CHAPTER 1

What the Facilitator Needs to Know About Providing Gender-Responsive Services

Understanding the need for gender-responsive treatment services for men is critical for anyone who will be using this curriculum. It is important to understand the process of trauma and its effects on addiction and recovery. It is also important to understand the connections between gender, trauma, addiction, and crime. There is much room for improvement in traditional treatment for men, and a discussion of the history of the development of gender-responsive services for both men and women and how these have been expanded beyond the binary model can help to explain this. This chapter provides a brief overview of these issues as well as the theoretical foundation for this curriculum.

New Approaches to Men's Treatment

It would be reasonable to assume that men's issues are adequately addressed in alcohol and other drug (AOD) treatment, because the overwhelming majority of treatment was developed for, by, and about men. However, we believe that "gender-neutral" treatment models are inadequate to meet the service needs of both women and men.

Helping Men Recover: A Program for Treating Addiction, Special Edition for Use in the Criminal Justice System, Second Edition. Stephanie S. Covington, Dan Griffin, and Rick Dauer.

If we did not begin with the assumption that we know what men need, what would we discover? If we look at the effects of male socialization, what issues will arise? Through the creation and implementation of this curriculum, we have discovered that, when they feel safe enough, people are willing to look at many important, although difficult, issues commonly overlooked in traditional treatment. Some of these are relationships, sexuality and sexual behavior, power and control, criminal behaviors, privilege and entitlement, and grief. Working collaboratively with professionals in the field, we have created activities that help participants begin to reflect on their common experiences and that are designed to improve their chances of achieving sustained recovery.

Much of this curriculum would work well for individuals in other behavioral health programs that address issues such as anger management and interpersonal violence.

What We Have Learned

Our understanding of addiction and the best ways to treat it has changed in the past decades. Previously, there was a disconnection between mental health systems and addiction services systems. This left clients stuck between the two as they attempted to deal with their addictions and any accompanying mental health issues. Today, we have clear research that shows the effects of drugs on the brain and the mechanisms of addiction. We have known for some time that addiction is a chronic disease. The service systems, the funding streams, and the research that supports the systems are finally being set up to enable providers to treat clients and evaluate their services in this context. Now, after years of poor outcomes for clients, trainings in co-occurring disorders are becoming the expectation (rather than being regarded as the exception) for addiction professionals.

There also have been changes in what we consider effective treatment for men. Two elements of the old treatment model that have deep roots, especially for men, are no longer considered to be as effective as was once thought. First is the concept of denial and the need to break through an individual's denial in order for him to be receptive to treatment. This approach tends to be shame-based and assumes that the person is willfully ignoring the reality and consequences of the problem. Our understanding of the process of change—through the "stages of change" model—has forced us to rethink the idea of denial (DiClemente, 2006). Rather than simply being about people's lack of ability or willingness to look honestly at their problems, this model puts the burden on the clinician to connect with each client and provide services based on which stage of change the client is in.

Second is the idea that confrontation is an effective strategy for getting people to engage in treatment and be willing to look at their problems. There is no clinical

evidence pointing to the therapeutic efficacy of confrontation, and there is ample clinical evidence that this approach results in poor outcomes and can even cause harm (Miller & White, 2007).

Men, Addiction, and Crime

According to the U.S. Department of Justice, in 2019 there were 1,430,805 individuals in custody in state and federal correctional facilities. Of these, 1,322,850 (92 percent) were male (Bureau of Justice Statistics, 2020).

The correlation between substance use disorders and criminal behavior is well-documented. A comprehensive study by the National Center on Addiction and Substance Abuse (CASA) titled *Behind Bars II: Substance Abuse and America's Prison Population* (2010) found that 65 percent of all incarcerated individuals met criteria for a diagnosis of substance use disorder or dependence. The following statistics from the CASA report illustrate the relationship between substance use and criminal behavior:

- Alcohol is implicated in the incarceration of over half (56.6 percent) of all inmates in America. In addition to the inmates who were convicted of an alcohol law violation, 51.6 percent of illicit drug law violators, 55.9 percent of those who committed a property crime, 57.7 percent of inmates who committed a violent crime, and 52.0 percent of those who committed other crimes were either under the influence of alcohol at the time of the crime, had a history of alcohol treatment, or had an alcohol use disorder.
- Illicit drugs are implicated in the incarceration of 75.9 percent of all inmates in America. In addition to the inmates who were convicted of a drug law violation, 54.3 percent of alcohol law violators, 77.2 percent of those who committed a property crime, 65.4 percent of inmates who committed a violent crime, and 67.6 percent of those who committed other crimes either committed their crimes to get money to buy drugs, were under the influence of drugs at the time of the crimes, had histories of regular drug use, or had a drug use disorder.
- Of the 1.5 million prison and jail inmates who met clinical diagnostic criteria for a substance use disorder in 2006, only 11.2 percent had received any type of professional treatment since admission. Only 16.6 percent of facilities offer treatment in specialized settings (which can produce better outcomes for offenders, as has been measured by drug use and arrests post-release). Few inmates actually receive evidence-based services, including access to pharmacological treatments. The availability of highly trained staff is limited. Simply offering

treatment, even in specialized settings, does not mean that the treatment is available to all who need it or of adequate quality.

- Substance-involved offenders are likelier to recidivate than those who are not substance involved. Over half (52.2 percent) of substance-involved inmates have one or more previous incarcerations, compared with 31.2 percent of inmates who are not substance involved.
- Relative to the population at large, people of color and Hispanics are overrepresented in America's prisons and jails. Substance involvement does not explain this overrepresentation, as Black and Hispanic inmates report lower rates of drug use in the months prior to their arrests and have lower rates of substance use disorders than white inmates. Blacks make up 12.3 percent of the U.S. population but comprise 41.0 percent of the inmate population; 60.2 percent have substance use disorders. Hispanics make up 14.8 percent of the U.S. population but comprise 18.8 percent of the inmate population; 58.3 percent have substance use disorders. Whites make up 66.4 percent of the U.S. population and 34.6 percent of the inmate population; 73.1 percent have substance use disorders.

Over the past 50 years, the "war on drugs" has resulted in a massive infusion of addicted men and women into the criminal justice system. (As is noted, the increased enforcement of drug crimes has disproportionally affected men of color.) The criminal justice system has become the primary catchment area for people with addictions. This presents an opportunity for cost-effective intervention. For every dollar spent on community-based treatment for offenders, the community saves as much as $12.00 in related costs (National Center on Addiction and Substance Abuse, 2010). Jail and prison-based treatment is even more cost-effective because housing is already provided.

Historically, the socialization process for individuals who have been raised as men contributes to the problematic attitudes and behaviors that underlie both addiction and criminal behavior. *Helping Men Recover* is the first curriculum for men (and those who identify as men) involved in the criminal justice system that addresses addiction through the lens of socially conditioned masculinity. In the decade since this curriculum was first published, we have discovered that, when they feel safe enough, participants are willing to engage in the challenging issues that are commonly overlooked in traditional treatment. Some of these issues are: anger, power and control, the tolerance of violence, physical and sexual abuse, trauma, effective expression of emotions, conflict resolution, supportive relationships, healthy sexuality, and spiritual development. Participants learn that the "rules" of manhood that previously reinforced addiction and antisocial behaviors can be recast into a more prosocial and self-enhancing belief system.

Implementing This Program in a Custodial Setting

This curriculum is designed for use in both custodial and community-based programs. However, some of the activities will need to be modified in a jail or prison setting in order to comply with security and safety regulations. We also recommend that *Helping Men Recover* be augmented by other available rehabilitative programs, such as anger management, Moral Reconation Therapy, and trauma-focused cognitive skills training.

Although we believe that the relationship between criminal justice and the treatment field is one of moral and economic necessity, historically it has been ill defined, often not mutually supportive, and frequently antagonistic. The proliferation of treatment courts is an excellent example of how these two systems can work collaboratively. Treatment professionals have come to realize that developing such collaborative relationships increases the likelihood that their clients will achieve long-term recovery and avoid future legal difficulties.

Safety

When providing treatment to individuals in the criminal justice system, the first and foremost issue is safety. This includes physical and emotional safety for both the participants and the staff. In 2009, the Prison Rape Elimination Act established national standards for the elimination of sexual abuse in custodial settings (Prison Rape Elimination Act Commission, 2009). Specific recommendations for male offenders are:

- At a minimum, employees use the following criteria to screen male inmates for risk of victimization: mental or physical disability, young age, slight build, first incarceration in prison or jail, nonviolent history, prior convictions for sexual offenses against an adult or child, sexual orientation of gay or bisexual, gender nonconformance (e.g. transgender or intersex identity), prior sexual victimization, and the inmate's own perception of vulnerability.
- At a minimum, employees use the following criteria to screen male inmates for risk of being sexually abusive: prior acts of sexual abuse and prior convictions for violent offenses.

Incarcerated people who are transgender or nonbinary are more likely to face abuse (including bullying, humiliation, harassment, physical abuse, and sexual abuse) by both staff members and other inmates (Wilber, 2015). Transgender and gender

nonconforming people are nearly ten times more likely to be sexually assaulted than others in the general prison population (Beck, 2014).

Trauma-Informed Responses and Criminal Justice Interventions

The following table illustrates some of the tensions between trauma-informed practices and the criminal justice system. Note that the first three principles of both are the same. Drug courts, more than any other criminal justice intervention, should be able to balance these elements.

Trauma Informed	**Criminal Justice**
Structure	Structure
Consistency	Consistency
Predictability	Predictability
Safety	Accountability
Therapeutic	Punitive
Healing and growth	Behavioral correction
Collaborative	Directive
Responsive	Reactive
Exploration	Restriction
Empowerment	Deterrence
Trust	Fear
Mutuality	Hierarchy
Flexible	Rigid

Fundamentals of Gender-Responsive Services

Perhaps the most important concepts to consider are those of gender and sex. *Sex* refers to one's biological identity, traditionally limited to male or female but more broadly interpreted today to include "intersex"—meaning that a person has sex characteristics that do not fit the traditional male/female dichotomy. *Gender* is a social construct in which specific messages are given to individuals regarding acceptable behaviors and characteristics. The role of gender varies from culture to culture and even within cultures and it is affected by many other factors, such as socioeconomic status, race, ethnicity, and sexual orientation.

