The Eight Agreements on Males, Trauma, and Addiction Treatment

A collaborative work of MATRIC

The Eight Agreements on Males, Trauma, and Addiction Treatment were developed in May 2013 at the Males, Trauma, and Addiction Summit – held in La Quinta, California as part of the West Coast Symposium on Addictive Disorders. This historic summit was funded through a grant from the Ohrstrom Foundation. The summit was led and organized by Dan Griffin and co-sponsored by C4 Recovery Solutions, the Bridge to Recovery, and Griffin Recovery Enterprises, and marked the first time that professionals in the addiction and recovery field had come together to discuss males' experience of trauma.[i] The group emphasized the importance of more effectively and comprehensively addressing the issue of trauma as a keystone of males' recovery.

The group unanimously concluded that in order for professionals to best help all males recover and promote a process of healing from trauma, they must understand males' unique issues and needs. The goal of the Eight Agreements is to achieve the most efficacious treatment of males with addictive problems by urging the field to recognize the importance of comprehensively addressing their trauma. The group strongly believed that recognition of these agreements will lead to the development and implementation of more effective interventions to help maximize the health and recovery of males with addictive problems and increase the likelihood of their successfully achieving long-term recovery.

The following document is an elaboration of these Agreements co-authored by the founding members[1] of the Males, Addiction, and Trauma Recovery International Consortium (MATRIC) for the Gender Matters, Men Matter conference sponsored by University of Colorado Hospital Center for Drug and Alcohol Recovery (CeDAR) held in Broomfield, CO in October 2014.

[1] Started in July 2014, the founding members of MATRIC are: Dr. Mike Barnes, Steve Millette, Rick Dauer, Dan Griffin, David Washington, Chris Dorval, Tony Marquez, Cody Gardner, Dr. Roger Fallot, and Dr. Richard Bebout

Agreement 1:

While progress has been made in the understanding of trauma, there remains a myth that trauma is not a major issue for males.

Posttraumatic Stress Disorder is a relatively new diagnosis. It was first formalized in the Diagnostic and Statistical Manual (3rd Edition) in 1980. Prior to that time, trauma was discussed in terms of the events that survivors experienced, such as rape, combat, spousal abuse, etc. Once it was determined that all trauma survivors, regardless of trauma type, experienced a relatively universal set of symptoms, researchers, scholars and practitioners set out to identify the biological, psychological and social implications for trauma survivors and their families.

To understand the origins of the belief that trauma is not a major issue for males, it is important to recognize how this emerging dialog about trauma challenged the longstanding societal rules of silence regarding sexual abuse, rape, domestic violence, and other issues. For the first time, women were empowered to speak about abuses and other family secrets that had been widespread for generations. At the same time, the evolution of the women's movement, feminist theory, and multiculturalism provided women with an emerging political strength, which garnered support throughout many areas of mainstream society. Within this process, advocates for women's issues challenged the dominant patriarchal worldview and brought an increased focus on the role of men as perpetrators. While this process was a significant achievement for women, it resulted in the minimization of the experience of boys and men as fellow trauma survivors.

As social support grew for women to speak about their traumatic experiences and seek treatment to resolve their traumatic stress, the social support for men who were victims of similar types of abuse did not materialize. Despite this progress, young boys and men continued to experience the social pressure to act strong, take it like a man, and to be angry rather than sad or hurt. Combat and other war-related experiences were the exception to this rule, and men who experienced trauma within a military context fought for social

acceptance of their experience of trauma and to receive services for their diagnosed PTSD. This exception led to a skewed belief that men only experienced trauma following extreme events and that these men had societal support for coming forward and seeking treatment.

Several of the agreements that follow will address how this ongoing socialization continues to play a role in how men acknowledge trauma. Of significant importance in this "new" discussion is how male socialization impacts the incidence of addiction and the effectiveness of addiction treatment.

Agreement 2:

Trauma is a significant issue for males with substance use and/or process addictive disorders.

The prevalence data clearly demonstrates that boys and men experience traumatic events at alarmingly high rates. This is particularly true for the men who enter the addiction treatment system. The abuse of mood-altering chemicals is a very effective (in the short term) coping strategy to manage many of the symptoms of post-traumatic stress. And subsequently, the use of alcohol and other drugs can lead to significant problems, including additional trauma.

The widely accepted principles of trauma-informed care lead us to recommend that "universal precautions" are adopted. In other words, assume that every man entering a treatment facility has experienced trauma. This does not mean that we label all of our clients as trauma victims. In fact, this could be equally as harmful as failing to address the issue at all. What it means is designing services and creating organizations that are trauma-informed and gender-responsive. The strategies for managing the symptoms of trauma are useful and effective coping skills for every man.

Agreement 3:
Males are biologically and culturally influenced to minimize or deny traumatic life experiences.

