reliable normative data exist for any of these instruments, and most have been used primarily in research (sometimes with populations that may not reflect the clients with whom many treatment providers work). However, if a client expresses an interest in improving his understanding of issues concerning masculine roles/norms, the clinician may use one of the instruments discussed here to help him explore the topic. In some cases, the client can use these scales and score himself without sharing the information with the clinician—if that will make him more comfortable. The decision to use any of these instruments or to perform an in-depth assessment of masculinity at all must be based on the ongoing sensitivity of the counselor to the client's situation, needs, and current status.

Assessing Family History

Repeated substance abuse by men tends to be consistent across generations within the same family (Kirisci et al. 2001). Consequently, any comprehensive behavioral health assessment of men with substance use disorders should include careful documentation of family history. A family tree can help document the nature and extent of substance use disorders and related problems in both the immediate and extended family (Gerson 2008). Marlin (1989) had men construct family trees to identify destructive, repetitive family processes occurring across generations. For more on family trees and assessing family history, see TIP 39, *Substance Abuse Treatment and Family Therapy* (CSAT 2004b).

Any assessment of family history should explore current relationships with family as well

as the client's concerns and wishes about how those relationships might change with continued abstinence from substances. For example, a man may hope that abstinence will improve his relationship with his children or worry about its effect on a relationship with a partner who continues to use. Men may have strong feelings about improving their relationships with children, spouses, or significant others, but might be reluctant to discuss those feelings and concerns; the assessment of family history is an opportunity for counselors to introduce these issues.

It is equally important to assess a man's family strengths. A sense of bondedness with significant others, the ability to rely on family for support, expressed concern from family members and their willingness to offer help, the physical proximity of family members, and a family history of resolving crises among family members are all indices of family strengths that can support clients in crisis.

Assessing a history of childhood abuse and neglect

Boys are more likely than girls to experience emotional neglect and to sustain a serious injury as a result of physical abuse (Sedlak and Broadhurst 1996). Although sexual abuse of boys is less common, its effects are lasting. Zielinski (2009) found that a significant proportion of men who have been sexually abused in childhood are negatively affected into adulthood. Men are likely to experience childhood sexual abuse differently than women, and a number of adverse effects from this abuse are uniquely experienced by men. Chapter 3 discusses the impact of childhood abuse and neglect (and other trauma) on men and suggests how to address it in treatment.

TIP 36 (CSAT 2000b) includes recommendations for formal assessment of child abuse and parental neglect. The short form of the

Childhood Trauma Interview (Bernstein et al. 2003) is a structured research interview that evaluates exposure to childhood abuse and parental neglect in adults who abuse substances. The instrument screens for childhood exposure to physical, sexual, and emotional abuse and physical and emotional neglect. TIP 36 includes a listing of standardized instruments for evaluating the psychological consequences of experiencing abuse and parental neglect as a child (CSAT 2000*b*).

Assessing current physical or sexual violence in the client's family

Several validated, structured protocols can screen, assess, and treat individuals who may be involved in ongoing domestic violence. Men with histories of physical or sexual violence typically present with angry defensiveness. The State-Trait Anger Expression Inventory-2, for example, helps identify men who are excessively angry (Spielberger 1999) by measuring experience and expression of anger. (For information on treating anger problems, see Chapter 3 of this TIP.)

Screening substance abuse treatment clients for the experience of domestic violence is important (Chermack et al. 2000; TIP 25, *Substance Abuse Treatment and Domestic Violence* [CSAT 1997*b*]; Easton et al. 2000). Screening measures, such as the Revised Conflict Tactics Scale (Straus et al. 1996), and guidelines, such as those developed by EMERGE (1995), can help determine the extent of abuse (see TIP 25, CSAT 1997*b*, p. 43). Additionally, understanding and applying Prochaska and DiClemente's stages of change model (1984) can help counselors perform a basic evaluation of the client's readiness to address intimate partner violence (Alexander and Morris 2008). The "Safe at Home" instrument for assessing readiness to change intimate partner violence is a 35-item self-report measure that can be administered when domestic violence is sus-

pected or reported (Begun et al. 2008). Counselors can be trained to do basic screening for domestic violence, but assessment services are more complex and require in-depth knowledge and skill (see TIP 25 [CSAT 1997*b*]).

A variety of instruments can help clinicians assess domestic violence risk. These include the Sexual Violence Risk-20 instrument (Boer et al. 1997), the Risk for Sexual Violence Protocol (Hart et al. 2003), the Spousal Assault Risk Assessment Guide (Kropp et al. 1995), and the Historical-Clinical-Risk Management instrument (Webster et al. 1997). Given the sensitivity of these issues and the differing stages of development these testing instruments are in, counselors should seek guidance in their selection and administration from behavioral health professionals who are trained in testing instruments and are knowledgeable about intimate partner violence.

Substance abuse and especially alcohol abuse are associated with increased domestic violence; substance abuse also is associated with increased victimization by domestic partners. Men may be the victims of domestic violence (perpetrated by either male or female partners) as well as the perpetrators. Although the extent of female-on-male domestic violence is debated, data suggest that it occurs more often than most people think (see Chapter 3 for more information and citations). Due to gender role expectations and norms, most men are reluctant to discuss victimization by their partners or even refuse to see violent behavior directed toward them as domestic violence.