In the past, the term *gender-specific* has meant woman-centered. This came from the need to develop programming for women in a field that assumed that both men and women addicted to alcohol and other drugs would respond to the same type of

services. In developing gender-informed services for women, clinicians have realized that it is important to look at how the socialization process has affected the lives of females and influenced their needs in recovery. Similarly, in *Helping Men Recover*, we have applied what we know about the effects of male socialization to develop a gender-responsive program for those who experience the world from a masculine perspective.

The term *gender-responsive* indicates the creation of a treatment environment, through site selection, staff selection, program development, and program content and materials that reflects an understanding of the realities of participants' lives and that addresses and responds to their challenges and strengths. The keys to developing effective treatment for men are acknowledging and understanding their life experiences and the impact of living as a man in a male-based society. This means exploring the challenges as well as the benefits (entitlements) that men experience from living in such a society. Sometimes the terms gender-specific and gender-responsive are used interchangeably; however, that is incorrect. Gender-specific is about the services, and gender-responsive is about the whole system.

In a report for the National Institute of Corrections, a multidisciplinary review of the literature and research was conducted on women's lives in the areas of addiction, trauma, health, education and training, mental health, and employment (Bloom, Owen, & Covington, 2003). The report's guiding principles provide a blueprint for a gender-responsive approach to the development of services for women both in and out of the criminal justice system. We believe that these same principles apply to a gender-responsive approach for the development of treatment services for men and gender-diverse people.

Gender-responsive principles include the following:

- *Gender*. Acknowledge that gender makes a difference.
- *Environment*. Create an environment based on safety, respect, and dignity.
- *Relationships*. Develop policies, practices, and programs that are relational and that promote healthy connections to children, family members, significant others, and the community.
- *Services*. Address addiction, trauma, and mental health issues through comprehensive, integrated, and culturally relevant services.
- *Socioeconomic status*. Provide clients with opportunities to improve their socioeconomic conditions.
- *Community*. Establish a system of comprehensive and collaborative community services.

Gender Differences

Gender traditionally has been the experience of growing up male or female with all the social messages about how one should be. That is changing. Even though the past fifty years have helped to redefine what it means to be female, the traditional messages about manhood are still prevalent. We refer to these as "The Man Rules." Boys are taught to present as strong and not to exhibit any form of weakness. A boy is told not to cry and to "act like a man." Strength, aggression, and competition are considered to be "manly." Being manly means being powerful, in control, and self-sufficient. It means never asking for help or acknowledging pain. It means being a fixer and a protector and knowing all the answers.

As treatment services develop to accompany our expanded understanding of society, we embrace the understanding that gender is not just binary: masculine and feminine. Gender occurs on a continuum, and people identify with various experiences and use many terms to define themselves. Here are some definitions of current terms (Green & Mauer, 2015):

- *Cisgender:* A person whose gender identity matches the biological sex assigned at birth. This is the traditional form of identification. It is sometimes abbreviated as "cis."
- *Transgender:* A person whose gender identity does not match the biologic sex assigned at birth. The term can refer to those who were assigned "female" at birth but who identify as boys or men and those who were assigned "male" at birth but who identify as girls or women. The term is sometimes abbreviated as "trans."
- *Gender nonconforming:* A person whose gender expression is perceived as being inconsistent with cultural norms expected for that gender. Specifically, it refers to boys or men who are "not masculine enough" or who present as feminine and to girls or women who are "not feminine enough" or are masculine. Not all transgender people are gender nonconforming, and not all gender nonconforming people identify as transgender. Cisgender people also may be gender nonconforming. Gender nonconformity often is inaccurately confused with sexual orientation.
- *LGBTQIA+:* An acronym for: lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual or agender.
- *SOGIE:* An acronym for: sexual orientation, gender identity, and gender expression. It is important to distinguish between gender expression (how we identify

and view ourselves in the world) and sexual orientation (who we are attracted to and sexually desire).

- *Asexual:* A person who does not have sexual feelings or feel physical attraction to others.
- *Agender:* Identifying as not having a gender or experiences themself as gender neutral.

Helping Men Recover includes an expanded perspective (and corresponding language) of the range of gender identities, including trans men, trans women, nonbinary and nonconforming people (e.g., agender, genderfluid, and genderqueer). In this curriculum, we use the terms *nonbinary* and *gender nonconforming* to refer to people who don't identify as trans or cis men and women.

One of the questions being debated currently is whether a program should include a transgender man in a men's group. Most jurisdictions assign people to custodial settings according to their sex at birth (based on genitalia). There are a few countries and some U.S. jurisdictions that incarcerate people according to how they self-define their genders.

A transgender man can be appropriate for a men's group, especially if he has been living as a man for a period of time. Depending on his process of transitioning or identity development, he may not be comfortable in the group. Unless he has experience living as a man long enough to have male experience and levels of insight, the group topics may or may not be sufficiently relevant. However, ultimately, he is the expert on his life and should be able to decide how he feels about being part of the group. In conducting the group, the facilitator should honor and validate his experiences.

Despite disciplinary codes in jails and prisons that prohibit all sexual activity, such behavior still occurs. Many inmates who engage in same-sex activity while in jail or prison do not self-identify as gay or bisexual. Others, who may recognize that they are gay or bisexual, do not openly proclaim that fact in custodial settings because they fear reprisals. Incarcerated individuals may engage in same-sex behaviors for many reasons, not all of which reflect their sexual identities. Self-identified heterosexuals may engage in prostitution for money or have sex in order to gain the protection they need to survive within the jail or prison. For such individuals, sexual identity can become an especially important issue upon release as they try to understand their behavior it relates to their senses of self. There are men within the prison system who have had more sex with men than women but who still identify as heterosexual. These individuals may face particular difficulties when they return to sex with female partners and may be drawn to use substances in order to facilitate heterosexual activity (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013b).

Theoretical Framework

In order to develop gender-responsive treatment and services for anyone, it is essential to have a theoretical framework. Three fundamental theories for creating men's services are addiction theory, relational-cultural theory, and trauma theory. These three theories create the foundation for *Helping Men Recover*.

Addiction Theory: How Addiction and Recovery Work

The terms "substance abuse," "chemical dependence," "substance use disorder," "problematic substance use," and "addiction" often are used interchangeably, and there has been criticism of their lack of specificity. In previous editions of *The Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR*; American Psychiatric Association [APA], 2000), there was a diagnosis for both substance abuse and substance dependence. In the current version, *DSM-5* (APA, 2013), the language has been replaced with "substance use disorder" (SUD), with diagnostic categories of mild, moderate, and severe.

The change from "substance abuse" to "substance use disorder" came about, in part, to underscore the biological underpinnings of substance use dependence and addiction and to move away from the pejorative connotations of the term *substance abuse*, which implied moral weakness. *Helping Men Recover* uses the terminology of the *DSM-5* and also uses the word *addiction*. The model in this program can be used with people who are struggling with a broad range of addictions: substances as well as behavioral addictions—sometimes called "process" addictions (e.g., shopping, gambling, sex, and use of social media). The term *substance misuse* also is used in the *DSM*. It describes a patterned use of a drug or substance that is harmful in amount and/or method to the person using the substance and/or to others. "Substance misuse" is now preferred over "substance abuse." However, there is a growing recognition of the pejorative nature of the word "misuse." In this program, we want to communicate that people use for many reasons, including recreation, peer acceptance, and self-medication for trauma and mental health conditions. Some clients will come into the program with a firmly entrenched belief that their chemical use is not "the problem." Indeed, if a man has been using to manage emotional or physical pain, he is likely to see his chemical use as the solution.

Models of Addiction

For generations, societies saw addiction as a moral issue (Platt, 2013). The use of alcohol or other drugs and the things people did while using them were viewed as

signs of something morally wrong with the user. From this perspective, relapse is attributed to a lack of willpower or seen as a crime. The temperance movement and the "war on drugs" reflect this model.

In the 1950s, mental health professionals proposed a psychological alternative to the moral model of addiction: Addiction was seen as a sign of an underlying psychological disorder. If one could somehow solve that disorder, the addiction would go away. Any loss of control while drinking or using other drugs was seen as temporary and secondary to the primary problem. If a person drank excessively to cope with other difficulties, and those difficulties were removed, the person would go back to drinking moderately.

Also in the 1950s, the addiction treatment field was born. Largely drawing on the work of E. Morton Jellinek (1946), alcoholism was defined as a disease by the American Medical Association in 1956. Practitioners outlined and advocated a model that viewed addiction as a primary condition with its own symptoms, not as a secondary effect of another disorder. They compared addiction to diabetes, a physical disease that carries no moral stigma. Neither addiction nor diabetes can be managed through willpower; both require a person to maintain a lifestyle regimen for emotional and physical stability. Practitioners in the field of addiction also understood that the disease of alcoholism included not just physical but also emotional and spiritual dimensions. However, even if the diabetes analogy is useful, it often seems too individualistic and simplistic to adequately explain addiction in individuals' lives.

Today the addiction treatment field considers addiction a chronic, progressive brain disease, although its treatment methods are more closely aligned to those of the emergency-medicine specialist (acute care) than the chronic-disease specialist (ongoing care) (White, Boyle, & Loveland, 2002). Research indicates that treating severe and chronic substance use disorders through screening, assessment, admission, and brief treatment, followed by discharge and minimal aftercare, is ineffective and results in the shaming and punishing of clients for failing to respond to an intervention design that is inherently flawed (White & Tuohy, 2013).

