Men, Trauma, and Homelessness: Paths to Recovery

An Edited Transcript of the PATH National Teleconference
Sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA)

May 18, 2004

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This telephone/Internet presentation was supported by a technical assistance contract with the Substance Abuse and Mental Health Services Administration (SAMHSA). However, the content of this teleconference does not necessarily reflect the views of SAMHSA or the U.S. Department of Health and Human Services. For further information about this teleconference, please contact Terri Tobin, Advocates for Human Potential, Inc. (978-443-0055).

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Welcome and Introduction

Amy Salomon

Welcome, everybody. This is the first call in a two-part series called, "Men, Trauma and Homelessness: Paths to Recovery." My name is Amy Salomon, and I'm here in Sudbury, Massachusetts, with Advocates for Human Potential, Inc. We're the technical assistance contractors for the PATH program, and I'm going to be your moderator. There are going to be people on this call from all over the country, including staff from PATH-funded service provider agencies, and representatives from State and Federal governments. We're very pleased to have two nationally recognized experts with us today who have prepared a presentation specifically for the PATH audience.

Before we begin, I'd like to ask Gigi Belanger to say a few words. Ms. Belanger is the Assistant Director of the PATH program, and has worked closely with Dr. Michael Hutner, the PATH Project Officer, to promote the PATH program within CMHS, as well as to develop more effective ways of delivering training and technical assistance to PATH projects.

Gigi also has a special interest in the topic of trauma among individuals experiencing homelessness and has been an invaluable resource in our effort to plan this presentation today. Gigi?

Gigi Belanger

Thank you, Amy. Welcome to all of you listening in today. On behalf of CMHS, I'd like to thank you for taking time out of your busy schedules to join us. We're very excited to be offering this PATH-sponsored technical assistance on trauma, a topic that has been overlooked for a very long time.

Trauma, as you all may know, is extremely disabling, largely ignored, and highly pervasive. SAMHSA considers trauma to be so much of a priority that the administrator has incorporated trauma and violence as one of the agency's crosscutting principals that will guide program policy and resource allocation.

The President's New Freedom Commission on Mental Health developed a set of recommendations to transform the mental health system, and the report identified trauma as one of the four understudied areas. Recognizing the importance of understanding the impact of trauma on mental health and the need to develop trauma-informed and sensitive service systems, SAMHSA is working with the National Institutes of Health (NIH) to enhance the evidence base and evaluate service models in this area.

SAMHSA expects that anyone in the business of providing services to individuals who are homeless and anyone who provides mental health services and/or substance abuse services be equipped with the knowledge, skills, and attitudes that address trauma sensitively. To help States make trauma a priority, CMHS is working with the National Association of State Mental Health Program Directors, which will conduct State and regional training.

In the past, attention has been paid to the impact of combat on soldiers, and more recently to the impact of trauma on women. In fact, SAMHSA has a number of programs to improve trauma services for various populations. However, little attention has been paid to the impact of early childhood trauma on men. We know that histories of trauma and violence are common for individuals who are homeless and experience mental illness and/or substance abuse issues, and that our programs tend to see more men than women.

We are extremely lucky to have Roger Fallot and David Freeman from Community Connections with us today to share their expertise and experiences on trauma and men.

CMHS is very interested in increasing awareness and understanding of trauma, and we would like to have your feedback on what you think you would find helpful and useful for CMHS to sponsor on trauma. What types of TA would be useful, and what other types of support might be helpful?

With that, I'm very excited to hear our presentation.

Amy Salomon

Thank you, Gigi. As some of you may know, PATH presented a national teleconference last year on working with trauma survivors who are homeless. This drew one of the largest audiences we've ever had for PATH's national teleconferences.

For those of you who were not part of that call, you can find the written transcript for it on the PATH Web site. Go to the technical assistance page and scroll down to 2003, and you'll have what is essentially a background paper on this topic that should be very helpful.

Clearly, this introductory presentation touched a real chord of interest among PATH providers and others to understand more about the impact of trauma, its relationship to the experience of homelessness, and what providers could do to recognize its signs and symptoms and respond appropriately.

The presentation today is a response to that interest, honing in specifically on men who are homeless and trauma survivors and their pathways to recovery. We're going to look at the prevalence of trauma on men, its impact on multiple life spheres, the types of exposure that men have to trauma, and the stages of trauma recovery.

We're also going to explore the meaning of a trauma-informed approach to practice, specifically outreach and engagement with men. This presentation is the first in a two-part series on the topic of men, trauma, and homelessness. The second call on June 15, 2004, will provide more in-depth information on some of the key concerns that men who are survivors bring to human service relationships and how providers may respond to these concerns.

