Males and Trauma-Informed Care

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Roger D. Fallot, Ph.D.
Richard Bebout, Ph.D.
Dan Griffin, MA
Rick Dauer, LADC

Introduction

Trauma-informed care may be thought of as one of five values-based approaches to behavioral health. These include a recovery-orientation, cultural competence, and spiritual enrichment as well as trauma-informed and gender-responsive cultures of care (Fallot, 2014). This article discusses trauma-informed and gender-responsive cultures of care, as these apply to males.

Trauma-informed care (TIC) has grown out of a recognition that the vast majority of people who come to behavioral health service centers have been adversely affected by experiences of violence and abuse, either directly and/or as witnesses. Accordingly, behavioral health services need to take into account in every aspect of their functioning--the physical environment as well as every contact, relationship, and activity-- the reality of violence and abuse in the lives of men and its impact on the diverse paths to recovery males may take. In short, the entire culture of these programs needs to be sensitized to the potentially debilitating impact of trauma in the

lives of the men and boys served. And the culture needs to be attuned to the way that we have created a social world where males and females often experience trauma very differently.

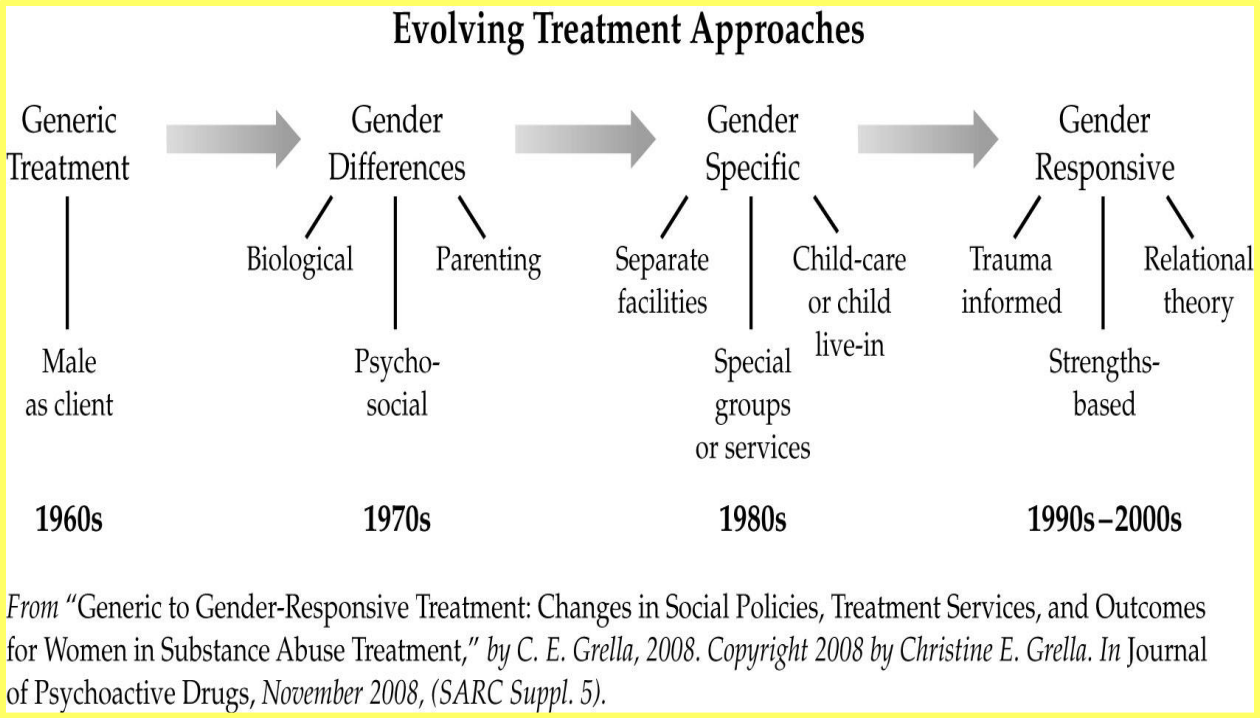
One of the newer movements in terms of trauma-informed care has been the incorporation of gender-responsiveness into the TIC culture changes. The authors of this article fundamentally believe that, on the whole, men experience, respond to, express the symptoms of, and heal from trauma differently than women. Until recently, gender-specific and gender-responsive services were, in truth, only *female*-specific and *female*-responsive services. The term "gender" was essentially synonymous with women and women's experiences. For the most part, men's unique issues and needs were ignored or it was assumed that these were addressed in the generic and putative "gender-neutral" services that men have always received.