An alternative to the acute-intervention model is behavioral health recovery management (BHRM). This concept grew out of "disease management" approaches to other chronic health problems; it focuses on quality-of-life outcomes as defined by the individual and family. It also offers a broader range of services earlier and extends treatment well beyond traditional (medical) services. BHRM models extend the current continuum of care for addiction by including (1) pretreatment (recovery-priming) services, (2) recovery mentoring through primary treatment, and (3) sustained, post-treatment, recovery-support services (Kelly & White, 2010; White et al., 2002). BHRM

is more aligned with the concepts of holistic health care, as the following list of guiding principles for BHRM, from White, Boyle, and Loveland (2003), shows:

1. *Recovery focus:* Emphasize hope for high quality of life while managing recurring episodes of illness and emphasizing client strengths and resilience.
2. *Client empowerment:* Clients are involved in all aspects of service delivery and design.
3. *De-stigmatization of experience:* Experiences with behavioral health disorders are normalized to the extent possible.
4. *Evidence-based interventions:* Scientific evidence and broad professional consensus are used to inform interventions at all stages of treatment and recovery.
5. *Service integration:* Multi-disciplinary, multi-agency models are used that integrate services previously provided in isolation from one another.
6. *Recovery partnership:* The professional role shifts from purely a "treater" to a "recovery consultant" in partnership with the client. Emphasis is on the long-term continuity of this relationship over time through various episodes of care.
7. *Ecology of recovery:* The family and community systems are utilized extensively for long-term support of recovery. Multiple connections are promoted between the client and community systems to provide support for recovery.
8. *Sustained monitoring and support:* Flexible monitoring and easy re-engagement at an appropriate level of care, if necessary, is available, rather than a rigid, traditional "assess, admit, treat, discharge" process.
9. *Continual evaluation:* Assessment and evaluation are continual throughout treatment episodes, as well as between and across episodes of care.

A Disease of the Brain

The American Society of Addiction Medicine (ASAM) has defined addiction as a chronic brain disorder and not simply a behavioral problem involving too much alcohol, other drugs, gambling, or sex (ASAM, 2011). This was the first time ASAM had taken the official position that addiction is not solely related to problematic substance misuse. Dr. Michael Miller, past president of ASAM, who oversaw the development of the new definition, says: "At its core, addiction isn't just a social problem or a moral problem or a criminal problem. It's a brain problem whose behaviors manifest in all these other areas. . . . Many behaviors driven by addiction are real problems and sometimes criminal acts. But the disease is about brains, not drugs. It's about underlying neurology, not outward actions."

The repeated use of addictive drugs eventually changes how the brain functions. Psychoactive substances produce their effects by modifying chemical signaling in the

brain, which affects feelings, perceptions, thought processes, and behavior (SAMHSA, 2016). Resulting brain changes, which accompany the transition from voluntary to compulsive drug use, affect the brain's natural inhibition and reward centers, causing the addicted person to use drugs in spite of the adverse health, social, and legal consequences (Baler & Volkow 2006; Volkow, Wang, Fowler, Tomasi, et al., 2010). Addiction affects parts of the brain involved in reward and motivation, learning and memory, and control over behavior (National Institutes of Health [NIH], 2018). Drugs disrupt the mechanisms responsible for generating, modulating, and controlling cognitive, emotional, and social behavior (Leshner, 1998). When some drugs are taken, they can release two to ten times the amount of dopamine that natural rewards such as eating and sex do, and the effects on the brain's pleasure circuit dwarf those produced by naturally rewarding behavior (Volkow, 2014). A substance's effect on the brain depends in part on the overall substance dosage, including the length of time a person has been using the substance, the frequency of use, the typical amount used, and the route of administration (SAMHSA, 2016). Addiction is a progressive disease, with the severity of biological, psychological, and social problems increasing over time (Center for Substance Abuse Treatment, 1994; SAMHSA, 2014). The longer and heavier the use, the more likely it is that a substance will have negative effects on the brain (SAMHSA, 2016).

Cravings may be triggered by contact with people, places, and things associated with prior substance use, as well as by stress (NIH, 2018). Neuroscientists have found that recreational drugs target the brain's "reward circuit," and that brains that are stressed undergo biological changes that can make them more susceptible to addiction (Fowler, Volkow, Kassed, & Chang, 2007). On the other hand, people whose brains have more dopamine receptors have higher natural levels of stimulation and pleasure and are less likely to turn to drugs (Martinez et al., 2010). Drug use affects the dopamine (D2) receptors. One study found that people addicted to cocaine, heroin, alcohol, and methamphetamines experience a reduction in their D2 receptor levels that persists long after drug use has stopped and that exposure to drugs also contributes to a loss of self-control and restraint (Volkow, Wang, Fowler, & Telang, 2008).

Two additional factors that affect drug use are genetics and age at onset of substance use (SAMHSA, 2016). The age at which an individual begins to use substances also affects brain development. The prefrontal cortex is the part of the brain that enables us to assess situations, make sound decisions, and keep our emotions and desires under control, and this part of the brain is still developing during adolescence. Therefore, substance misuse during this period may cause brain changes that have profound and long-lasting consequences (Gogtay et al., 2004).

The cognitive effects of chronic substance use may abate relatively quickly with abstinence, resolve after weeks or months of abstinence, abate only with extended

abstinence, or not abate at all (SAMHSA, 2016). This is why ongoing support and engagement in services is recommended.

Medication Assisted Treatment

Medication assisted treatment (MAT) is the use of prescribed medications (methadone, buprenorphine, suboxone, naltrexone, disulfiram [Antabuse], etc.) in combination with behavioral therapies to provide a whole-patient approach to the treatment of substance use disorders. It primarily is used for the treatment of opioid use but also is used for the treatment of alcohol and other substance use disorders (SAMHSA, 2016). Medications can reduce cravings and other symptoms associated with withdrawal by occupying receptors in the brain associated with using the drug (agonists or partial agonists), blocking the rewarding sensation that comes with using the substance (antagonists), or induce negative feelings when the substance is taken (National Institute on Drug Abuse, 2016; SAMHSA, 2016). Medications are used in two major ways: to help suppress withdrawal symptoms during detoxification and to help re-establish normal brain function and decrease cravings (NIH, 2018). One study of treatment facilities found that medications were used in almost 80 percent of detoxifications (SAMHSA, 2014).

The research suggests that MAT, along with behavioral approaches and ongoing support, is more effective than behavioral approaches alone, particularly with opioid use disorder (Knudsen, Abraham, & Oser, 2011; NIH, 1997) and especially as an early intervention in the process of long-term recovery. MAT supplements other therapies. All medications for the treatment of opioid use disorder (OUD) should be prescribed as part of a comprehensive individualized treatment plan that includes counseling and other psychosocial therapies, as well as social support through participation in Narcotics Anonymous and other mutual help programs (SAMHSA, 2016).

Despite the substantial evidence supporting MAT for the treatment of OUDs, few jails or prisons offer this treatment. In 2017, only 30 jails or prisons (out of 5,100) offered methadone or buprenorphine. Approximately 50 percent of drug courts required that participants discontinue MAT as a condition of involvement. Moreover, most individuals with a history of opioid misuse are not connected with MAT services in the community on release from custody or diversion (SAMHSA, 2019). The National Academies of Sciences, Engineering, and Medicine (2019) assert that: "For people with OUD involved with the criminal justice system, a lack of access to medication-based treatment leads to a greater risk of returning to use and to overdose after they are released from incarceration."

The Holistic Health Model of Addiction

Much of what has been learned about alcoholism has added to our understanding of the addictive process in general. Alcoholics Anonymous (A.A.) was one of the first proponents of a holistic health model of addiction. Health professionals in many disciplines have revised their concepts of all diseases and have created a holistic view of health that acknowledges the physical, emotional, psychological, and spiritual aspects of disease.

In a truly holistic model, the environmental and sociopolitical aspects of disease are included. Men-centered treatment has social-justice goals that are guided by knowledge about men's lives, including men's roles in society; how these affect their alcohol, other drug, and tobacco use and problems related to that use; and how these factors can influence recovery (for example, barriers to treatment and self-help, retention, and relapse). In using a holistic model of addiction (which is essentially a systems perspective), we try to understand every aspect—physical, emotional, and spiritual—of the man's self, as well as the environmental and sociopolitical aspects of his life, in order to understand his addiction.

An integration of BHRM and the holistic health model of addiction is the most effective theoretical framework for developing treatment services for men because it is multidimensional. It allows clinicians to treat addiction as the primary problem while also addressing the context of men's lives and the complexity of issues that men bring to treatment, including genetic predispositions, health consequences, legal difficulties, shame, isolation, histories of abuse and trauma (experienced and perpetrated), economic disparities, and family relationships.

Such an approach is consistent with the findings of thirty-five years of research by the National Institute on Drug Abuse (NIDA) and the Center for Substance Abuse Treatment (CSAT). Although there are different theories about why people become addicted to alcohol and other drugs, it is important to know that addiction is the result of many influences. Using the holistic model, we can describe the many dimensions of addiction as follows (Covington, 2007, pp. 21–22):

- *Physical*. The physical dimension of addiction involves the way in which people's bodies are harmed by drug use and become dependent on drugs. These include changes in the brain's chemistry and functions that occur with chronic drug use.
- *Psychological*. One important psychological dimension of addiction is denial about alcohol or other drug use. When a person does not see or admit to a problem, that person is unable to seek or, at the very least, engage in the treatment he needs. Denial can be a way of coping with a self-image or behavior that one doesn't like.