Part II will also draw on lessons learned from the Men's Trauma Recovery and Empowerment Model, known as M-TREM, which is group intervention for survivors. We hope you'll join us for that call on June 15th.

At this time, I'd like to introduce our featured experts. Roger Fallot and David Freemen both work at Community Connections, a private not-for-profit agency providing a full range of human services in metropolitan Washington, DC.

Roger Fallot is a clinical psychologist and co-director of Community Connections. His professional areas of interest include the development and evaluation of services for trauma survivors and the role of spirituality in recovery. The author of numerous clinical and research articles, Dr. Fallot is a contributing author to and co-editor with Maxine Harris of *Using Trauma Theory to Design Service Systems*. Dr. Fallot is currently the principal investigator on the District of Columbia Trauma Collaborative Study, which is a federally funded research project examining the effectiveness of integrated services for women trauma survivors with mental health and substance abuse problems.

Dr. Fallot is also a member of the adjunct faculty in pastoral counseling at Loyola College in Maryland and is a contributing author and editor of *Spirituality and Religion in Recovery from Mental Illness.*

David Freeman has worked with vulnerable and disenfranchised consumers at Community Connections for 13 years. He's been a case manager, a team leader, a program director, and is currently responsible for quality improvement in the care of 500 consumers. Dr. Freeman has participated in the development of several programs at Community Connections, including federally funded projects on dual diagnosis, supported employment, trauma, and homelessness. He's developed family support and mind/body programs at Community Connections, as well as Creative Connections, a consumer-driven, value-based, capitated care model.

Dr. Freeman has directed the Psychology Training Program at Community Connections for five years and has been adjunct faculty at George Washington University and Howard University. He has several publications related to the innovative care of those with severe mental illness.

Dr. Freeman has been involved in the development of a men's trauma recovery program for the past eight years. In addition to his work at Community

Connections, Dr. Freeman has a private practice where he specializes in psychotherapy with adolescents and couples.

Welcome to our presenters, and thank you both for taking the time to be with us this afternoon. Roger, would you like to start?

Men, Mental Illness, and Violence

Roger Fallot

Thank you, Amy, and thank you, Gigi. We're very grateful for the invitation to do this presentation on "Men, Trauma, and Homelessness" this afternoon and hope that our discussion is helpful to listeners.

Several years ago, I was invited to attend a focus group designed to address violence in the lives of people diagnosed with severe mental disorders. There were about 10 of us from the public mental health services arena, and we were gathered around a table to look at and discuss the results of a research project in this area.

The discussion got started, and something was just not clicking; all of us were rather confused. I felt like I had the first time I went to a dinner where there were seven forks and spoons around my plate. I just didn't know where to start. We looked at each other for a while. We looked at the leader. We scratched our heads, and then we had a flash of insight.

The research project was examining violent acts that were committed by people diagnosed with mental disorders. We were supposed to be discussing the perpetration of violence. But for most of us in the room, this was simply not the first thing that came to our minds in relating mental health problems to violence. Most of us were much more accustomed to working with people who had been victims of violence, not perpetrators. We were confused because the usual realities we had been dealing with on a day-to-day basis were being turned on their heads. It was not that the research was unimportant, but it was decidedly secondary in terms of our everyday experience, where the frequency of victimization far outweighed the frequency of perpetration.

Some of you may have a similar reaction this afternoon. When we think of men and violence, our first thoughts are often of men as perpetrators. The fact indeed is that most violent acts are committed by men. The fact is most violence against women is committed by men, and the fact is that most of the lethal violence in relationships is committed by men. But men are certainly not only nor even primarily perpetrators of violence. Men and boys are all too often the victims and survivors of violence and that's our topic for this afternoon.

Let me give you a brief example. Last year, we were beginning a new trauma recovery group for men at Community Connections. In the first session, we talked about the importance of beginning groups that address the impact of violence in men's lives. One of the men immediately said he had a story that he wanted to share.

He talked about a time when he was about 16 years old. He was feeling confused and in turmoil, especially about issues of religion and his faith. He had many, many more questions and concerns than he had answers, so he sat down and he wrote a long detailed letter to Reverend Ike asking for answers to these questions.

He gave the letter to his sister to mail. His sister, being somewhat suspicious about this letter, gave it in turn to his mother. When his mother saw the content of this letter, she came into his bedroom and beat him—beat him severely, hitting him repeatedly with her fists on the sides of his head to teach him the importance of adhering to his family's strict religious beliefs. That night, at 16, he made his first suicide attempt by eating a box of rat poison.