Gender neutrality is frequently discussed particularly in trauma work. An oft-quoted phrase is: "we simply meet them where they are at." We do not believe gender neutrality is a viable solution to the psychic pain of males seeking services, at least not at the beginning of the therapeutic process. While transcending gender may be possible for individuals, we believe it is ineffective and misguided to take this approach at the beginning of the individual's engagement in clinical services. While it is true the dominant model of services was created by men and served men, these men were primarily working under the "Male Messages" (Fallot, Harris, Bebout, et al., 2005) or "Man Rules" (Griffin, 2014). And, the identified victim was assumed to have experienced trauma primarily – or even solely - through military combat. We are now painfully aware that male trauma occurs in a variety of settings and takes many forms. It is increasingly evident that there is a great benefit to taking into consideration men's unique issues and needs, particularly with respect to male psychological development and socialization, when developing and providing services. (Griffin & Anderson 2008; Lyme et al. 2008; Griffin 2009; Griffin, Covington, and Dauer 2011; Fallot & Bebout (2012); Griffin 2014.) This article constitutes a significant step forward to include the experiences of males in the trauma-informed care culture.

There is no question that male socialization has a distinct undercurrent of violence. The rules about masculinity are learned very early and often come with a high degree of coercion and abuse as part of the process of inculcation. A principal message is not to admit weakness, the quintessence of which would be acknowledging abuse or the incredible pain caused by traumatic events. This fact alone should have us significantly questioning the idea of gender-neutral trauma services. Furthermore, many men are raised to see violent/abusive events as normative, not as trauma. There are numerous messages in the process of male socialization that support not only the development of trauma – particularly as children and adolescents - but also influence men to remain silent about, if not completely unaware of, trauma long into their adult years. Phrases such as, "I deserved it" or "It was for my own good" permeate many men's psyches long into their lives and even during their recovery from addictive problems and/or mental health challenges.

Brief Overview of Gender-Responsive Services for Males

For the past several decades we have focused on women's unique needs and issues - understandably so. The original model of care was designed by men, with men as the primary users of services and this simply was not clinically appropriate for women. Beginning in the 1970s, women began to argue, fight for, and design services that truly spoke to their experience. While we must continue to focus on and improve women's services, we have unfortunately spent almost *no time* rethinking and enhancing services for men. The traditional regimen of treatment services has always been focused on men but it has not been focused on men's unique challenges and needs in the context of how men are raised *to be men* in this society. .



From "Generic to Gender-Responsive Treatment: Changes in Social Policies, Treatment Services, and Outcomes for Women in Substance Abuse Treatment," *by C. E. Grella, 2008. Copyright 2008 by Christine E. Grella. In* Journal of Psychoactive Drugs, *November 2008, (SARC Suppl. 5).*

As seen in the graphic just above, the first model of treatment did not take gender into account because the assumed client was male. Once women began accessing services with some regularity it became clear that the dominant model was not the most effective one for them. This awareness led to the gradual development of what is known as gender-separate treatment. This model of treatment physically separated men and women, but primarily provided the same treatment services with the addition of parenting support for women and some attention to biological differences. Men and women would be in separate groups or program tracks, but would receive essentially the same care. The next stage in this evolution were the creation of gender-specific services. Gender-specific implies the provision of services that speak to the unique experiences and needs of boys/men and girls/women, as well as the impact of the socialization process on psychological development. (Covington & Bloom) Again, women were in the forefront of this movement, and a significant component of this new model was a recognition of the violence and abuse that women had been suffering in silence with. The focus was on designing materials and approaches that would best meet the needs of girls and women because the assumption that men did not need special attention persisted.

Today's best practices in behavioral health care are gender-responsive. This term implies that therapeutic interventions are focused on the totality of services. This includes site selection, staff selection, client goals and objectives, programmatic structure, and program content and materials. (Covington & Bloom) Gender-responsive services also focus on the pervasive experience of trauma. We contend that gender-responsive and trauma-informed are conceptual paradigms that cannot exist independently.

Many behavioral health facilities and private practice clinicians have made significant strides in designing gender-responsive services for girls and women, including addressing the experience of trauma. Only recently has the field started to look at the prevalence of male trauma, how men experience and heal from trauma, and how unresolved trauma is a major barrier in recovery from process addictions and other mental health disorders. This article is our attempt to promote this conversation and to suggest some meaningful advances in the way that we think about men and the burdens they carry.

The Man Rules

One of the most significant and powerful experiences a human being goes through is gender socialization. Throughout the world when a baby is born, one of the first observations is of the genitalia and, from that, a determination of the portal through which that human infant will pass and what will gradually become the filter through which they see the world. Gender, however, varies across cultures significantly. Nonetheless, our experience is that there seem to be some common threads in how males are raised to be men, particularly in Western culture. Fallot, Harris, Bebout , et al. (2005) developed the Men's Trauma Recovery and Empowerment Model (M-TREM) that draws heavily on the "Male Messages" men and boys receive in this culture around gender socialization. Messages such as "Men are tough and strong and stay cool in the face of danger;"Men are independent;" "Men are competitive and win;" "Men have a lot of sex;" "Men do not cry no matter what;" "Men take charge and are in control;" (among

others) form the basis for men's self-understanding in this group intervention. In his book, *A Man's Way through Relationships: Learning to Love and Be Loved,* Griffin (2014) discusses at length the concept of male socialization through what he calls the Man Rules (see the list below.) While very similar to the Male Messages his interpretation of them is notable. .