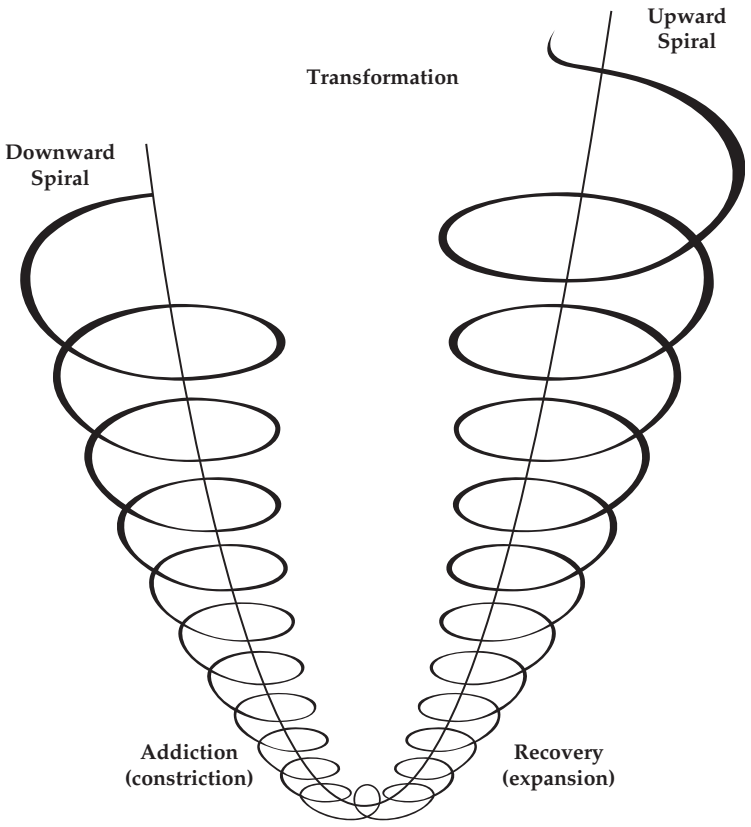
- *Emotional*. This dimension of addiction involves a person's expression of emotions. Men are not raised to have a very broad emotional language. Some have difficulty containing their emotions; others have difficulty expressing them. A person may use alcohol or other drugs in order to deal with emotional pain. Some may use alcohol or other drugs to repress or avoid feelings and memories.
- *Behavioral*. The behavioral dimension includes the high-risk actions individuals engage in to get alcohol and other drugs. It also refers to the high-risk actions they take when under the influence of mood-altering substances. Risk taking is a trait commonly associated with masculinity. When discussing this dimension, it is imperative to talk about men's relationship to violence, as well. This is of particular importance when working with a criminal justice population.
- *Spiritual*. The spiritual dimension refers to the negative impact that alcohol and other drugs have on a person's awareness and connection to himself, others, and the world around him.
- *Environmental*. The environmental dimension involves the family, friends, groups, and social networks that surround a person. These often include people who support the individual's use of alcohol or other drugs and lead the person back to using. In addition, it involves those who perpetuate men's belief that they are entitled to certain things in life simply because they are men.
- *Sociopolitical*. The sociopolitical dimension includes society's negative stereotypes of and labels for people who are addicted to alcohol and other drugs. It also includes a variety of beliefs and stereotypes about men and women. For men, it is especially important that they begin to have awareness of the system in which they live that favors them for being men as well as the costs they experience in their lives because of how they were raised.

The Spiral of Addiction and Recovery

We can envision the process of addiction and recovery as a spiral (Covington, 2019). The downward spiral of addiction revolves around the primary drug of dependence. Addiction pulls the person with addiction into ever-tighter circles, constricting his life until he is completely focused on the drug. Using alcohol and other drugs, protecting his supply, hiding his addiction from others, and cultivating his love-hate relationship with his drug come to dominate his world.

When a person is in this downward spiral, the counselor's task is to help him acknowledge the impact that his addiction is having on his life. As we discussed earlier, the concept of denial historically has been used to shame people with addictions. The intent in this model is simply to support the user in facing reality, even if that means telling him what he does not want to hear and helping him to see what he does not want to look at.

The Spiral of Addiction and Recovery



Source: *Helping Women Recover: A Program for Treating Addiction* (rev. ed.), by Stephanie S. Covington, 2019. San Francisco: Jossey-Bass. Copyright 2008 by Stephanie S. Covington. Reprinted with permission.

When a person is in this downward phase of "constriction," the facilitator's/counselor's task is to help him to identify and acknowledge his problematic substance use. He must come to a point of transition, in which he shifts his perceptions in three ways. He must shift from believing "I am in control" to admitting "I am not in control." He must stop believing "I am not an addict" and admit "I have an addiction" (S. Brown, 1985, p. 34). And he must shift from an unwillingness to ask for help to being willing to admit "I can't do this alone."

Each of these shifts can feel humiliating. We must understand that anyone who enters treatment may come with a heavy burden of shame. The feelings of shame are exacerbated when the individual has been incarcerated and lost the freedom to make basic adult decisions about how to conduct his life. He does not need to be shamed further; rather, he needs to be offered the hope that he can recover.

The upward spiral of recovery revolves around the drug in ever-widening circles, as the addiction loosens its grip and the individual's world expands away from the drug. His world grows to include healthy relationships, an expanded self-concept, and a richer sexual and spiritual life.

Notice that the process is not merely one of turning around and ascending the same spiral, but one of transformation, so that one ascends a different spiral. When people speak of recovery, they speak of a fundamental transformation: "I'm not the same person. I'm different than I was." Transformative change is unplanned, profound, positive, and permanent. This transformative change process needs to be respected and allowed to emerge in its own time. The role of the professional is one of support and helping the client to transition from recovery initiation to recovery maintenance (White, 2017).

Addiction Defined as Neglect of Self

The definition of addiction developed for this program is "A chronic neglect of self in favor of something or someone else."

Practitioners who have studied men often see people with addictions as self-focused and perceive their task as breaking that obsession with self. Some who are addicted typically build up grandiose false selves that must be dismantled before they can discover and cultivate their true selves. Both male and female addicts may appear self-obsessed, because their lives are constricted around their drugs, while healthy give-and-take with others recedes into the background. However, their obsessions with their drugs hide their true selves.

Questions then arise: How does one shift from a chronic neglect of self to a healthy care of self? How does one shift from the downward spiral to the upward spiral? How does one grow and recover? How can we facilitate and support this process? These are the questions that this treatment program begins to answer.

A New Focus on Men's Psychological Development

For almost forty years, a growing group of male scholars and therapists has been reexamining the psychological development of men and male-specific psychological needs. In the past decade, there has been a substantial increase in the scholarly contribution to the developing theories and practices. Seminal thinkers such as Stephen Bergman, Gary Brooks, R. W. Connell, Glenn Good, Michael Kaufman, Michael Kimmel, Paul Kivel, John Lee, Ronald Levant, Michael Messner, Joseph Pleck, William Pollack, Michael Schwalbe, Terry Real, and David Wexler have created a vision of what "maleness" is and of male-specific services. This curriculum is influenced by and explores many issues that have been core to the work of

these men: the social construction of masculinity, the role of anger in men's lives, the effects of abuse and violence on men's relationships, creating a healthy sexuality, looking at shame, embracing grief, defining a masculine spirituality, and looking at the privilege many men experience in our society.

In 1994, Dr. Covington wrote *A Woman's Way through the Twelve Steps*, the first gender-responsive and trauma-informed guide for women in Twelve Step recovery. It was followed by a workbook in 2000 and a facilitator's guide in 2009. In 2009, Dan Griffin, using his master's work and *A Woman's Way* as a model, wrote *A Man's Way through the Twelve Steps*, the first gender-responsive guide for men in Twelve Step recovery. (The Twelve Steps of A.A. can be found in Appendix 1.) Griffin followed that book up in 2014 with *A Man's Way through Relationships: Learning to Love and Be Loved,* which looks comprehensively at the ways in which men engage in healthy relationships in the context of recovery and male socialization. In 2013, the Substance Abuse and Mental Health Services Administration published *TIP 56: Addressing the Specific Behavioral Health Needs of Men*, the first comprehensive document to look at men's specific issues within the treatment improvement protocols that are meant to provide guidance on best practices in order to improve traditional addiction treatment.

One of the most significant challenges is getting men to enter and stay in treatment. Although men represent approximately 70 percent of the treatment population, they are much less likely than women to voluntarily seek services and much less likely to finish services once they have begun. Because expressing one's feelings is one of the main objectives of treatment, this often is a barrier for men. One way to help break this barrier is for clinicians to provide some degree of self-disclosure to help assure a man that it is safe for him to break one of the strongest "rules" of masculinity (SAMHSA, 2013a). For instance, without going into great detail, a facilitator can talk about his experience in learning how to acknowledge his feelings or his own experience with asking for help. Such a gesture could prove to be pivotal in establishing an effective therapeutic alliance.

Men come into treatment with strongly held beliefs about what it means to be a man. These should not be viewed as entirely negative; nor should traditional masculinity as a whole be viewed in such a way. All aspects of masculinity do not need to be rejected, and men who embrace "The Man Rules" should not be made to feel as though there is something wrong with them (Griffin, 2014). These characteristics can contribute to a healthy sense of self for a man. What should be of concern is the degree to which men express the extremes of the behaviors associated with traditional masculinity. This is commonly referred to as hypermasculinity or toxic masculinity, and these extreme behaviors and attitudes are major contributing factors in interpersonal violence.

One of the most significant behaviors is the disconnection from self and others. Lyme, Powell, and Andrew (2012, p. 5) ask the pivotal question: "How can we teach

men, who are socialized to be incapable of sustaining trust, that their only hope of relief is to trust and to allow themselves to become vulnerable with their peers?" The answer lies—at least partially—in helping men learn how to have healthy relationships and supporting them as they strive to improve their existing relationships.

Relational-Cultural Theory

Jean Baker Miller, a psychiatrist, posed the question of how women grow and develop in her groundbreaking book *Toward a New Psychology of Women* (1976). Until its publication, traditional theories of psychology described development as a climb from childlike dependence to mature independence. A person's goal, according to these theories, was to become a self-sufficient, clearly differentiated, autonomous self. A person would spend his or her life separating and individuating until he or she reached maturity, at which point the person was ready for intimacy.

Miller challenged the assumption that separation was the route to intimacy for everyone. She suggested that a woman's primary motivation is to build a sense of *connection* with others. A woman develops a sense of self and self-worth when her actions arise out of, and lead back into, connections with others. Connection, not separation, is the guiding principle of growth for women. Since her writing, this theory has been applied to men's experience as well.