I don't know how isolated this incident was, but I have come to know many other men for whom this much is commonplace: violence, physical violence, sexual violence, emotional violence was historically and is currently a prominent and an often unavoidable feature of their interpersonal worlds. Whatever else may have been happening with this young man—spiritual crisis, an adolescent identity crisis, a deepening depression with major anxiety, perhaps a first glimpse of psychotic disorganization—the

episode was crystallized and the suicide attempt was prompted by the violence he experienced that evening. Whatever else may have been happening here, fear, helplessness, and shame came to dominate this young man's experience. Whatever else may have been happening here, an event occurred that remained immediate and very fresh in his experience years later, so that when a group focusing on violence convened, this man could literally not help but tell his story of abuse almost immediately.

Whatever else is going on with many, I would say most of the men we see in public mental health and substance abuse treatment, including especially those who were or are homeless, violence is a central part of their story. It has often shaped who they are, how they deal with other stressors, how they understand themselves, how they relate to others. In short, for many men, violence has become a part of them, and that's what we hope to unpack a bit this afternoon with your attention.

Trauma among Homeless Men

Amy Salomon

Thank you, Roger. Maybe we can begin by making sure that everyone who is on the line or on their computers has the same understanding of what we mean today by trauma. Why is it so important for PATH programs and providers to understand trauma among their client population?

Roger Fallot

The term itself, I think, has always had a sort of two-sided meaning. In some ways, it refers to the event itself—that is, a traumatic event. And at other times, it refers to the response of the person who has experienced the event, the traumatic response.

The event itself is usually considered in the DSM-IV as one that threatens death or bodily injury; although I think, in our experience, there are broader understandings of the nature of that event, and we rely perhaps more heavily on the second part of that definition, which is that the response to the event is one that involves extreme fear or experiences of helplessness or horror. In the response to those events, we are emphasizing the person's experience rather than some kind of defining characteristics of the event itself.

David and I will be focusing primarily on interpersonal violence in the lives of men, especially physical, sexual, emotional violence, especially during childhood; although, in the lives of homeless men, certainly there is a great deal of violence in adulthood as well. So we're going to be focusing on interpersonal violence as opposed to such events as natural disasters, and especially violence that has been perpetrated by one person against another.

We're focusing on this for a number of reasons. The first reason is because it is so pervasive. Community surveys have found extremely high levels of lifetime exposure to trauma, ranging from just over 50 percent to 90 percent. The wide range is because different surveys involve specific, distinct definitions of what constitutes a traumatic event. In general, individuals in these surveys report having experienced an average of nearly five traumatic events in their lifetime.

Rather than understanding trauma as a rare exception to peoples' experiences, we are coming to see trauma as epidemic: that it's a very, very common experience, and it's a community and societal event as well as an individual one. Trauma's impact is not restricted simply to an individual's experiences, but it affects relationships, both with people who are close to the individual and, as we've learned especially in the past several years, at the community level.

So there is certainly a pervasiveness of trauma in community level surveys. If we look more to people who have other kinds of identified problems—such as homelessness, mental health problems, substance abuse problems, and/or involvement with the criminal justice system—trauma prevalence is even higher. We have some very good surveys that have been done in the last five years or so involving people with severe mental disorders, for example. We see there virtually universal trauma exposure. Well over 90 percent report at least one traumatic event in their history.

Childhood sexual abuse is extremely common: 52 percent of women who have been diagnosed with a severe mental disorder and 35 percent of men who have been so diagnosed report histories of childhood sexual abuse. And sexual assault in adulthood is even higher for women—64 percent. Twenty-six percent of men who have been diagnosed with a severe mental disorder report adult sexual assault.

Men are particularly likely to report having been attacked with a weapon in adulthood, often in street violence, community violence, and sometimes in institutional-based violence: 49 percent of men and 30 percent of women. Witnessed violence is a very important part of many people's experience—43 percent of men have witnessed a killing or a very serious injury. Twenty-four percent of women with severe mental disorders have that experience.

So most of these studies have included a wide-range of experiences and if we look particularly at trauma prevalence among men, we see an increasing risk of trauma with more identified difficulties. In physical abuse, when you look at large-scale community samples, somewhere over 30 percent of men report a history of physical abuse, whereas in any kind of group that is identified as having a mental health or substance abuse problem, the numbers are considerably larger. So we know that mental health problems and trauma are strongly related. The trauma increases risk of later mental health difficulties.

In clinical samples, nearly 60 percent of men report childhood physical abuse, and 86 percent over the course of their lifetime. With sexual abuse, similarly, there are higher rates in any group of men who have been identified on the basis of their involvement with a public mental health system—30 percent to 35 percent in childhood report sexual abuse and around 25 percent in adulthood.