Research supports the reality that while men experience more traumatic events than women, women are diagnosed with PTSD more frequently than men. In the United States, three quarters of the population experience at least one traumatic event in their lifetime. From a gender perspective, approximately 60% of men and 50% of women report having experienced one traumatic event and approximately 10% of men and 5% of women report having experienced four or more traumatic events. Even though women seem to experience fewer traumatic events than men, it is noteworthy that they are diagnosed with PTSD twice as often as men.

There appear to be many reasons for these gender differences. One important reason is the fact that men and women process highly stressful and traumatic events differently in terms of their biological responses. Research indicates that men and women respond to the secretion of stress hormones such as Cortisol and Oxytocin in different ways. Women appear to shift more easily into a state of dissociation (the body's ability to avoid feeling states while experiencing trauma triggers), while men appear to remain in the fight or flight response (i.e., appear more angry and defensive). Both processes serve to allow the individual to avoid dealing directly with the traumatic event, while appearing to deny the root cause of their current experience. These gender-specific responses also impact the actual diagnostic process in that men often do not meet the full DSM V diagnostic criteria for PTSD due to their lack of parasympathetic/dissociative symptoms.

A second reason for the proliferation of this misperception is that men have been socialized to respond to traumatic events differently than women. Boys are often raised to adopt a worldview in which men must demonstrate strength and competence, avoid emotion, and deal with their problems without asking for help. As a result, anger is often the only allowable emotion, while more genuine experiences of hurt, fear, anxiety, depression, or grief remain unsupported and socially prohibited. This masculine response to traumatic

events often results in two significant outcomes: one, men being misdiagnosed as angry, antisocial, or personality disordered and two, men being much less inclined to identify any experiences as traumatic because the notion goes against any of the core characteristics of traditional masculinity. The angry or antisocial presentation is often viewed as an externalization process of defensive avoidance, blame, and perpetration of others, rather than as a male's socialized response to living with traumatic stress disorder.

Agreement 4:
Addiction treatment has been negatively influenced by cultural myths about males.

Although the traditional addiction treatment system has predominantly served men, addiction and mental health professionals have not focused on the unique issues and needs of males in the context of how they are raised to be men in our society. Additionally, many aspects of the predominant treatment models actually reflect harmful stereotypes about men. Some of these false stereotypes are:

- Men don't care about relationships
- Men don't care about or are unable to express feelings
- Men need to be broken down before they can be built back up
- Men act aggressively solely to manifest power and control

The perpetuation of these stereotypes within treatment settings is a contributing factor in poor engagement, atypical discharges, and high relapse rates.

While men may lack many relational competencies, they clearly care about their relationships and expressing their feelings, and they have a strong need for connection and intimacy. Men may not be fluent in the language of feelings, but this is often the result of powerful social pressures they experience from a very young age. Men may act in aggressive and even violent ways, but this also is rarely the product of conscious choice. Once we begin seeing these behaviors as adaptive survival mechanisms, we will begin treating men with compassion and we will honor their experiences.

This is not at all to suggest that men should not be expected to take responsibility for their actions and the consequences of their actions. It does suggest that if we give men a safe space and permission to explore new coping skills, we will find that the majority of them have a strong desire to connect with others in mutually supportive relationships.

Agreement 5:

Males are often assumed to be the perpetrator, which has negatively biased our concepts of trauma and models for addiction treatment, and often results in the re-traumatization of males.

Despite the progress we have made in the past two decades in understanding the complexities of interpersonal violence, the dominant model persists that women are the victims and men are the perpetrators. Prevalence data clearly indicates that many men entering the behavioral health care system have been abused, neglected, or otherwise maltreated. "Man as victim" has never been an integral part of the dialogue regarding trauma and trauma-informed care.

There has been a long held belief that if we acknowledge the influence of trauma on men's violent behavior we would be tacitly giving them an excuse to not take responsibility for ending any violent or abusive behavior they may be engaged in. That somehow identifying a man as a victim absolves him of responsibility for his behavior. This has significant ramifications. When males are identified solely as perpetrators, it is inevitable that we lose focus on male trauma. We ignore how the cycles of violence and abuse are transmitted generationally. We fail to view our male clients with compassion and warm regard. Perhaps most important, we don't take into consideration the considerable impact of male socialization on a man's ability to recognize and acknowledge trauma and how service delivery systems perpetuate this ignorance

In systems predicated on the belief that men are the problem, there is a danger that male victims of trauma will be re-traumatized. This occurs when men are not given a safe venue and permission to talk about their experiences. It occurs when their reality is not validated, thus replicating what may have happened within their family system at the time of the abuse. It occurs when the primary treatment modality is one based on confrontation. When men's anger, aggressiveness, and violence are seen exclusively as functions of power and control, rather than a desire for safety, we will inevitably default to a control model of treatment rather than a model dedicated to change and growth.

Agreement 6:

Male trauma must be assessed and treated throughout the continuum of addiction services.

Addiction professionals generally receive inadequate training for assisting patients in managing their trauma. As a result, in many treatment settings, counselors, therapists, peer advocates, and other human service workers are unlikely to screen or assess for a history of traumatic experiences following the initial intake assessment.