The Man Rules™

- ***Always be in Control***
- ***Don't Cry***
- ***Don't ask for help***
- ***Don't show emotion***
- ***Be a sexual superman***
- ***Don't show weakness***
- ***Be a protector***
- ***Know everything***
- ***Be a provider***

Some of the key elements of this interpretation are:

- The anti-female typified through the "don't be a girl" exhortation that is hidden in the admonitions to not be weak, not be vulnerable, not ask for help, etc. – all traits commonly associated with girls and women.
- The anti-relational through a focus on self-sufficiency, non-emotionality, hypersexuality, and independence.
- The non-identity based upon the significant number of "don'ts" in the Rules that tell men who they are not rather than who they might be.

While not inherently bad or wrong or unhealthy, when taken to an extreme the Man Rules can be severely damaging to a man and his relationships. The greatest impediment for men – and those of us attempting to help them – is not seeing the Man Rules or the Male Messages and the impact they are having on a man's life.

A fundamental concept in gender-responsive services for men is the powerful tension between the expected behaviors that are part of men's socialization and the expected behaviors when one is in treatment or engaged in therapeutic services of any kind. The table below created by Griffin© shows the tension between traditional male socialization and the common principles invoked for recovery, or even the therapeutic process – one side representing the rules by which men learn how to be men from their families, the community, and the media and the other side being key principles in the process of recovery and therapy.

The Man Rules™	*The Principles of Recovery/Therapeutic Change*
• ***Always be in Control***	• ***Show vulnerability***
• ***Don't Cry***	• ***Ask for help***
• ***Don't ask for help***	• ***Admit powerlessness***
• ***Don't show emotion***	• ***Let go of control***
• ***Be a sexual superman***	• ***Be responsible***
• ***Don't show weakness***	• ***Be of service***
• ***Be a protector***	• ***Express emotion***
• ***Know everything***	• ***Humility***
• ***Be a provider***	• ***Sobriety***

The tension between these two sets of expectations is obvious. However, this dichotomy is rarely acknowledged, let alone addressed, in men's treatment. Far too many men experience

therapy or treatment as threatening to their sense of identity and emotional safety. They are asked to abandon core beliefs, characteristics, and behaviors that may have developed over decades. And when they don't accede, we label them as unmotivated, resistant, not ready to get help. . To add to the confusion, some of the Man Rules – for instance, integrity, responsibility, and discipline – are also principles of recovery. The process of healthy recovery is not about rejecting the Man Rules and embracing the principles of recovery. Rather it is helping the men come to a place where they can freely choose the kind of man they want to be – integrating from both sets of expectations. .

When they first enter treatment programs or therapy, many men are in essence being asked to turn their backs on an identity they have worked tirelessly to create - one often forged in a crucible of coercion, threats of violence, and actual violence. We believe that exploring this dynamic with our clients in a safe space is a key to engaging them in therapy and beginning the process of healing. This last point is essential to effective work with men with trauma: at some point in their lives, men learn that following the Man Rules will keep them safe, not only emotionally but physically as well. For some men, in certain environments, particularly in the criminal justice system, breaking the Rules might literally put their lives in jeopardy. The Man Rules are entirely about safety; unfortunately they also make it extraordinarily difficult for men to acknowledge trauma. The Man Rules are also about strength and power – male trauma is about vulnerability and shame. We believe that exploring this dynamic with our clients in a safe space is a key to engaging them in therapy and beginning the process of healing.

The Eight Agreements

The Eight Agreements (Appendix A) 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. 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.

Returning to our previous discussion of trauma, it should be noted that the fifth agreement in the *Eight Agreements* document states: "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." While controversial, it reinforces the idea that males are the de facto perpetrators. This has made male as *victim* invisible. Combine the effects of the Man Rules with our preconceptions of who might be victimized, and this goes a long way toward explaining the historic under-reporting of male abuse, neglect, and trauma. This false concept insidiously pervades much of the thought on trauma. Simply imagine what a person with trauma looks like – do you see a male or a female?

The myth about trauma not being a significant issue for males has permeated the fields of addiction and mental health for decades. There are numerous reasons for the proliferation of this myth. Many current trauma services – including almost every single curriculum currently being used - in the addiction field were created by women, for women, and normed on women's experiences. Women broke the silence about sexual abuse, domestic violence, and

other dark secrets of the Western family. However, we must acknowledge that as a result there is a lingering belief – often in the background of our thought – that women are victims and men are perpetrators. When men behave aggressively, even if this represents an adaptive response to a history of trauma, we struggle to find compassion and understanding. It should not surprise us that male trauma has been massively under-reported and poorly addressed. There is a "perfect storm" of invisibility, shame, and public misperception that has kept this issue from receiving the attention it deserves. .