The Impact of Trauma

Amy Salomon

Roger, these numbers are just staggering, but maybe you and David could help the listeners understand a little better the impact of trauma in our society and for men especially.

David Freeman

We think of trauma as having a broad impact on people's lives. If you think about the different domains of life experience and tease apart each of those domains, and then consider the impact of trauma on each domain, you can begin to see something about the breadth of impact.

For example, if you think about the impact of trauma on the sense of self, you can see how easily people's sense of well-being, people's sense of personal boundaries, and people's sense of value and self-worth can be compromised by trauma. You can see how easily people's sense of self is damaged and overwhelmed by traumatic experience. You can see how one becomes brittle and weakened in the face of the traumatic experience.

If you think about the domain of relationships, you can also begin to imagine the substantial impact of trauma. As people who have been physically and sexually abused in the past embark on relationships in the present and consider the potential for relationships in the future, they expect a strong possibility that violence and abuse will be part of the experience. The traumatic experience goes a long way toward defining what people imagine is possible from relationships and, therefore, has an incredibly negative impact on people's hope for relationships.

Trauma also has an impact on psychiatric symptoms. There's significantly increased incidence of depression, PTSD, and anxiety disorders. There are intrusive thoughts. There are disturbed sleep patterns. The psychiatric symptoms that people present with a mental illness independent of traumatic experience are exacerbated, intensified, significantly worsened.

Substance abuse is another domain where trauma has a negative impact. Trauma survivors are likely to use substances to manage anxiety, to manage the stress, and to dissociate from horrible experience. Oftentimes, substance abuse is woven into traumatic experience. People are perceived to be more

vulnerable to the perpetrator if they are drunk, if they are high, or if they're desperate for drugs or for crack. They're more likely to be easily victimized if substances are involved.

People's residential experiences are significantly affected by traumatic history. There was a woman that I worked with some years ago who kept a weapon under her pillow at all times. She felt she needed to protect herself, but in doing so violated the rules of the house. There was a man who refused to lock the door for fear that he wouldn't be able to get out should he need to escape. There was another man who would sleep only on the couch, never in his bedroom, in violation of group home rules. The staff would get really upset with the fact that he was unwilling to go to bed. It disrupted the rule enforcement in his residential placement.

People's medical experiences are often significantly shaped by traumatic histories. For example, many men are more likely to be involved in somatization, with associated anxiety and depressive reactions, and are more likely to be sensitive to physical complaints.

In the area of employment, trauma survivors are often likely to have problems. Problems with authority figures can be exacerbated because, in past traumatic experiences, authority figures were abusive to them. So the struggle with authority can be intensified for survivors.

So in each of these domains—the sense of self, relationships, psychiatric symptoms, substance abuse, preserving a safe residence, medical stability and employment—stability and success are negatively affected by traumatic experiences. The impact of trauma on functioning is extremely broad.

People who may have a tendency, biologically, toward a paranoid experience find support for their positions when they've been traumatically victimized. If people mistrust others, they find a confirmation of their mistrust when they've had frequent traumatic experiences. The meaning of life, of purpose in life, of worth and worthiness, and of keeping oneself alive are all deeply questioned when people have had traumatic experience.

We also find that trauma is self-perpetuating. Many people who are perpetrators learn their behavior from people who victimize them. We can easily see how the intergenerational transmission of trauma gets established. Often times, a person who had been victimized as a child carries the impact of trauma in to adult life.

We also find that people who have been survivors of violence run the risk of being more likely to be revictimized, so that people lose the sense of how they can protect themselves. In so many different ways, we find that trauma has broad impact.

And then finally, we find that trauma is also insidious. Sometimes we ask, "Can it get worse for somebody who has been a victim multiple traumatic experiences?" The answer is, "Yes, it can." It's not like one more experience gets collapsed into the memory of all of the other experiences. Each traumatic experience makes things worse.

At the same time, these problems are interactive. So, for example, I was working with a man who had been homeless. We spent the better part of the year helping him get established in a residence. He actually started to connect with some others and to do pretty well in his residence. But, he was assaulted on his way home from work one night, and the assault was for him reminiscent of previous experiences. He was very depressed and anxious. He found that the only place he could turn was substances. He relapsed and was soon evicted.

Once he was evicted and homeless, he started sleeping on a park bench in an unsafe neighborhood. Sadly, he was assaulted by another homeless gentleman who was accustomed to sleeping on the same bench. The assault intensified my client's psychiatric symptoms, which had already increased because he had been without his medication while he was homeless. There was an interaction of the vulnerability and the fragility of his life situation with his mental health problems, with his substance abuse problems, with his trauma history—each feeding off the other, each making the other worse.