Experts in the mental health field have asserted that screening for and assessing trauma in the earliest phases of addiction treatment are critical for building therapeutic relationships with trauma survivors and for assisting them in developing an appropriate course of treatment. In recent years, some progress has been made in this area. However, the assessment process has occurred historically at the initiation of treatment services when there is no effective therapeutic relationship and is generally not repeated throughout the course of treatment.

This practice remains a significant barrier to men receiving the care they need. As a result of the socialization process, men are inhibited in their ability and willingness to acknowledge abuse. Many men will not endorse traumatic experiences until they have developed a trusting relationship with their peers and caregivers. Others may deny trauma as a result of how violence and abuse have been normalized within their family or community. Thus, the initial screening process, often predicated on close-ended questions, may yield a high percentage of "false negatives". It is imperative that the treatment process be a continuous cycle of assessment, problem identification, goal setting, development of therapeutic interventions, and re-assessment.

Agreement 7:
Male-responsive services will improve addiction treatment outcomes.

Gender-responsive and trauma-informed treatment settings can enhance addiction treatment effectiveness. We propose that programs that employ systemic interventions like gender-responsive and trauma-informed treatment will engage professionals who recognize gender-specific trauma symptoms and understand that male anger and acting out behaviors may be a defensive response to threat, rather than a sign of low motivation or resistance to treatment. Treatment will focus on providing a safe therapeutic environment, where men can move through the treatment process learning about the effects of gender socialization, the effects of abuse, and the intersection between trauma and substance use disorders. Men will learn how to identify trauma symptoms while also learning to manage autonomic nervous system responses of anger and defensiveness. Within this treatment process, men can begin to feel safe, physically and emotionally, and learn to more fully acknowledge and resolve trauma symptoms, while entering a culture of recovery.

Unfortunately, there are relatively few programs that utilize this integrative treatment philosophy and even less research to date on the impact of such services on behavioral health (addiction and mental health) outcomes for the males who participate in these programs. Although there are excellent clinical reasons to expect that gender-responsive services for males will have a positive impact on outcomes, it is important to establish an evidence base for these services by conducting research and evaluation programs that examine this impact. Within this process, it will be important to continue to develop and test the utility of gender-specific interventions such as “Helping Men Recover” and “Men’s Trauma Recovery and Empowerment Model” that focus on trauma, addiction, and mental health. Once implemented, it will be critical to investigate the impact that gender-responsive cultures of care, which take gender into account in all aspects of program functioning, have on recovery outcomes.

Agreement 8:

Effective treatment of male trauma will help to interrupt cycles of violence, abuse, neglect, and addiction.

In the aftermath of trauma, individuals develop coping mechanisms in an effort to prevent further harm or to numb painful feelings and memories. For many men, these adaptive behaviors can become problematic with respect to physical, emotional, and spiritual wellbeing. These adaptive behaviors can also have a devastating impact on interpersonal relationships. For instance, some men who have been the victims of abuse will become abusive as a means of feeling safe and powerful. Other men might respond to trauma by isolating and avoiding intimate relationships.

Trauma is a risk factor for the onset or exacerbation of substance use issues. Mood- altering chemicals numb feelings of pain and, in the short-term, help survivors of trauma deal with unpleasant feelings, thoughts, and memories. Brain research has also clearly shown that the areas of the brain that addiction affects overlap considerably with the area of the brain that trauma affects. Unresolved trauma increases the probability that violence, abuse, and addiction will continue within affected family systems. Helping men learn to manage their symptoms and develop coping mechanisms that are more self-enhancing and pro-social will inevitably help to interrupt these cycles and support men in establishing long-term recovery and engage in and sustain healthy relationships.

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[i] The following individuals arrived at consensus on the Eight Points of Agreement as part of the West Coast Summit: Miles Adcox, Onsite , Mike Barnes, Ph.D., CeDAR, Richard Bebout, Ph.D., Community Connections, Allen Berger, Ph.D.,. Lou Cox, Ph.D., Judy Crane, The Refuge-A Healing Place, Richard Dauer, River Ridge Treatment Center, Tian Dayton, Teresa Descilo, Trauma Resolution Center, Eduardo Duran, Ph.D., Norma Finkelstein, Ph.D., Institute for Health and Recovery, William Ford, Ph.D., C4 Recovery Solutions, Rawly Glass, The Bridge to Recovery, Dan Griffin, Griffin Recovery Enterprises, Inc. & Males for Trauma Recovery, William Pollack, Ph.D., Harvard Medical School , David Powell, Ph.D., International Center for Health Concerns, Pat Risser, Males for Trauma Recovery, Jaime Romo, Ed.D., Males for Trauma Recovery , Cheryl Sharp, The National Council for Behavioral Health, Dr. Brian Sims, M.D., Psychiatrist, Correctional Mental Health Services, David Washington, Males for Trauma Recovery, Rob Weiss, Elements Behavioral Health , Jacquie Wheeler, Jaywalker Lodge