The Role of Shame

Central to the creation of trauma-informed and gender-responsive cultures of care is a deep understanding of the role of shame. Shame is a complex experience with physical, cognitive and emotional elements that are nearly always present for both men and women surrounding their experiences of trauma. The fundamental experience of shame—of not being enough, not measuring up, being "less than"—appears to be similar for men and women, though shame may be triggered, managed and expressed differently. The ground-breaking qualitative research on vulnerability and shame done by Brene Brown (2007, 2010) offers a useful framework for this discussion. Fallot and Bebout (2012) have often contended that women are more likely to experience *guilt* in connection with traumatic interpersonal violence—believing they have *done* something to invite their abuse, whereas men experience *shame* at *being* weak, not being man enough to prevent it. A serious violation of the Male Messages and the Man Rules. Nevertheless, men and women have much in common in this regard. Brown (2007) first interviewed hundreds of women about their experiences of shame and later incorporated men into her study—revealing key similarities as well as differences. Representative responses from female participants include:

- "Shame is being rejected."
- "When you can't do it all and people know you're failing."

- "You work hard to show the world what it wants to see. Shame happens when your mask is pulled off and the unlikable parts of you are seen. It feels unbearable to be seen."
- "Shame is feeling like an outsider—not belonging."
- "Shame is being exposed—the flawed parts of yourself that you want to hide from everyone are revealed. You want to hide or die."

Brown identifies the primary trigger for women as falling short of an internalized ideal that demands that women be able to do it all and take care of everyone around them and likens the experience of shame to being entangled in "a web of layered competing and conflicting expectations."

After being challenged by a man in the audience at one of her presentations, Brown ultimately widened the scope of her research to include men which revealed notable similarities and differences (2010). For men, shame is represented by "a small box" in which the expectations, as we have expressed in multiple ways, center on masculinity and what it means to be "a real man". Representative responses for male participants include:

- "Shame is failure. At work. On the football field. In your marriage. In bed. With money. With your children. It doesn't matter—shame is failure."
- "Shame is being wrong. Not doing it wrong, but being wrong."
- "Shame is a sense of being defective."
- "Shame happens when people think you're being soft. It's degrading and shaming to be seen as anything but tough."
- "Showing fear is shameful. You can't show fear. You can't be afraid. No matter what."
- "Shame is being seen as the guy you can shove up against the lockers."
- "Our worst fear is being criticized or ridiculed—either one of these is extremely shaming."

Men report feeling trapped by a single "suffocating" message—DO NOT BE WEAK.

What further differentiates men and women is often what happens after the initial experience of shame and how we manage the powerful feelings and automatic thoughts that accompany shame. Two sets of responses prevail. First—there is the overwhelming desire to hide and retreat, which men often do to extremes. The following brief vignette illustrates the wish literally to not be seen.

Nick, a man in his late 50's, joined a group trauma recovery program for men at an urban behavioral health center. Over the life of the group, Nick disclosed that he had been sexually abused by a much older brother who would come into his bed at night to "share" what he referred to as "brother love." He also later suffered sexual abuse in juvenile detention that was far more violent—and only then did his understanding of his the abuse by his brother shift. Notably, Nick always wore dark sunglasses to the groups. In a session focused on the emotion of shame, Nick articulated that his glasses were a manifestation of shame and his profound fear of being seen and a desire to hide his history of victimization that he sensed others would recognize if they looked in his eyes. Other group members resonated with Nick's experience. The leader first affirmed the legitimacy of Nick's way of managing the wish to hide and attempted to install hope, saying, "It seems you've figured out just what you need to do for now, and I look forward perhaps to a day when you no longer need the glasses all the time."

Two years later, Nick enrolled in another group and introduced himself as 'Marion,' his middle name, saying that he was a new person since completing a residential drug treatment program, and could never go back to being 'Nick' again. He came without the customary sunglasses, stood taller, and welcomed eye contact—proud in his recovery and able to tolerate, even able to embrace being seen.

The second reflexive response that men exhibit in response to shame (far more often than women) is the impulse to strike out and to engage in destructive responses, both toward self (drinking and drugging) and toward others. Indeed, it is hard to overstate the stakes here. One

study showed that the strongest predictor of violence and aggression is rigid conformity to gender role norms combined with the experience of a public failure. Thus helping men to recognize, tolerate and manage shame effectively should be understood as a critical recovery skill to be taught in both substance abuse and mental health treatment settings.

Again, Brown's work is enormously helpful. She introduces the concept of "shame resilience" and describes new "habits" or self-regulatory skills that must be acquired through practice and repetition. Specifically, Brown (2007) defined shame resilience as "a person's ability to recognize and understand shame, move through it constructively while maintaining a basic level of authenticity, and increase his or her level of courage, compassion, and connection as a result of experiencing shame."

Individuals with high shame resilience, those who navigate shame well, have high levels of accurate self-awareness, recognize specific shame triggers to which they are most vulnerable, reach out and share their shame stories with someone they trust, and verbalize shame. Brown (2009) developed a 12 session model called the Connections Curriculum to build shame resilience, but it seems that these concepts and skills can and must be embedded in trauma-informed and gender responsive care and are predicated on the TIC values of safety, , trustworthiness, choice, collaboration and empowerment (Fallot and Harris, 2007). Compassion for men in recovery also demands that we always be mindful of just how necessary acquiring these new skills are AND just how counter this learning is to the culture of masculinity.