Many people have been retraumatized by people who have defined themselves as helpers. People who work with trauma survivors should themselves be carefully supervised to reduce this risk. The helping relationship is often dominated by a strong sense of authority, and the helper is granted a certain amount of power. Because the victim is often quite vulnerable, the provider who victimizes others may deny the individual's experience. For example, the provider can say, "Well, that's just the survivor's delusions." So there are, certainly, survivors who have been victimized by helpers in the past. As people interview and talk to men who are survivors, they should be aware that some stories that they hear about abuse in supposedly safe places, though shocking and horrible, may well have a basis in truth and need to be heard.

For many men, trauma is recent and ongoing. So we're not talking simply about childhood experiences. For men with severe mental disorders, 8 percent say that they've experienced sexual assault within the past year, and 34 percent say that they've experienced physical assault in the past year. You have to consider the possibility that people's experience of violence is both recent and remote.

So the final point on this is that when people have been victimized, the possibility of repeated victimization increases, because every time that people are victimized, they're at risk for being less able to protect themselves in the future.

The Association between Trauma and Homelessness

Amy Salomon

Thank you, David. Clearly, the impact of trauma can be profound. What more do we know about the experience of trauma specifically among men and men who are experiencing homelessness? How is trauma associated with homelessness?

Roger Fallot

I'll respond to that but before I do, I want to sum up what David has been saying because I think it's very important to highlight the extent to which there are non-obvious connections between trauma and subsequent experiences.

Everyone has come to recognize in the last several years, if not before, the prevalence of PTSD, for instance, as a specific response to trauma that may develop and become problematic for people, but there have been a wide number of studies that go beyond the PTSD diagnosis. I'll mention just one of them that has gotten a good bit of publicity lately and that people may be interested in following up on, the "Adverse Childhood Experiences Study." It's sometimes just referred to as the ACE Study. If people are interested, they have a nice Web site, www.acestudy.org.

The investigators—Robert Anda from the Centers for Disease Control and Vince Felitti, who is with Kaiser Permanente in Southern California—have conducted a large-scale study over the past decade. What prompted their interest in this was that they were doing a study of obesity and found that a lot of people who were involved in obesity programs, and were doing well, seemed to drop out of the program at fairly high rates.

They were curious about what led to this high drop-out rate among people who were doing well in the program. They started talking with the people who left and found a very, very high rate of childhood physical and sexual abuse. Their understanding of this phenomenon was simply that obesity was one of the possible responses that people had developed to keep themselves safe, to keep other people at a distance, and to maintain relationships that felt safer because they involved less physical contact and more interpersonal safety. They started following up that kind of observation with a series of more careful interviews and data analysis.

What they have found is that the number of adverse childhood experiences, including physical and sexual abuse, are directly connected to a whole host

of later difficulties, some of which we would say are predictable, including the kind of psychosocial problems that David has mentioned, but also many that are not at all predictable. So I think we're at a point in this field where we're starting to realize the tremendous range in responses to trauma that go well beyond PTSD.

Let me talk briefly about why the focus on men's trauma. This is in no way intended as a competition to decide which sex has been most victimized. There is, unfortunately, more than enough pain and victimization to go around.

Looking at gender differences is important in understanding the potentially different impacts of trauma and how to make helpful responses. First of all, men and women are likely to be exposed to different kinds of trauma. Women report more sexual assault and more extensive abuse, both physical and sexual, in childhood, whereas men report more physical assault, especially physical assault at later ages, more exposure to combat, and more exposure to life-threatening accidents.

Even when men and women experience the same kinds of trauma, their experiences are often quite different. In terms of childhood sexual abuse, for example, women talk more about what is often referred to as "negative coercion," the use of threats and force in relationship to sexual abuse, whereas men report more "positive coercion," the use of rewards or the promise of rewards to lure boys into sexual relationships. Women are also more likely to report multiple victimizations in childhood and abuse by close family members. Sexual abuse is more likely to occur for women in close relationships, whereas for boys and men, it is somewhat more likely to occur at the hands of strangers or distant acquaintances.

Men and women often make different attributions about the kinds of traumatic experiences they've had. Men, for instance, not surprisingly in terms of gender role expectations, are less likely to report extreme fear than women. Men are also less likely to blame themselves for abuse or to perceive the world, in general, as a dangerous place. It's not to say that men do not blame themselves, but relative to women, they are somewhat less likely to blame themselves and, therefore, more likely to be angry and rageful in response rather than depressed.

In coping with trauma, men are more given to action-oriented responses, including the classic fight-or-flight style, which all of us learned back in Psychology 101 was the most common stress response. Recent research has questioned whether that is really as common among women as it is among men and has suggested in fact that women are often more likely to be emotionally expressive and turn to others for support. One article summarized this is a "tend-and-befriend" style rather than a fight-or-flight style.