For more information on screening and assessing anger and violence, see TIP 25 (CSAT 1997*b*). TIP 25 includes the Revised Conflict Tactics Scale for couples, among other resources. The Family Violence Prevention Fund offers a Practitioner Reference Card (<http://fvpfstore.stores.yahoo.net/prreca.html>) that suggests model questions to ask about

abuse, how to make referrals, and how to document findings.

Assessing Male Sexuality

Sexual assessment involves talking with clients about sensitive topics, including sexual trauma, sexual behavior, and the client's history of sexual development. For many clients, this area is fraught with anxiety and shame; sensitivity to the client's level of comfort in discussing these issues is needed, especially during the assessment stage when counselor and client are just beginning to develop a therapeutic alliance (Pridal 2001). Clients should be reassured of the confidentiality of any information they provide. To approach the matter with clients in an open and nonjudgmental way, counselors must explore their own concerns related to sexuality and should always have access to supervision to help them address this issue.

Assessment of a client's sexuality should address multiple aspects of sexual behavior as well as the client's *understanding* of that behavior. In terms of sexual orientation, for example, counselors should understand how the client self-identifies (e.g., gay, straight, bisexual) and what types of sexual behavior he engages in and with whom. Determine whether clients understand the importance of taking measures to prevent the sexual transmission of disease and how to use birth control when necessary. Explore the client's feelings about the relationship of emotional intimacy to sexual activity and the importance of sexual activity in defining his masculinity.

Chapter 4 of TIP 37, *Substance Abuse Treatment for Persons With HIV/AIDS* (CSAT 2000c), includes a section on HIV/AIDS risk assessment that is useful in assessing client risk for various sexually transmitted diseases. It provides a section on sexual risk reduction,

which should play a part in any assessment of men's sexual behavior. Some clients engage in risky sexual behavior because they do not understand the risks involved (and need to be educated), but others may gain pleasure from pursuing risk; the text box on the next page explains the motivations of this particular group of clients.

The Sexual Sensation Seeking Scale (Kalichman et al. 1994; Kalichman and Rompa 1995) and the Sexual Compulsivity Scale (Kalichman and Rompa 1995) help clients examine sexual risk-taking behaviors. The Sexual Sensation Seeking Scale is an 11-item self-report measure of sensation seeking related to sexual interests, and the Sexual Compulsivity Scale is a 10-item self-report measure of excessive preoccupation with sexual encounters. The reliability and validity of these brief scales when used in research on diverse samples of men has been documented (Kalichman et al. 1994; Kalichman and Rompa 1995). The Sexual Risk Scale is a 9-item self-report scale that measures risk for exposure to sexually transmitted disease based on engagement in specific sexual behaviors in the previous 6 months (Li et al. 2011).

Assessing for Shame

Clinicians and researchers have repeatedly highlighted the role that shame plays in the socialization of men (Pollack 1998b). Because men tend to be sensitive to experiences that provoke feelings of shame, clinicians need to be aware of how this sensitivity can affect treatment beginning in the screening phase. Although shame is not a male-only problem, the specific reasons men feel shame may be different from the reasons women do—and men may manifest their shame differently than women.

Understanding Risk-Taking

Human beings seek stimulation beyond that which satisfies their biological needs. This behavior is often referred to as sensation seeking. On the underlying motivation for high risk behaviors, Zuckerman (1979, 1984, 1994) hypothesized that certain individuals, called sensation seekers, were physiologically predisposed to seek out and engage in a variety of different, highly stimulating, novel behaviors. These included recreational activities (such as parachuting or mountain climbing), occupational activities (such as police work or car racing), increased experimentation with various substances (such as alcohol or marijuana), and increased exploration with numerous sexual partners and sexual practices. Early definitions of sensation-seeking emphasized the performance of actions that entailed physical risks. However, later research showed that other kinds of risk were also involved in this trait, including legal, social, and financial risks.

Burns and Wilde (1995) define risk-taking as any behavior for which there is significant uncertainty regarding potential losses associated with the outcome (e.g., speeding). Losses are undesirable consequences, whether foreseen or not (e.g., a speeding ticket or a car crash). The benefits of taking risks serve as positive reinforcers (e.g., making it to work on time or feeling that one has accomplished something others are afraid to do). When the subjective or perceived benefits of this behavior exceed the losses, the person is motivated to take the risk. However, sensation-seeking need not involve real threats or risks. For example, bungee jumping may seem terrifying and very risky, yet is not especially dangerous given appropriate safety precautions. The risk is deceptive. It is possible to experience the heightened arousal associated with this seemingly risky activity without great risk. Thus, being a sensation seeker does not always signify the taking of actual risks.

Male and female sensation seekers often take risks, but such activity is more pronounced in men. For many men, masculinity involves taking risks. As Thom (2003) notes, "most...leading causes of death among men are the result of gendered behaviours" related to risk-taking (p. 4).