Males and the Core Values of Trauma-Informed Care

The five core values of trauma-informed cultures of care are safety, trustworthiness, choice, collaboration, and empowerment (Fallot and Harris, 2007). These are derived from the experiences of many trauma survivors and stand as the antidotes to the toxic impact of trauma and abuse. For those people who have experienced the world as dangerous and unpredictably

so, safety is understandably a top priority. For those whose reliance on others has been betrayed and who have been taken advantage of, trustworthiness is a high priority. For those who have been silenced and who have not been heard, then having choices and a voice are top priorities. For those whose world has been arrayed consistently in a series of one-up, one-down relationships, with them in the one-down position, the realistic offer to share power and decision-making in a collaborative and equal way is a high priority. And, finally, for those who have felt powerless to do anything meaningful about the painful realities of their lives, being empowered is a top priority.

Men and women, however, often do not experience these values in the same way. Safety, for example, is something many men frequently take much more for granted than do women – or at least they seem to. What is clear is that men have been well trained not to communicate any lack of safety thereby masking what could very well be common feelings of *not* being safe. Men, because of the male messages they have frequently absorbed, believe themselves to be stronger than others and able to ward off danger (or at least that they "should be"). Women, by contrast, rarely consider themselves to be physically strong and so are more open about their feelings of vulnerability and their needs for safety. In terms of emotional safety, similarly, men are socialized to see themselves as relatively invulnerable (recall that "real men don't cry"). Women, on the other hand, are expected to be emotionally more "soft," open about their feelings of endangerment. So for men and women, though the needs for safety remain paramount, these needs may be expressed very differently. Men may appear tough and talk tough, even (perhaps especially) when they are fearful. So in working with males, it is important not to underestimate their safety needs. As we note later on, this is particularly true for men who may then have acted aggressively toward others. It is thus equally important to consider men's needs for physical and emotional safety as it is for women, in spite of the fact that men may minimize their feelings of fear or weakness

Safety is as fundamental for men as it is for women. Men, however, frequently present as if they are invulnerable ("Mean are tough and strong and stay cool in the face of danger" is a common male message.) As we have noted previously, the expectations of disclosure that

permeate many service settings are seen as dangers by many men—dangerous to their senses of security and safety, to be sure. Yet how infrequently do we consider such dangers in addressing men, especially early in their engagement in services? Because we are, all of us, immersed in the messages that attend male gender role socialization, it is rare that we consider men's needs for safety, physically as well as emotionally. When men first come to a substance use treatment setting, for example, one of the first things often required of them is to give a urine sample. How trauma-informed is this practice? Is the rationale for this practice explained fully in advance? Are men offered choices about how (or perhaps even whether) they are observed? Safety is a precondition for effective engagement in services and safety for men looks different than safety for women.

Trustworthiness presents a somewhat similar pattern, in that men may say they can either trust or not trust virtually everyone depending on their sense of their own position in the world. In the "disconnection dilemma" we have discussed in a previous paper, we describe how men often feel an internal split between hanging on to their sense of being "real men" and their sense of being vulnerable. (Fallot & Bebout, 2013) This split then shows up in numerous other domains, including the perception of trust and of trustworthiness. Men who see themselves as (consciously) strong, may be willing to trust more in other people, depending on their previous experiences. Men who see themselves as more vulnerable, by contrast, may be unable or unwilling to trust others. It is of course possible that men, like women, may have their "people-pickers" broken by those who have taken advantage of them. This may leave men without a firm grasp about how to decide if someone is trustworthy or not. One man, for example, trusted too much in a group of men who asked him to carry a package across town for them. It never dawned on him that the package might contain drugs, a fact that led to his being beaten. In contrast to women who more readily acknowledge their lack of trust in others or the extent to which their certainty about whom to trust has been compromised, men are more likely to appear sure of themselves in this domain, regardless of the reality. For men in relationships more generally, then, whether the relationships are romantic ones (with women or with other men), business ones, platonic friendships, or merely "acquaintances," the need for trustworthy

responses by the other person is essential. It is important for those working with such men in recovery, then, to take seriously the underlying misgivings men may have about trusting others.

In terms of the value of choice, men and women may differ significantly in their approaches and these differences need to be taken into account in a trauma-informed culture. Men may deny or minimize the restrictions that are placed on them by their histories of violent victimization. They may thus be less willing than women to say that they feel they have little choice in how they go about living their daily lives. Unless they are incarcerated and thus confronted every day with a lack of choice, men often express a considerable, overstated, degree of freedom in their lives. Giving men choices, though, does not inappropriately validate their exaggerated sense of freedom. In fact, offering and focusing the supportive relationship on the maximizing of men's choices is frequently the best way for men to "grow into" their images of themselves as free agents.