In 1978, Dr. Miller, along with three psychologists, Judith Jordan, Irene Stiver, and Janet Surrey, began meeting twice a month to reexamine developmental psychology and clinical practice (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). Their meetings led to the creation of the Stone Center at Wellesley College for exploring the qualities of relationships that foster healthy growth in women. According to the Stone Center's relational model, true connections are mutual, empathic, creative, energy releasing, and empowering for all participants. This theoretical approach is now called relational-cultural theory (RCT).

Mutuality means that each person in a relationship can represent his or her feelings, thoughts, and perceptions, and can both move with and be moved by the feelings, thoughts, and perceptions of the other person. Each person is willing and invested in being seen and heard by the other, as well as seeing and hearing the other. Each person, as well as the relationship, can change and move forward, because there is mutual influence and mutual responsiveness.

Empathy "is a complex, highly developed ability to join with another at a cognitive and affective level without losing connection with one's own experience" (Covington & Surrey, 1997, p. 336). An empathic person feels personally authentic in the relationship and also feels that he or she knows the other person.

Mutuality and empathy empower men, not through power *over* others but through power *with* others. Men feel more able to share power for constructive, creative ends. Mutual, empathic relationships are growth fostering and provide all participants with "five good things": (1) increased zest and vitality, (2) empowerment to act, (3) knowledge of self and others, (4) self-worth, and (5) a desire for more connection (Miller, 1986).

RCT also explores the effects of disconnection: diminishment of zest, empowerment, clarity, worth, and desire for connection. Disconnections happen at the sociocultural level, as well as the personal level, through racism, sexism, heterosexism, and classism. The issues of dominance and privilege are aspects of relational-cultural theory (Jordan & Hartling, 2002).

Although RCT was developed to understand women's psychological experiences, it is being used to gain a better understanding of all human experience. We are discovering that the willingness to develop connection with others is a predictor of long-term success for men. In addition, special attention is being paid to the importance of difference, particularly difference formed by imbalances in power and privilege. RCT is the foundation for a growing body of research on depression, trauma, eating disorders, substance use disorders, chronic illness, mother-daughter relationships, lesbian relationships, racism, sexism, heterosexism, classism, and many other psychological and social problems (Hartling & Ly, 2000).

Helping Men Recover is designed to foster mutual, empathic relationships among participants, and between leaders and participants, in order to cultivate what Miller describes as the "five good things." It is a man-centered empowerment model.

The Importance of Growth-Fostering Relationships

In recent years, the conceptual framework of RCT has been applied to men's programming in some organizations and has been found to have a positive effect. Still, there is not a substantial body of research or other work on RCT and men. Dr. Stephen Bergman, a Harvard-trained psychiatrist and the partner of Janet Surrey, wrote an important article on men and RCT in 1995. Bergman acknowledges that men are raised to want independence and individuation but he suggests that these carry a significant cost: "As with women, the sources of men's misery are in disconnections, violations, and dominances and in participation in relationships that are not mutually empowering" (Bergman, 1995, p. 68). Men are raised to separate, be separate, and be the "captains" of their ships, irrespective of the harm it does to them and others. Control and power are the primary tools through which boys are encouraged to develop into men. That is what leads them to be what RCT practitioners refer to as "agents of disconnection."

When men enter recovery and have successfully resolved, or begun to resolve, their issues with alcohol and other drugs, they often are left with their issues with relationships (Griffin, 2014). Bergman believes, as do we, that for men, as for women, "there is a primary desire for connection with others" (Bergman, 1995). As men move forward in their recovery, particularly in the Twelve Step culture, they find these connections to be valuable. They learn how to have relationships primarily because what was once culturally *proscribed* is now culturally *prescribed* (Denzin, 1993; Griffin, 2009). In other words, men in Twelve Step communities are encouraged to learn how to invest emotionally in all their relationships, including those with other men. Such behavior is now viewed as a strength and a sign of mature recovery rather than as a sign of weakness.

The challenge for men is being able to overcome years of separateness, isolation, and varying degrees of relational struggle. When men get into intimate relationships and find their partners wanting—even begging for—communication, vulnerability, and openness, they often freeze up or are deeply afraid of what lies on the other side of this kind of intimacy. Bergman (1995) refers to this process, which reinforces men's separateness and disconnection from their relationships, as "male relational dread." One of the primary purposes of this curriculum is to support men in looking at all the barriers that keep them from co-creating and engaging in healthy relationships.

Reparenting

Growth in any dimension—cognitive, emotional, or sexual—is a process. People who use substances often struggle with developmental issues for at least two reasons. First, they often come from dysfunctional families that did not support their growth. Their parents may have neglected them and left them to parent themselves, or their families may have abused them, leaving them traumatized. Second, addiction affects a person's emotional, sexual, and even physical development, depending on the person's age. It is not unusual for a man in his thirties to seem emotionally and sexually adolescent if he became addicted in his teens.

Kohut (1984) theorized that, in order to develop a cohesive sense of self, a child needs a parent to fulfill three functions. First, he needs a parent to *mirror* back his experience. The child falls down and cries, and the parent mirrors with a pained facial expression and empathic words, such as, "Ouch, that hurts, doesn't it?" By mirroring his pain, the parent validates his experience. The child learns that his subjective feelings reflect something real. Second, the child needs to be able to *idealize* the parent. He needs to be able to see good qualities in the parent that he wants to adopt as part of himself. Finally, the child *twins* with his parent. He looks at his parent and says, "We're alike. We both have dark, straight hair; we both like baseball." In twinning, the child looks at the parent and sees not just a mirror for his emotions but a separate

person who shares common traits. A child needs a parent to fulfill these three functions in the context of safety. Mirroring, idealizing, and twinning cannot occur effectively when a child lives in an abusive environment.

An individual in recovery often needs to be reparented in order to develop a cohesive sense of self and to heal. A counselor, a Twelve Step group, a correctional officer, and a sponsor all can participate in reparenting. A person also can learn to reparent himself in important ways. Both the facilitator and the other group members in this program can share in reparenting each member. For example, if the group members accept a participant's reality without challenging it, they are mirroring his experience back to him. Twelve Step groups forbid cross-talk in order to safeguard the mirroring function of the group. Twelve Step groups also encourage members to choose sponsors who have qualities they like and want to adopt. The sponsor becomes someone to idealize. Members of Twelve Step groups acknowledge the twinning function in their groups with comments such as, "If you go to meetings long enough, someone will tell your story." In this program, participants may begin to idealize the facilitator and other members of the group. They also are likely to hear aspects of their own stories from the other group members.

Trauma Theory

Trauma is a response to violence or some other overwhelmingly negative experience. It occurs when an event overwhelms a person's internal and external coping mechanisms. It can happen on multiple levels, from the general and chronic oppression of an entire group of people—through discrimination based on gender, race, poverty, sexual orientation, gender identity, disability, or age—to the repeated sexual abuse of a child that continues over years. Violence and trauma take many forms, including emotional, physical, and sexual abuse, as well as assault, war, natural disasters, and political terrorism (Covington, 2003).

The Diagnostic and Statistical Manual of Mental Disorders, or *DSM-5,* defines trauma as "exposure to actual or threatened death, serious injury or sexual violence in one or more four ways: (a) directly experiencing the event; (b) witnessing, in person, the event occurring to others; (c) learning that such an event happened to a close family member or friend; (d) experiencing repeated or extreme exposure to aversive details of such events, such as with first responders" (American Psychiatric Association, 2013, pp. 271–272). Trauma is not limited to suffering violence; it includes witnessing violence as well as stigmatization because of gender, race, poverty, incarceration, or sexual orientation.

Research has shown that traumatic experiences, especially traumatic events that occur during childhood, are associated with both behavioral health and chronic

physical health conditions. Substance use (e.g., smoking, excessive alcohol use, and taking drugs), mental health conditions (e.g., depression, anxiety, and PTSD), and other risky behaviors (e.g., self-injury and risky sexual encounters) have been linked with traumatic experiences. Because these behavioral health concerns can present challenges in relationships, careers, and other aspects of life, it is important to understand the nature and impact of trauma, and to explore healing (SAMHSA, 2019).

There is a difference between men and women in terms of their risk for physical and sexual abuse. Boys and girls are both at risk for physical and sexual abuse from family members and people known to them. However, there are significant gender differences over a life span. Adolescent boys are at risk, especially in their own homes. We are learning more and more about the frequency of young men who are abused by those who are supposed to protect and love them. The risk increases if they are gay, transitioning, young men of color, or gang members. Some of the greatest risk is from peers, people who dislike them, and the police. Teenaged girls are at most risk in relationships, from the people to whom they are saying "I love you." For an adult man, the risk for abuse comes from being in combat in the military or from being a victim of crime. For an adult woman, the risk is again from the person to whom she says "I love you." Note that it is even more confusing and distressing to have the person who is supposed to love and care for you do harm to you than it is to be harmed by someone who dislikes you or is a stranger.

Addiction, Trauma, and Violence

There has been a growing effort to address addicted men's needs in regard to past trauma. Dr. Maxine Harris and a team of clinicians created a trauma recovery and empowerment model (TREM) program for women (Harris & the Community Connections Trauma Work Group, 1998). The program has been adapted for men by Roger Fallot and Richard Bebout (the Men's TREM or M-TREM) and has been used nationally; however, the focus of this program is not on addicted populations (Fallot et al., 2001). *Helping Men Recover* is the first addiction treatment curriculum that fully integrates a male-based, trauma-informed approach.

According to Harris and Fallot (2001), trauma-informed services do the following:

- Take the trauma into account
- Avoid triggering trauma reactions or retraumatizing the person
- Adjust the behavior of counselors and staff members to support the person's coping capacity
- Allow survivors to manage their trauma symptoms successfully so that they are able to access, retain, and benefit from the services

In addition, trauma-informed services for men should take into consideration the degree to which a man has internalized traditional beliefs about being a man and any beliefs that could prevent a meaningful engagement in the therapeutic process. Histories of abuse and trauma for men in addiction treatment need to be expected, not considered exceptions. Any program for men with substance use disorders should take into account that many of the men will have suffered abuse. Traditional addiction therapy has not done the best job of talking about the abuse that men *experience* or the abuse that men *perpetrate* in the context of a cycle of violence and trauma out of which many men are acting. Given men's tendency to externalize the effects of trauma, some of the most difficult clients may be acting out trauma histories. Many men who used to be considered "treatment failures" because they relapsed may now be understood as trauma survivors who return to the use of alcohol or other drugs in order to medicate the pain of their trauma. All staff members must understand that they are probably dealing with trauma survivors and that they need to practice universal precautions, which means assuming that every client has had some experience with trauma.