In terms of the effect of trauma, boys are likely to externalize and girls to internalize. That is, boys are more likely to be aggressive, to miss school, to drink and drug, especially early on, while girls are more likely to become depressed and anxious and develop PTSD.

So I don't know whether men and women are really from different planets—Mars and Venus—or some other planets, or even if they, as my teenage daughter sometimes claims, represent different species. Maybe they're just different sexes. In any case, men and women certainly reflect different cultural expectations that shape the way they experience and respond to trauma. It's important for us to take those kinds of gender role expectations and cultural expectations into account in understanding how people experience trauma, the way in which they interpret trauma, and the ways in which trauma recovery proceeds, so that when we start working with trauma survivors, we understand the context of violence and the ways in which violence may be understood.

In terms of the kinds of exposure to violence that are likely among homeless men, when we started to talk about violence in the lives of men at Community Connections who had spent a lot of time on the streets or in shelters, we found that violence was not only pervasive but very diverse: emotional abuse, physical abuse, sexual abuse—and especially important

and often overlooked—community violence and institutional violence.

For many men, especially men who have extensive histories of homelessness, the violence they've experienced on the street is especially difficult for them to come to terms with. As adult men to have been subjected to physical and sexual violence while homeless is often a source of shame and humiliation. Institutional violence is also especially difficult in the context of so-called "helping institutions," as in hospitals and schools that have often perpetuated rather than minimized the experience of violence in men's lives. So to take seriously these contexts of violence, in addition to the physical and sexual abuse that occur in early childhood, has been very important for us.

Witnessed violence is often minimized. Some studies done in urban settings suggest that by their late teens, more than a third of the children surveyed had witnessed a shooting or stabbing. It's a startling statistic that these kinds of experiences are so frequent. So violence is really all around us, not only in the public sphere, but in our personal vulnerability.

The connections between trauma and homelessness are several. First of all, there are, as I'm sure people on this call know, multiple risk factors for homelessness, some of which have to do with such systemic or structural factors as a lack of affordable housing in a particular area, which is certainly often the case in large urban settings like the District of Columbia. There are also multiple individual risk factors. We found, for instance, that childhood backgrounds of poverty, of being placed out of the home and living apart from parents, and childhood housing disruptions are significant risk factors for adult homelessness.

In addition, childhood abuse and neglect is an individual risk factor that seems to exacerbate other risk factors, whether that's by exacerbating symptoms of a mental health problem, exacerbating severity of substance abuse problems, or contributing to job loss. The three most common ways in which men find themselves homeless are through severe mental health problems, severe substance abuse problems, and job loss. Those three are all likely to be worsened by histories of childhood abuse and neglect.

Then, of course, homelessness itself is an additional trauma. The loss of housing and the things that go on in shelters and living on the streets often constitute trauma that feeds back into the vulnerabilities that men have experienced.

Finally, as David mentioned, homelessness is certainly a risk factor for revictimization. Anyone who has talked to folks living on the streets knows the kinds of every day, moment to moment dangers that affect people where there are high rates of drug use and violence.

I think one of the ways I've tried to capture that is on this next slide, which I've titled, "A Vicious Cycle." I've limited myself to four categories here: violence and trauma, homelessness, substance abuse, and mental health problems. I could easily have included incarceration as an increasingly common experience for men who have these other difficulties.

What we know is that violence and trauma increases the risk of each of these other kinds of problems, and each of those, in turn, increases the risk of experiencing every other one, so that men often seem to be on a kind of inescapable circuit that goes from the streets to the hospitals to the jails to detox centers and back again, with violence and the threat of violence lurking everywhere.

David and I work in a mental health agency, but the last time we started a men's trauma recovery group, every one of the men in the group had been homeless. Every one of the men in the group had spent time in jail, and virtually all of them had serious substance abuse problems at one time or another. It didn't really matter where the group was located. It happened to be at our mental health agency. It could easily have been in a local prison or a residential drug treatment center or in a shelter or in some other kind of location. What we had was a snapshot that was taken of men who were in perpetual motion. If we had taken the snapshot three months or six months or a year later, we may easily have found them in a different place,

but they would still be carrying with them the same set of concerns and the very same kind of trauma history.

Lessons for PATH Providers

Amy Salomon

Thank you. Let's shift a little bit and move on to the implications of this information that you've provided on the prevalence and the impact of trauma in so many aspects of people's lives. What is the implication of this information for PATH staff? What's important for them to understand, especially for the staff working on outreach and engagement in terms of providing what you've called a "trauma informed service"?