Collaboration is an especially important area for men, who may strive to be one-up, believing that their very sense of manhood is dependent on maintaining that position in their relationships—or who consider themselves to be "lost causes" who have no right to expect to share power with those who have more power than they do. (Note once again the possibility of a split here.) It is especially valuable, then, for those working with men in recovery to attempt to establish a truly collaborative relationship with men, one that is based on a fundamental equality in spite of any differences in the system of care's view of their relative power. This means doing things "with" men rather than "to" or "for" them; it means cultivating a position in which decisions about the man's life are made primarily by the man himself with the support of the worker. This emphasis on shared decision-making, with the default setting in favor of the man's choices, is a key expression of a collaborative position. Because women may be more socialized to this collaboration or because it fits so readily with expanding women's choices, this is frequently an easier position to arrive at with a woman than with a man. Perhaps because women are frequently socialized to accept being in the one-down position, the option to be in a more equal relationship feels more inviting to them. Because men have so frequently been socialized to value only being one-up in relationships, it is often

more difficult to get them to accept an equal sharing of power as a valuable position. Nonetheless, the value of relational mutuality is evident once men experience it more fully.

Fifth, the value of empowerment constitutes another mixed area for men, some of whom may feel (accurately or not) that they are already fully empowered whereas other men are acutely aware of the disempowering impact of violence and abuse in their lives. For those men whose compensatory self-protective stance involves an apparent sense of empowerment (or, as it is frequently mislabeled- "entitlement"), it is a central trauma-informed response to validate this need for empowerment and to reframe it so that it might become a genuine empowerment rather than primarily a compensating one (i.e., a response to a feeling of being disempowered). The issue of male empowerment is so significant that we have devoted a separate section to it later in this article.

In addition to these five core values, Griffin & Fallot (personal communication) have suggested that two additional values might be helpfully added to the changes necessary in most services cultures dealing with males. The first of these is mutual responsibility, the notion that, in a positive, healing relationship, the idea of accountability relies too heavily on issues of power (i.e., that one person is accountable to another for their behavior implies that the person with less power is the one held "accountable"). Contrast this with an idea of mutuality in relationship (see "collaboration" above), in which each person is responsible for their part of the relationship, for their own behavior. This successfully avoids blaming the victim while at the same time, holding out the value of responsibility as a mutually held position. Accountability, then, is not discarded but becomes a secondary part of the mutuality of responsibility that is expected in a trauma-informed culture. Each person is "accountable" to the other, in equal measure, within the relationship.

And, finally, the value of compassion may be usefully added to this list. Being compassionate with (literally, *feeling* with) the experiences of males who come for services is a key to successful culture change. Especially if this compassion is extended to the entirety of males' experiences, not only those that fit with the stereotypical aspects of male experience but those

that are inconsistent with the "Man Rules" or the "Male Messages," is it likely to make a significant difference in the lives of the males we serve. Compassion necessarily begins with self-compassion (not self-pity). It is, akin to forgiveness, best experienced first as a value one holds toward oneself. Men need to have the experience of receiving compassion, though, before they can apply it to themselves or to others. For many men, this has been a remarkably rare occurrence in their lives. Being empathically accepted for who they are rather than for who we want them to be, is a first step in registering this compassion. This principle of compassion directly challenges the notion that dominates much of the services provided to men that seeks to "break them down" and "put them in their place", particularly in the criminal justice system.

Compassion applies also to those individuals who may have acted at times inconsistent with society's values, especially by being violent themselves. We know that "hurt people hurt people,' that those who have themselves been victims of violence are more likely to become perpetrators. Compassion requires us to look at the entirety of the person and the contexts in which they have lived , rather than being judgmental and dismissive of these men as "defective" or "lacking a conscience" or, perhaps worst of all, "just being men." Compassion is, in sum, a way of expanding our understanding and acceptance of the full range of human behavior. By communicating compassion to the men we serve, we offer them a lifeline for reconnecting meaningfully to other people.

Males and Power

For most individuals, one of the most immediate and profound responses to a traumatic event is a sense of powerlessness. The boy or man is torn, frequently without warning, from his sense of security and safety. He may be unable to extricate himself from a violent, abusive, or otherwise threatening situation. His identity as a male, which in most cultures is synonymous

with power, prestige, and control, may be challenged and damaged on multiple levels, internally and externally. If the event occurs at an early age, he may have only a fledgling concept of masculinity, however, as he grows into adolescence this issue takes on more significance and import. It is in looking back on his life, after he has fully internalized the Man Rules and Male Messages that he seeks to further distance himself from the psychic pain of childhood and adolescent trauma through the dismissal of such events as painful, let alone traumatic. The image of boy is synonymous with weak and "not a man" and so any pain a boy experiences is, by definition, not manly. Any acknowledgment of the pain of his past or the possibility of trauma is entirely against the Man Rules and therefore becomes suppressed and a source of deep and unspoken shame.

In the aftermath of the traumatic event, these perceived losses of safety, power, and masculinity may not only persist, but are frequently exacerbated by the coping strategies that the man employs in an attempt to regain safety and power. An example would be acting aggressively and violently in his relationships with others. This initially affords him a sense of control, but may result in loss of relationships, physical harm, or legal charges, and thus ultimately a further loss of power. The addiction and mental health fields have been aware of this behavioral cycle for decades. We have used terms like counter-productive or self-defeating to describe this pattern. If we look at these behavioral patterns through the lens of trauma, if we ask men not, "What's wrong with you?" but rather, "What has happened to you?" we would recognize that many of these behaviors are adaptive survival strategies. We would recognize that, in the moment, the man is acting in what he genuinely perceives as his own best interests and perhaps as the only means available to him to stay emotionally or physically safe.