Shame associated with a socially stigmatized behavioral health problem can cause some men to avoid screening and comprehensive assessment or to resist, in a hostile manner, screening and assessment (Fortenberry et al. 2002). Once the screening and assessment process begins, sensitivity to shame may cause men to withhold information about specific thoughts, feelings, and behaviors (MacDonald 1998). Because shame involves an interpersonal dimension, fear of shame will frequently be of concern to men as they begin to develop a helping relationship with a clinician (Retzinger 1998). Moreover, shame can influence compliance with specific aspects of a comprehensive assessment, particularly medical assessment and screening for sexually transmitted diseases (Fortenberry et al. 2002).

To evaluate shame accurately, clinicians must understand the conceptual differences between

shame and other negative emotions, particularly guilt. To evaluate men for sensitivity to shame, observe for it during the initial interview (Tangney and Dearing 2002)—clinicians usually can distinguish accurately between shame and other emotions. According to Retzinger (1998), shame generally is not expressed verbally, but verbal clues can show that a client may be feeling shame. Shame can be overt, with associated feelings projected onto an external source (such as another client); shame can also cause someone to focus on himself and his inferiority, which is known as bypassed shame. Signs of bypassed shame can include rapid speech, thought, or behavior, or comparing self to others. Another common sign of shame in men is anger, often used to hide from the pain of rejection (Retzinger 1998).

Advice to Behavioral Health Clinicians: Identifying and Evaluating Shame

- The best way to evaluate men for shame is to observe for it during the initial interview.
- Signs of bypassed shame include rapid speech, thought, or behavior, or comparisons between self and others. Another common sign of shame among men is anger.
- The Differential Emotions Scale, Experiential Shame Scale, and State Shame and Guilt Scale are brief measures designed specifically to measure current feelings of shame.
- When evaluating shame associated with victimization, questions like “Do you feel ashamed about ____? Can you describe how you feel? Do you feel like that often?” can help quantify frequency and intensity of shame reactions.
- The Internalized Shame Scale documents the extent to which shame as a negative emotion is magnified and internalized as feelings of inferiority, worthlessness, inadequacy, and alienation.
- The timing of the exploration of shame is important; such an assessment may need to wait until a working alliance has been formed between client and counselor.
- Shame can be evaluated through structured interviews and self-report instruments. The Test of Self-Conscious Affect-3 is a measure of how likely someone is to feel shame.

If shame is evident, behavioral health clinicians can use a simple procedure (Andrews et al. 2002) to evaluate shame responses. When evaluating shame associated with victimization, Andrews and fellow researchers simply asked their subjects, “Do you feel ashamed about ____? Can you describe how you feel? Do you feel like that often?” Responses to this short series of questions are then used to quantify frequency and intensity of shame reactions. The timing of this exploration is key and may need to wait until a working alliance exists between client and counselor.

Structured interviews and self-report instruments provide additional means for evaluating shame. Tangney and Dearing (2002) outline conceptual issues relevant to the measurement of shame and review many of the instruments commonly used to measure shame as an emotional state, as well as the tendency to feel shame as a psychological disposition. The Test of Self-Conscious Affect-3 (Tangney and Dearing 2002) is a measure of how likely someone is to feel shame. The Differential Emotions Scale, Experiential Shame Scale, and State Shame and Guilt Scale are brief measures designed specifically to measure current feelings of shame (for reviews, see Tangney and Dearing 2002). Although clini-

cians are unlikely to rely solely on such instruments to gauge the extent and nature of client shame, it is useful to understand the methods researchers use to evaluate shame.

Cook (2000) developed the Internalized Shame Scale to document the extent to which shame as a negative emotion is magnified and internalized as feelings of inferiority, worthlessness, inadequacy, and alienation. The most recent version of the scale includes norms developed from a sample of more than 1,100 men and women drawn from the general population. The reliability and validity of the scale has been documented when used with men who have substance use disorders (Cook 2000; Rybak and Brown 1996). Thompkins and Rando (2003) used it to associate internalized shame with male gender role conflict. For men with substance use disorders, however, Tangney and Dearing (2002) argue that the instrument may blur distinctions among shame as an emotion, the psychological predisposition to experience that emotion, and self-esteem as a stable personality trait representing general appraisal of self across situations.

These instruments have, for the most part, been used in research; norms against which to evaluate the emotional world of men with substance use disorders must be secured from

research reports but should be used cautiously. Each instrument also can be influenced by culture, including cultural and/or gender differences between the counselor and the client. For example, in some cultures, sustained or direct eye contact may be perceived as a sign of disrespect. For some men from certain cultures, it is more difficult to share shame with a woman, whereas others will find it more difficult to

admit shameful feelings to other men. Chapter 3 provides information on how to address shame and stigma in treatment. For more information on issues relating to cultural competence, refer to the planned TIP, *Improving Cultural Competence* (SAMHSA planned c); Georgetown University's National Center for Cultural Competence also offers numerous resources (<http://nccc.georgetown.edu/>).

Appendix A—Bibliography

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