David Freeman

There are so many different angles on this question, Amy. Let me reflect on a couple. You mentioned the whole issue of staging in trauma recovery for homeless men, and with a special focus on outreach and engagement. But step back for a second and think about the stages of treatment and the stages of change, and how these overlap and interact with each other.

Looking at the stages of treatment, for example, you start out with outreach and identification; move into engagement where there's the building of a collaborative relationship; move into active trauma recovery where there's specific individual and group work that focuses on these issues; and then develop a sense of a future orientation—continued healing, consolidation of recovery skills, ability to look into the future and give back to others.

Roger Fallot

Just to put this in context for people, when you look over this slide, the first two of these stages are really what we're going to talk about for the rest of today: "outreach and identification" and "engagement." We're going to talk about trauma recovery work and future orientation in our next phone call, depending, of course, on your feedback. So let us know about your preferences.

David Freeman

Starting with outreach and identification, we want you to be aware of two common problems. One is that traumatic experiences are underreported by men. This has a lot to do with gender roles. It's very hard to identify yourself as having been injured by another if you have to be strong and independent. If you don't have the cognitive frame of reference that you can be hurt, it's hard to identify with the role of a victim or survivor.

There's a tendency to minimize experience that's reported. There's the feeling of being overwhelmed on the part of the helping person. The survivors' stories can be so intense that people who want to help back away. There's the strong tendency to minimize the impact, both by the helping person and also by the person who's reporting the experience. Sometimes, survivors report a horrendous experience and then back away from it immediately.

Clinicians are often disturbed by the fact that they don't feel they have tools and resources for responding in an effective way to the traumatic experiences that people are describing.

Amy Salomon

David, what are some of the issues in making that initial contact that our listeners should be aware of, both in terms of the coping styles, specifically from men with histories of trauma, but also as providers, their own attitudes and beliefs? And how does that all mix with a trauma-informed approach to addressing these challenges?

Approaching Trauma Survivors

David Freeman

When clinicians are approaching survivors, it's useful to reframe some very common and typical attitudes. For example, when people are describing symptoms in somebody who is a trauma survivor, it can be very helpful to reframe those symptoms as coping mechanisms. So, if you have somebody who is quite paranoid, it's useful to forget about

the paranoia and think about the symptom as an understandable mistrust. Here is somebody who has been in relationships where they've been taken advantage of or abused in many, many different ways. Look at the paranoid symptom as an effective coping mechanism—something that is helping protect the individual.

By the same token, you can look at hyper-vigilance in men who are homeless and trauma survivors. By rethinking hyper-vigilance, it can be regarded as a self-protective measure. Hyper-vigilance can be regarded as a strength.

A lot of men who are homeless and trauma survivors are really angry, and clinicians often focus on the anger as something that needs to be diminished. But it can also help to regard the anger as a way that the individual preserves a comfortable distance from others. Again, think about the symptom as the coping strategy.

The same is true for withdrawal. Rather than simply regarding withdrawal as a pathological symptom, regard it as the individual's last effort to find some safe space.

So at every opportunity, think of the survivor as enormously creative and resourceful in coping with the things that have been done to them. Set aside a deficit approach and think in terms of a strength orientation.

Another thing that's useful is for the providers to stop regarding themselves as experts. The role of expert can put off people who mistrust authority, people who have been in contact with "experts" in the past who have actually been abusive. Providers should be very sensitive to the power differences between themselves and those who are vulnerable.

Sometimes Roger and I talk about types of people, and this can be overblown. But think of porcupines, bears, armadillos, and shape-changers. The porcupine is the person who as soon as you approach them, the quills are raised, and there's just no getting close to the individual. Think about this strategy not as pathology, but as a way of coping, a way of self-protection. The bear, the angry bear that is going to stand up on hind legs and frighten you, is somebody who is still trying to protect itself. The armadillo that rolls up into a ball and doesn't let anybody penetrate their space is protecting themselves. The shape changer—the person who doesn't stay in any one role, but who confuses providers more than anybody else by being in one role and then another and another—keeps others off balance as a way of keeping them at a distance.

Then there are those survivors who are really very clingy. This is not always a problem in the outreach stage of treatment, because when people are seeking contact aggressively, they're drawn to providers. But providers often feel overwhelmed by the intensity of the demands that comes from the person who has been so severely traumatized. The provider sometimes pushes away the clients who are effectively establishing contact.

Adopting a Trauma-Informed Approach

The best way to adopt the trauma-informed approach is to encourage people to review every part of their service delivery system, from the very first contact in outreach through the repeated frustrations that inevitably occur in outreach and in making the initial contact; then through the engagement process, trying to maximize some specific guiding principals as they make connections with people, ensuring always an individual's physical and emotional safety. It is important to review all of your policies and procedures and practices to be sure that physical and emotional safety is preserved, to maximize at every opportunity the survivor's sense of choice and control.