Powerlessness can be experienced in myriad ways. The man may feel a lack of power with respect to his environment, his relationships, his emotions, and his physiological responses. He may abandon the idea that he can exercise sufficient control over any aspect of his life. While this sense of powerlessness may have been initially externally imposed, many men will internalize this to the point of developing a core belief system or schema – an ingrained and

calcified self-definition marked by helplessness, anger, fear, and shame. This process of internalization is particularly likely to occur as the result of prolonged or repetitive trauma.

When a man feels powerless, he is likely to feel less than a man. He will frequently not be able to ask for his needs to be met. He may feel as though he doesn't deserve the positive attention and support of others. He may fear that his request for support will be rejected. He may be convinced that he won't be heard or believed, or that his masculinity will be impugned and he will be seen as weak. The Man Rules and the Male Messages are all about not feeling weak or being perceived as being weak. And, of course, weakness places a male at greater risk of being threatened, abused, hurt, and re-traumatized. Prolonged violence or abuse will inevitably inhibit him from acknowledging and enunciating his needs. Thus, the cycle becomes self-perpetuating and all encompassing. Perhaps the most damaging effect is that he inevitably feels disconnected from others and persists in survival strategies that preclude trust, intimacy, and mutual support.

All relationships between groups and individuals are characterized by power differentials. As a society, we tend to blame those with less power; in effect, the victim got what he deserved. We also see the victim as less than a man. One can't be a victim and a real man at the same time. Thus, we demean the victim and consequently may fail to fully hear and appreciate his story. Industrialized societies tend to view and contest power dynamics as a zero-sum game. That is, there is a finite amount of power available in any given relationship and if one party gains power, then the other party must lose an equivalent amount. A traditional message delivered by behavioral health professionals is the notion that power and control are either illusions or intrinsically damaging. This has been particularly true in the field of addiction treatment, and has been compounded by the axiomatic belief that men with substance use problems must admit and embrace powerlessness in order to embark on a path of recovery. Our contention is that the drive for power and control is not only inherently human, but is also healthy and should be supported by helping professionals. The tactics that are utilized by many men, especially trauma survivors, may be problematic. These include, but are not limited to, abusing mood-altering chemicals, aggression, intimidation, violence, abuse, exploitation, manipulation,

and neglect. Too often, men who have been abused turn their pain and fear into violence against others who are perceived to have even less power than they have. Behavioral health settings are not immune to the challenges embedded in the prevailing paradigm of power dynamics. As enlightened clinicians we may work tirelessly to practice the core principles of trauma-informed care. These principles all speak to consumer autonomy and choice. And, yet, our organizations and practices are predicated on power differentials, both overt and covert. We establish the structure, the basic expectations, and all too often, the modalities and objectives. This is, to a certain extent, unavoidable. Therapy without some structure has limited efficacy and we frequently are forced to sacrifice individual choice in order to protect other consumers or to maintain the integrity of the organization. If a client's aggressive, violent, or otherwise problematic behavior, which might be a byproduct of his trauma, proves to be too disruptive or threatening to other group members, that individual may face sanctions including discharge from services. If the man has criminal justice involvement, this will generally result in further punishment up to a complete loss of freedom.

An additional factor to consider in treatment settings is that for many clinicians, their sense of safety is rooted in the structure and predictability of the setting and services from their perspective. Far too many clinicians, male and female, fear men. Far too many men are socialized to ignore or deny all emotions except anger, and this one permissible emotion is often expressed in ways that are interpreted as dangerous or anti-social. Thus the clinician may directly or subtly inhibit conversation about traumatic events to maintain his or her own sense of safety.. The therapeutic relationship is then likely to be characterized by imposing control rather than facilitating change. It all too often becomes about the clinician's comfort level or the smooth functioning of the organization rather than the consumer's needs.

It is important to note that "power" and "safety" are related concepts frequently addressed in conversations about men's trauma, however these are not identical or interchangeable. We believe that safety is the deepest, most primal drive and that the quest for power and control is but one mechanism for achieving both emotional and physical safety. It is interesting that safety has historically been a highly desirable goal for women in recovery from trauma, but has

only recently been identified as such for men. This is at least partially a function of how the need for safety has not been considered a masculine virtue. For many men, the only alternatives when facing emotional or physical threat have been to either seek power and control, usually employing aggressive tactics, or to thoroughly disengage from any intimate relationships. Finding refuge and safety within relationships is almost antithetical to masculine sensibilities.

Validating men's real strengths (not the superficial ones) is one avenue to genuine empowerment. Another is assisting men in developing the skills they may not have had an opportunity to develop because of their trauma histories. As noted in sections above, women may have more transparent need for empowering responses from others, having been socialized to accept the reality of their historic disempowerment. Males, in contrast, have similar needs, but these are frequently hidden behind a false bravado. In order for men to feel comfortable relinquishing this façade of false strength and exchanging it for genuine strength, they must be treated with a respect that acknowledges their underlying weaknesses without forcing them to "confess" this is a manner that engenders feelings of shame. True empowerment for men, then, comes from a recognition that they are genuinely strong because of, not in spite of, who they are.