As the understanding of traumatic experiences has increased among clinicians, mental health theories and practices have changed. It is important for service providers to understand trauma theory and to provide trauma-informed services for their clients. It is also critical for practitioners to understand the prevalence and impact of traumatic experiences.

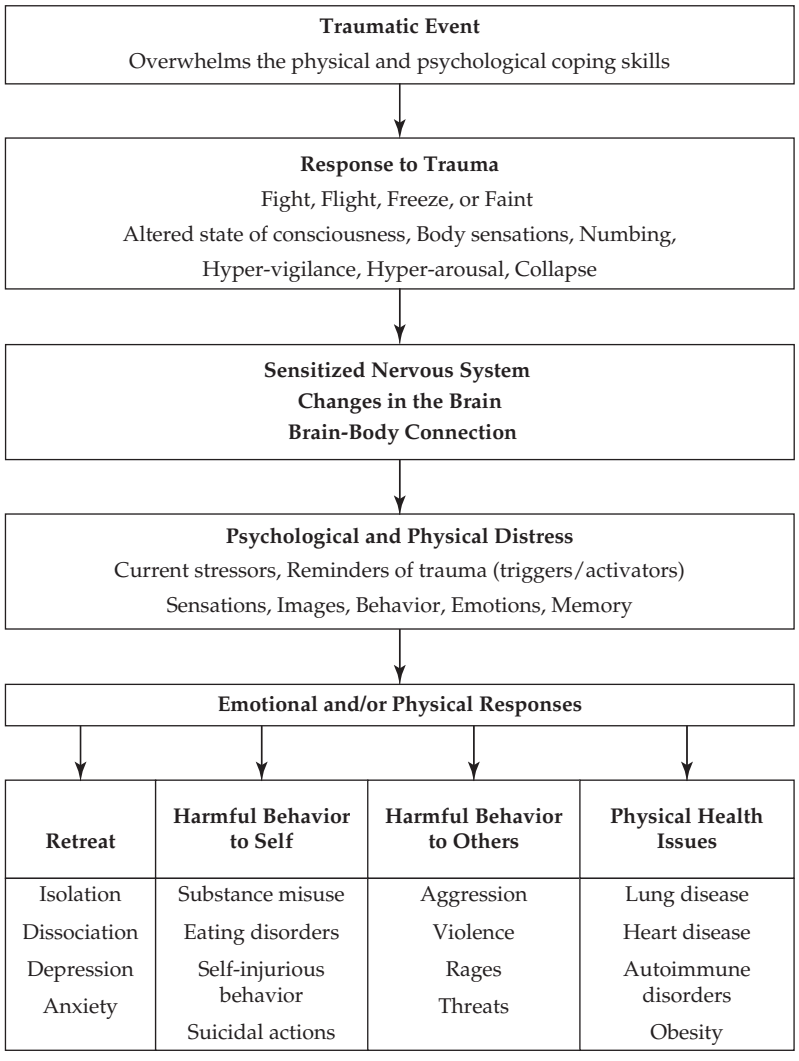
- Within the United States specifically, approximately 25 percent of men and 75 percent of women report having experienced childhood sexual abuse, and those who experienced sexual abuse also have higher rates of childhood physical abuse, maltreatment, and neglect (Perez-Fuentes et al., 2013).
- Using the Adverse Childhood Experiences (ACES) Questionnaire, a sample of violent offenders reported experiencing childhood adversity, on average, at four times the rate of the general population (Reavis, Looman, Franco, & Rojas, 2013).
- Children who experienced childhood abuse and neglect are significantly more likely as adults to perpetrate criminal violence, abuse their own children, and commit intimate partner violence than are children without such histories (Milaniak & Widom, 2015).
- Approximately 50 percent of boys who witness family violence will perpetrate such abuse and violence as adults (Hamby, Finklehor, Turner, & Ormrod, 2011).
- In the United States, 13.8 percent of men have experienced severe physical violence at some point in their lives (Black et al., 2011) and 30 percent of men have experienced intimate partner violence (Smith et al., 2017).

- In a study of males who perpetrated intimate partner violence, 77 percent of them reported past trauma exposure, 62 percent of them had multiple trauma exposures, and 11 percent had positive diagnoses of PTSD. PTSD levels also helped to predict relationship abuse (Semiatin, Torres, LaMotte, Portnoy, & Murphy, 2017).
- Approximately 60 percent of men will experience at least one traumatic event in their lifetimes. Of these, approximately 4 percent will develop posttraumatic stress disorder (PTSD) (National Center for PTSD, 2020).
- Forty-seven percent of transgender individuals have been sexually assaulted (National Center for Transgender Equality, 2015) and 50 percent experience some sexual violence in their lifetimes (James et al., 2016).
- Trauma is very common among incarcerated men. Rates of current PTSD symptoms and lifetime PTSD were significantly higher (30 to 60 percent) than rates found in the general male population (3 to 6 percent, although it can be safely assumed that the rates for the general male population are lower than actuality (Wolff, Heuning, Shi, & Frueh, 2014).
- Traumatic experiences are linked to opioid use. Individuals who reported five or more adverse childhood experiences were five times more likely to engage in injection drug use and three times more likely to misuse prescription pain medication (Quinn et al., 2016).
- Individuals who use opioids, including misuse of prescription opioids, often report extensive histories of childhood maltreatment. Some research suggests that opioids may be the preferred type of drug for individuals with histories of childhood trauma because they have the potential to numb both physical and psychological pain (National Child Traumatic Stress Network Policy Task Force, 2018).
- Opiate users are 2.7 times more likely to have a history of childhood sexual and/or physical abuse than non-opiate users, after controlling for diagnostic and sociodemographic variables. Opiate use is higher among those reporting physical abuse alone (24.1 percent) or both physical and sexual abuse (27 percent) than among those reporting sexual abuse alone (8.8 percent) (Heffernan et al., 2000).
- According to the National Survey on Drug Use and Health, 19.7 million American adults struggled with an active substance use disorder in 2017. In that same year, 8.5 million Americans suffered from both a substance use disorder and a co-occuring mental health disorder (SAMHSA, 2018).
- In a comprehensive review and meta-analysis of prison populations worldwide, researchers found that male prisoners were five times more likely to have PTSD than men in the general populations. They estimated that more than 300,000 prisoners in the United States have PTSD (Baranyi, Cassidy, Fazel, Priebe, & Mundt, 2018).

The Process of Trauma

The participants in your group may be at various stages in addressing their abuse. Some will remember their abuse clearly, some will remember certain aspects, and some will remember nothing. Some will talk openly about their abuse right away, and some will not. Because they will be at different stages and because they all need to feel safe, you will begin by normalizing the existence of interpersonal violence. If you have little or no experience working with trauma, the chart below will help you to understand the process of trauma.

The Process of Trauma



Retreat	Harmful Behavior to Self	Harmful Behavior to Others	Physical Health Issues
Isolation	Substance misuse	Aggression	Lung disease
Dissociation	Eating disorders	Violence	Heart disease
Depression	Self-injurious behavior	Rages	Autoimmune disorders
Anxiety	Suicidal actions	Threats	Obesity

Source: *Beyond Trauma: A Healing Journey for Women* (rev. ed.), by Stephanie S. Covington, 2016. Center City, MN: Hazelden.

Trauma begins with an event or experience that overwhelms a person's normal coping mechanisms. The first response that a person has when threatened is either fight, flight, freeze, or faint. Then there are physiological reactions in response to the event: hyper-arousal, altered consciousness, numbing, collapsing, and so on. These are normal reactions to an abnormal situation.

There are changes in the brain, and the person's nervous system also becomes sensitized, making it more vulnerable to any future stressors. The changes in the brain also can affect the functioning of the body. This is referred to as the brain-body connection. The person also may experience triggers in his current life as the result of reminders of the traumatic event that happened in the past. These triggers or activators may come from sensations in the body, images, smells, feelings, or memories. There may be nightmares and flashbacks to the earlier experience.

This creates a painful emotional state and subsequent emotional and/or physical responses. The responses we often see can be placed into four categories: retreat, harm to self, harm to others, and physical health problems. Women are more likely to retreat or be self-destructive, and men are more likely to engage in destructive behavior to self or others. Women often internalize their feelings, and men often externalize theirs. Both women and men can experience the physical health problems. From this chart, we can see that substance use is a common response to trauma. We know that no two people experience trauma in the same way. Many things influence how a person responds to a traumatic event: age, history with other trauma, family dynamics, support systems, and so on. We know that what is a traumatic event for one person may not be a traumatic event for another. Sometimes, trauma has occurred, but may not be recognized immediately because the individual may see the violent/abusive event as normal.

The Effects of Trauma

The Adverse Childhood Experiences Study (Felitti & Anda, 2010; Felitti et al., 1998) revealed a strong link between childhood trauma and mental health problems. Ten types of childhood traumatic events were assessed: emotional abuse, emotional neglect, physical neglect, physical abuse, sexual abuse, family violence, family alcoholism, parental separation or divorce, incarcerated family member, and out-of-home placement. A score of four or more events increased the risk of both mental and physical health problems in adult lives. Having a score of four or more increases a person's risk of having a variety of chronic health problems, including heart disease, autoimmune diseases, lung cancer, pulmonary disease, skeletal fractures, and sexually transmitted infections.