Conclusion

This document is not intended to be a comprehensive examination of male trauma, the range of clinical strategies for trauma resolution, or a detailed blueprint for building a trauma-informed practice. It is our intention to articulate what we believe to be the guiding principles for designing services that offer men with trauma histories the best chance for healing and growth. And to illuminate how many of our current services are compromised by a failure to identify and address trauma. But most importantly, we want to initiate a conversation among behavioral health clinicians and organizations.

We assert that clinical services cannot be fully trauma-informed without also being gender-responsive. Gender socialization and psychological development exerts a profound influence on the experience, the symptomology, and the process of healing from trauma. Our systems of care and therapeutic interventions must take this into account to achieve positive outcomes.

There are specific instruments and skills that have demonstrated efficacy in working with male trauma survivors. And there are protocols available for effecting institutional changes that will result in a trauma-informed environment. We believe that equally important is whether the helping professional genuinely understands and cares for men and infuses this spirit into all aspects of care. Are we creating spaces where men can feel safe? Are we giving them permission to share their stories, their, pain, anger, and shame? Are we treating them with kindness and compassion, tempered by mutual responsibility and commitment? Are we helping them develop pathways to personal empowerment that are based on connection and mutuality?

Given the profound impact of shame and power dynamics, we suggest the following strategies to truly engage our male clients who have adopted traditional gender identities. This list is by no means meant to be exhaustive: 1) Address the tension between the Man Rules and the process of healing and recovery. This helps to mitigate the pain, confusion, and dissonance in the early stages of therapy or treatment. 2) Offer him multiple opportunities to share traumatic experiences. Validate these experiences and the residual emotional and physical effects. 3) Help him understand the difference between self-pity and self-compassion. The Man Rules do not encourage compassion, especially for oneself. 4) Acknowledge and honor the survival and the adaptive measures that he has utilized. Reinforce the strength, courage, and resiliency that he has demonstrated. 5) Assert and reinforce the profound importance of regaining a sense of genuine strength and power. And of course, help him explore alternative methods of gaining power, especially through mutually supportive relationships. 6) Encourage him to evaluate the costs and the benefits of continuing to employ strategies that were initially highly adaptive. Recognize that he is unlikely to willingly abandon these until he feels confident that he has mastered alternative methods of feeling powerful (and safe). 7) Provide ample opportunities to

develop new skills such as; emotional regulation, distress tolerance, and grounding and self-soothing techniques. These are highly effective strategies for managing some of the symptoms of post-traumatic stress. 8)) Distinguish between the concepts of safety and trust. Taking care of oneself may initially mean choosing not to trust. 9) Assist him, once he has self-identified as a victim of trauma, in beginning to move the narrative from victim to survivor.

In sum, taking seriously the full impact of male socialization adds a unique element to the delivery of trauma-informed care. The need to join gender-responsiveness to trauma-informed cultures of care has become increasingly evident to those of us working with men in behavioral health settings. Offering males the opportunity to connect meaningfully with others (and themselves) by challenging the Man Rules or Male Messages—those messages that so many of us have been steeped in—is a meaningful first step in creating a gender-responsive care setting. As we move together with women in recognizing our mutual responsibility for creating and sustaining such settings, we are taking a significant step toward creating organizational cultures that reflect our shared commitment to trauma-informed and gender-responsive approaches to behavioral health care.

Appendix A: The Eight Agreements

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

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

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

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

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.

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

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

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

The following individuals arrived at consensus on the Eight Points of Agreement as part of the Summit:

1. Miles Adcox, Onsite
2. Mike Barnes, Ph.D., CeDAR
3. Richard Bebout, Ph.D., Community Connections
4. Allen Berger, Ph.D.
5. Lou Cox, Ph.D.
6. Judy Crane, The Refuge-A Healing Place
7. Richard Dauer, River Ridge Treatment Center
8. Tian Dayton
9. Teresa Descilo, Trauma Resolution Center
10. Eduardo Duran, Ph.D.
11. Norma Finkelstein, Ph.D., Institute for Health and Recovery
12. William Ford, Ph.D., C4 Recovery Solutions
13. Rawly Glass, The Bridge to Recovery
14. Dan Griffin, Griffin Recovery Enterprises, Inc. & Males for Trauma Recovery
15. William Pollack, Ph.D., Harvard Medical School
16. David Powell, Ph.D., International Center for Health Concerns
17. Pat Risser, Males for Trauma Recovery
18. Jaime Romo, Ed.D., Males for Trauma Recovery
19. Cheryl Sharp, The National Council for Behavioral Health
20. Dr. Brian Sims, M.D., Psychiatrist, Correctional Mental Health Services
21. David Washington, Males for Trauma Recovery
22. Rob Weiss, Elements Behavioral Health
23. Jacquie Wheeler, Jaywalker Lodge