Posttraumatic Stress Disorder (PTSD)

PTSD often precedes substance use disorders (Kessler, 2000). PTSD is a trauma and stressor-related disorder that affects a person's physical and psychological

health (APA, 2013). The symptoms of PTSD are common among victims of abuse and neglect. It is helpful for anyone working with people who have experienced trauma to be familiar with the symptoms of PTSD and with the criteria for resolving the disorder. The *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* of the American Psychiatric Association (APA, 2013) lists the following symptoms:

- Recurrent, involuntary, and intrusive memories
- Reexperiencing the event through nightmares and flashbacks
- Prolonged distress when reminded, in any manner, of the trauma
- Avoidance of stimuli associated with the event. (For example, if a woman was raped in a park, she may avoid parks. If a man was assaulted by a man with long blond hair, he might avoid men with long blond hair.)
- Inability to remember key aspects of the trauma
- Negative self-perception (for example, "I am a bad person" or "I am flawed and undeserving")
- Negative beliefs about the world (for example, "I am not safe anywhere in the world")
- Persistent, inappropriate self-blame for the traumatic event
- Persistent distressing feelings, such as sadness, guilt, shame, terror, self-disgust, and anger
- Inability to feel interested in important activities that were significant before the trauma
- Inability to feel positive emotions
- Estrangement (the inability to be emotionally close to anyone)
- Numbing of general responsiveness (feeling nothing much of the time)
- Self-destructive and/or aggressive behavior toward others
- Hypervigilance (constantly scanning one's environment for danger, whether physical or psychological)
- An exaggerated startle response (a tendency to jump at loud noises or unexpected touch)
- Problems sleeping and/or concentrating

Some people with PTSD may experience dissociative symptoms. According to the *DSM-5*, these symptoms include feelings of depersonalization (feeling detached or disconnected from oneself, as though observing someone else experiencing events

rather than oneself) and derealization (experiencing life events as though they aren't really happening). It is important to be aware that trauma victims may experience one, some, or all of these symptoms.

There are two categories of PTSD: simple and complex. Simple PTSD stems from a single incident (such as an earthquake or automobile accident), usually experienced as an adult. Complex PTSD (or a complex traumatic stress reaction) is the consequence of a history of repeated or multiple traumatic experiences, such as childhood sexual abuse or domestic violence. In general, there are more symptoms and a more complicated recovery process with complex PTSD (Herman, 1997; Najavits, 2002; Williams & Sommer, 2013).

It is important to know that most trauma survivors will develop a belief system in response to traumatic events. Although many of these beliefs may appear either irrational or self-defeating, this is an adaptive response designed to make sense of what happened and to seek some level of diminished perceived threat.

Some common beliefs are

- I am to blame
- I am broken
- I can't be trusted
- The world is not safe
- I have no control
- I will eventually get hurt
- I don't deserve good things
- I do not fit in
- I will always be alone
- I can never get what I need or want
- If I show any vulnerability, I will get taken advantage of
- Everyone is only out for themselves
- If others knew who I really am, they would reject me
- The best way to protect myself from a hostile world is to strike first

It is also important to understand and acknowledge the varied and long-term effects of trauma. Traumatic events may affect a person for the rest of his or her life. However, there are criteria that you can reference when assessing a person's recovery. Healing from trauma is defined as follows (Harvey, 1996, 2007):

- The physical symptoms of PTSD are within manageable limits.
- The person is able to bear feelings associated with traumatic memories.
- The person has authority over his memories (that is, his memories don't limit what he does; he chooses what to do, rather than being immobilized in some areas).
- The memory of trauma is linked with feelings.
- Damaged self-esteem is restored (for example, a victim of sexual abuse realizes that the assault did not occur because he asked for it or was a bad boy).
- Important relationships have been reestablished.
- The person has reconstructed a system of meaning and belief that encompasses the story of the trauma (for example, he understands that the assault was not caused by him and that some adults use power and control to get their needs met or get what they want).

Trauma and the Brain

As the result of considerable research over the past century, we now understand that there are commonalities between rape survivors and combat veterans, between battered women and political prisoners, and between survivors of concentration camps and survivors of abuse in the home. Because the syndromes associated with trauma have basic features in common, it makes sense that the recovery and healing process also follows a common path.

Some of the most remarkable advances in the understanding of trauma come from studies of the biological aspects of it. Exposure to trauma can have lasting effects on the endocrine, autonomic, and central nervous systems. Studies have found complex changes in both the function and structure of specific areas of the brain. For example, abnormalities have been found in the brain's structures that link fear and memory (Woon, Sood, & Hedges, 2010). The brain's chemical responses to trauma can predispose a person to alcohol and drug addiction, eating disorders, self-harming behavior, and other mental health problems. Although all survivors want to move beyond their trauma, the part of the brain that is devoted to survival (deep below the rational brain) is not very good at denial. Long after a traumatic experience is over, it can be activated at the slightest hint of danger. Then brain circuits are mobilized, and massive amounts of stress hormones are released. This creates unpleasant emotions and intensive physical sensations. It can trigger impulsive and aggressive actions. These posttraumatic reactions can be confusing, incomprehensible, and overwhelming. The fear of being out of control can create a sense of overpowering fear,

helplessness, and hopelessness (van der Kolk, 2014). The fundamental issue in resolving traumatic stress is to restore the balance between the rational and the emotional self.

Trauma Treatment and Recovery

Our increased understanding of how the brain works has led to new strategies for treating trauma. Clinicians historically had been trained to use cognitive-behavioral and/or exposure therapies as the sole or primary interventions when working with trauma survivors. One of the leading trauma researchers and clinicians, Dr. Bessel van der Kolk (2014), now recommends a wide range of what were previously considered unconventional treatment strategies. These include the body-mind approaches of yoga, mindfulness, EMDR (eye movement desensitization and reprocessing), EFT (emotional freedom techniques), neurofeedback, sensorimotor therapy, martial arts, animal-assisted therapy, guided imagery, and theater. It is very important to remember that some clients will be unable to tolerate and/or maintain recovery without trauma treatment.

Three Stages of Trauma Recovery

In *Trauma and Recovery* (1992, 1997), Judith Herman says that trauma is a disease of disconnection and that there are three stages of recovery: (1) safety, (2) remembrance and mourning, and (3) reconnection. These three stages are interdependent and usually do not occur in a linear fashion.

Stage One: Safety The typical person entering an addiction treatment program will be in stage one; his primary need is safety. During stage one, Herman says, "Survivors feel unsafe in their bodies. Their emotions and their thinking feel out of control. They also feel unsafe in relation to other people" (Herman, 1992, p. 160). The *Helping Men Recover* (*HMR*) program is based on stage-one interventions, so it is the stage to which facilitators of this program need to be most attuned. Safety, both physical and emotional, is so crucial for people in early recovery that it is referred to throughout the program. It is also important to recognize the lack of safety in many men's lives.

During stage one, a program should address the participants' safety concerns in all the domains (cognitive/thoughts, affective/feelings, and relational/relationships) identified by Herman. Each session in *HMR* begins with quiet time and grounding activities to help the participants settle into the room and get into the present moment. The program includes sessions that discuss abuse, but the participants are not asked to recall or relate their specific incidences of abuse. As Herman points out, it is inappropriate to work on memory retrieval while a person is in stage one. An individual may need some stable recovery, a consistently safe external environment, a repertoire

of self-soothing techniques, and a support system before he is ready to do memory work. Stage-one recovery focuses on self-care in the present. Many trauma survivors use alcohol and other drugs to medicate their depression or anxiety because they know no better way to comfort themselves. The facilitator in *HMR* teaches the participants to use self-soothing techniques (such as breathing, walking, listening to music, visualization, and meditation) rather than drugs.

This does not mean that the topic of trauma is avoided. Acknowledging the trauma and understanding and naming the consequences begin the process of creating meaning. Survivors begin to understand that their feelings and behaviors make sense in the context of what they have experienced. The question changes from "What is wrong with you?" to "What has happened to you?" or, as Christine Courtois titled her self-help book for survivors (2014), "*It's Not You: It's What Happened to You.*"

Stage Two: Remembrance and Mourning A man who is stabilized in his addiction treatment may be ready to begin stage-two trauma work. An example of a stage-two group is a survivors' group. Stage-two recovery groups focus on the trauma that occurred in the past. The participants tell their stories of trauma and mourn their old selves, which the traumas destroyed. During this phase, trauma survivors often begin to acknowledge the incredible amount of loss in their lives. Although the risk of relapse can be high during this phase, the risk can be minimized through anticipation, planning, and the reinforcement of self-soothing mechanisms. A brief "slip" is not necessarily a failure; it may be an old response to painful memories and often can be stabilized quickly. It can be used as an opportunity for deeper understanding and self-knowledge.

Stage Three: Reconnection Psycho-dynamically focused psychotherapy groups, which traditionally are unstructured and heterogeneous, reflect the third stage of recovery: reconnection. This stage focuses on developing a new self and creating a new future. For some, this work can occur only after several years of recovery. Some people may not feel safe in mutual help meetings until later in their recovery.

These stages are not meant to be applied rigidly. They are actually rather fluid in application.

It is important to remember that individuals who are incarcerated are living in an inherently traumatizing environment. This makes it even more critical that the focus of treatment be on stage-one activities. *Exploring Trauma+: A Brief Intervention for Men and Gender Diverse People* is highly recommended as a companion to HMR (Covington, et al., 2021).

Resilience and Posttraumatic Growth

Earlier, we discussed the upward spiral as a symbol of recovery and transformation. The upward spiral also represents resilience and the potential for posttraumatic growth. Resilience is the ability to adapt well in the face of difficult life events. It is the ability to recover from or adjust to misfortune or change. Although some people are more naturally resilient, a way to develop resilience is by working through the emotions and effects of toxic stress and painful events, including the experience of addiction. Resilience develops as people develop better coping skills. It also comes from supportive, caring relationships with others. One of the goals of *Helping Men Recover* is to increase participants' resilience and provide an opportunity for posttraumatic growth.

Posttraumatic growth occurs when a person experiences positive changes from a major life crisis. First identified in the mid-nineties by psychologists Lawrence Calhoun and Richard Tedeschi (1999, 2013), posttraumatic growth goes beyond resilience. By actively searching for good in something terrible, a person can use adversity as a catalyst for advancing to a higher level of psychological functioning. Five positive changes signify posttraumatic growth:

1. *Personal strength:* Although vulnerability can create a sense of powerlessness, paradoxically, it can boost self-confidence.
2. *Relationships:* Bonding can occur on a deeper level after a tragic event.
3. *Greater life appreciation:* Tragedy can shift a person's perspective, creating a new focus on gratitude and joy.
4. *Beliefs:* Beliefs may change or be reinforced by grief. People often see their roles in the world differently.
5. *New possibilities:* People may perceive new opportunities and pursue them.

Several factors facilitate the process of posttraumatic growth: receiving care from supportive people, approaching versus avoiding grief, and recognizing that a person is in control of the timing of his or her recovery process.

Trauma-Informed and Trauma-Responsive Services

Trauma has become so prevalent in our society that we now realize that any system working directly with people needs to become trauma informed. This means that everyone working in the organization needs to have a basic understanding of trauma and its effects. This includes everyone in admissions, bookkeeping,

housekeeping, transportation, administration, medical services, and clinical services. A trauma-informed facilitator or therapist will be much more effective in providing services. In short, "trauma informed" means what we need to *know*. (Specific training is available for criminal justice professionals; see Covington, 2020).

The next step is for an agency/facility to move from trauma-informed services to trauma-responsive services. This means incorporating knowledge about trauma into the environment and culture of the agency (Covington & Bloom, 2018). "Trauma responsive" means what we need to *do*.

Becoming trauma responsive is a culture change that creates a safe, supportive, and empowering environment for both clients and staff members. *Moving from Trauma Informed to Trauma Responsive: A Training Program for Organizational Change* (Covington & Bloom, 2018) can help to provide the structure and support you need to create a culture that will enhance the facilitation of *Helping Men Recover*.

A trauma-informed, therapeutic environment features the following core elements or values (adapted from Harris & Fallot, 2001):

- *Safety* (ensuring physical and emotional safety)
- *Trustworthiness* (maintaining appropriate boundaries, making tasks clear, modeling openness and honesty)
- *Choice* (emphasizing individual choice and control)
- *Collaboration* (equality in participation, sharing of power, and creating a sense of belonging)
- *Empowerment* (striving for engagement, agency, and skill-building)

Added to these five elements are two specifically identified for trauma-informed care for males (Fallot, Griffin, Bebout, & Dauer, 2015):

- *Compassion* (looking at the entirety of the person, including his experiences and environments, rather than being judgmental and dismissive)
- *Mutual responsibility* (each person is responsible for his part in the relationship and for his own behavior)

In a therapeutic program, safety is paramount. The participants in the program must feel safe in order to learn and grow. Facilitators can help to create a safe environment by keeping the program free of physical, emotional, and sexual harassment. Teaching grounding techniques to the participants will help them to feel internally safe. Programs conducted in correctional facilities face the challenge of creating a

sense of safety in an environment that is probably not consistently emotionally or physically safe. The facilitator needs to recognize, acknowledge, and find strategies for addressing this. *Helping Men Recover* is designed structurally and through content so that the facilitator can create a refuge for participants.

Although you cannot ensure a participant's safety outside the group, you can maintain an atmosphere of safety within the group by adhering to a set of group agreements. The most important of these is confidentiality. This is essential for a sense of psychological safety. What is said in the group remains in the group unless it involves a threat to a participant's safety or that of someone else. If the members of the group live with other people, in order to help ensure confidentiality, the facilitator may provide time for them to do their workbook activities immediately following the group sessions. The facilitator can then store the workbooks in a secure place between the sessions.

Triggers

A "trigger" (also referred to as an activator or reactivator) is a stimulus that sets off a memory of trauma. A single environmental cue related to the trauma—such as a noise, a sound, a smell, or another person's presence— can trigger a full fight-or-flight response. Profound dysregulation of psychological and physiological systems is a result of trauma; this means that the sufferer overresponds to neutral cues and underresponds to danger cues. The danger for men, and for those around them, is that their responses to these cues can lead to further victimization and their perpetrating violence on others as they externalize their reactions to the intense feelings they are experiencing.

Some triggering is inevitable. Because clients may be expected to be triggered in a therapeutic group setting, attention should be paid to increasing each client's awareness of the phenomenon and his skills for managing emotional distress (Najavits, 2002). Trauma survivors are used to having their boundaries ignored and their opinions or objections dismissed. A crucial element of successful treatment involves attention to the following components of a person's experience (Harris & Fallot, 2001):

- Boundary violations
- Lying and breaking integrity
- Chaotic treatment environment
- Lockstep rigid agency policies that do not allow a client to have what he needs
- Agency dysfunction
- Disruption in routines
- Secrets in the group
- Not listening to the client

- Not believing his account of the abuse
- Labeling intense rage and other feelings as pathological
- Minimizing, discrediting, or ignoring the client's responses
- Conducting urinalysis in a nonprivate and disrespectful manner
- Searches of living space in a custodial setting
- Frisking or pat-downs
- Shackling or handcuffing
- Cavity searches
- Loss of privileges without justification
- Solitary confinement

It can be very helpful to learn what makes someone feel triggered to the point at which the person goes into crisis mode. Each individual has a unique history and specific triggers. There is no single profile. Some questions you can ask are

- "What do you notice when you are triggered?"
- "What happens just before you lose control?"
- "What have you noticed in the past just before losing control?"

Some common responses to being triggered are

Internal

- Restlessness
- Agitation
- Shortness of breath
- Tightness in chest
- Increase in body temperature
- Rapid breathing
- Tight muscles
- Feeling on edge
- A knot in the stomach
- Heart pounding

External

- Teeth clenching
- Hand wringing

- Shaking
- Crying
- Giggling
- Rocking
- Bouncing legs
- Pacing
- Sweating

An important element of the *Helping Men Recover* program is teaching the participants grounding techniques that will help them to manage these and other symptoms.

A Man's Reluctance to Acknowledge Trauma

Although some level of abuse seems to be a basic part of how most boys are raised, acknowledging abuse, for many men, is emasculating. Entering a counseling service, asking for help, and engaging in emotional disclosure are difficult for most men (Lyme et al., 2012). At the heart of abuse are powerlessness, victimization, emotional pain, and/or physical pain. There is little to no benefit to a man in acknowledging abuse if he is invested in traditional masculinity. As a result, it is highly likely that the abuse of males of all ages is underreported. Many men, if not most, come into treatment following the grin-and-bear-it rule. As Lyme and his colleagues say: "Quite frequently we hear men share that they came from a 'good' home, that they had 'great' parents, and yet when we explore further there is often a tale of terror behind the lace curtain" (p. 43). Simply put, it is not manly for a man to acknowledge trauma, so many men will go to great lengths to avoid dealing with trauma. What we need to remember is that The Man Rules are about safety for men and that boys learn this very early in their lives. The Man Rules protect men from feeling emotional and psychic pain, and the denial of trauma is about protecting themselves from having to acknowledge the pain in their lives.

The Value of Twelve Step Programs and Other Mutual Help Groups

Helping Men Recover does not require that a group member participate in a mutual help (or mutual support) group. Facilitators may want to encourage the participants to attend such groups, either in conjunction with this curriculum or after they have

completed the program. We recommend having the participants utilize the mutual help groups that are available in jails and prisons and then develop community-based support to assist them with their transitions to the community. Such an approach aligns with the model of behavioral health recovery management (BHRM) mentioned earlier. Program participants are dealing with a chronic disease that they are able to put in remission but not cure. Mutual support groups are particularly critical, given the lack of understanding and support that our society offers in regard to addiction and recovery.

There is a positive correlation between involvement in A.A. and substance-use outcomes when treatment and A.A. are combined. Research indicates that people who attended treatment plus A.A. had significantly higher rates of abstinence than those who had treatment alone at one- and three-year follow-ups (Timko, Moos, Finney, & Lesar, 2000). Alcoholics Anonymous, Narcotics Anonymous, Rational Recovery, and SMART Recovery groups can provide bridges back into the community for men who are leaving jail or prison and can expand their ideas of what support is possible. Such groups also help men to experience the power of relational support, a primary emphasis of this curriculum.

Community-based support groups are especially important in a time when money for treatment and psychological services is limited. With the advent of Internet technology, participants also have the opportunity to engage in cyber support groups (specifically, Intherooms.com, the Facebook for people in recovery). If you deliver services in a rural environment, or if a participant is traveling as a result of his job or expresses concern about speaking in public or being in groups, the Internet can prove to be an invaluable tool.

Certainly, A.A. and the other groups have limitations. They stress individual change as the solution to a person's problems and often ignore social and political factors, such as understanding male-dominated systems; the impact of sexism, racism, and heterosexism on individuals; and the privilege that men experience simply by being men in our society. Atheistic and agnostic men may be uncomfortable with references to a "Higher Power," but the only requirement for membership in Twelve Step programs (A.A., for instance) is a "desire to stop drinking," so they are not required to change their beliefs. The Twelve Step culture welcomes a broad range of understandings of the higher power, including the group, "Buddha," and a "Deeper Self." Atheists and agnostics are absolutely encouraged to be a part of a Twelve Step group, although they may not always feel comfortable.

Secular Organizations for Sobriety (SOS) groups follow a format similar to that of A.A. but omit references to a higher power in any form. SMART Recovery groups are

available in the community and online. Information about these groups is contained in Appendix 2 of this guide. Information about online meetings is found in Appendix 3.

Mutual help groups are not a substitute for professional counseling. However, as part of a multifaceted support system, mutual help groups can aid individuals in their recovery. They provide the safe environments that are needed for trauma recovery and the growth-fostering relational contexts that serve men's psychological development. Mutual help groups help men to be grounded in a real community and to discover how to have the kind of relationships they want in their lives, with women and with other men. They help a man in recovery to understand what support, connection, and community can be like.