Preservation of choice, freedom, and self-directedness is challenging when a person is extremely distressed. I'm sure many people have been in a situation where they're trying to reach somebody who has now become a danger to themselves or others, and you have to move aggressively in order to protect somebody from hurting themselves or others.

For example, we had a man who was quite violent at our site the other day, but we persuaded the police to use the handcuffs that had less of an abrasive impact on the person's skin. This was at the request of the consumer.

So even when you think that you really don't have a lot of choices, sometimes by thinking things over in a really creative way and also by asking consumers what is it they'd most like, you can find another choice, another option even when the choices seem dreadfully limited.

It's important to clarify boundaries and roles with men who are trauma survivors, to not fake it or to pull the wool over somebody's eyes. It is important to be direct, to keep it simple, to be clear, and to be willing to admit sometimes that we don't know the answer to questions that are being asked. We can't always explain why things are happening. There was a homeless man we worked with recently who was going through a housing subsidy application and had been for six months. There were, honestly, times that I couldn't figure out myself why the housing subsidy process had become so confusing. Rather than try to come up with some sort of an answer, I just had say, "Look, I just don't know. All I can say is perhaps you and I can continue to work together even when we're both unsure and I'm not sure how it's going to work out."

Where possible, be collaborative and share power; recognize people's strengths and do not overestimate one's own strength. And always look for ways of building skills; always look for ways to empower people to make decisions. These are all ways that outreach efforts can be trauma-informed.

Amy Salomon

Thank you, David. What about the challenges in terms of moving from outreach to actual engagement? What would a trauma-informed approach to engagement look like?

Roger Fallot

Amy, that's a terrific question. Trying to move that contact to the basis for a safe and collaborative relationship is a challenging phase of working with someone.

Certainly, there are obstacles to men's involvement. I'll talk briefly about those and to how important it is to understand survivors' relationship styles. I think David's images of men's styles are very important to bear in mind, addressing the strength that men bring to services.

The first obstacle that needs to be understood if not addressed is the "disconnection dilemma." By that, what we mean is that men who are abused—physically, sexually, or emotionally abused—are faced with a profound dilemma. Being male in this culture and being a victim are fundamentally incompatible. Men who are trauma survivors often disconnect from some part of their experience. Either they can disconnect from their sense of masculinity and hang onto the reality of victimization, or they can disconnect from the horror of trauma and maintain their sense of being real men. But it's difficult to hang on to both of those at the same time.

So on one side, then, are images of strength and control and power and independence and on the other are weakness, loss of control, powerlessness, and dependence. Boys and men in virtually all subcultures in this country are raised to value the former set of attributes and avoid the latter. So you can imagine how hard it is simply to acknowledge victimization, and to acknowledge victimization is such a major step for men who are moving into the engagement phase of their work. To acknowledge the feelings of fear and vulnerability that go with that kind of victimization is an even more significant step.

Certainly, one thing that helps men make that kind of acknowledgement is for the provider to approach survivors with the notion that something terrible has happened to them. Not what is wrong with this man and what problems this man has, but what has happened to him. That kind of stance begins a possible reconnection in the midst of this dilemma.

The difficulty in acknowledging feelings, especially feelings of fear of vulnerability, is a second major obstacle. Most trauma descriptions are full of

emotional intensity. For many men who have been taught to ignore or minimize emotional reality, simply talking of feelings is exceedingly difficult. It's not surprising that the most common stress responses are labeled by actions rather than feelings. We don't say that there are feeling states related to stress responses. We say there are fight- or-flight responses, which are both behaviors.

In one of our recent groups in a session on anger, we asked group members how they know when they are angry. One man recently said, "I know it right after I hit him." There was just no awareness of any kind of feeling state that preceded the action. That kind of difficulty in acknowledging feelings is certainly an obstacle to engagement.

Men's lack of comfort with relationship-centered discussions is another obstacle. For many men, relationships bring with them unavoidable feelings of vulnerability, dependence, and threats to self-sufficiency. So you can imagine what goes with getting into a so-called helping relationship, where the very fact of being in the relationship is a vivid reminder of one's need for help, of an inability to handle one's own problems—in short, of weakness.

You probably remember the joke that the reason Moses led the Israelites for 40 years through the wilderness is because he was too stubborn to ask for directions. Men like their independence. They don't like needing to rely on others.

In the recent TV commercial with the man who was feeling pressure to call in the On-Star help line, you see his hand shaking as he puts his finger close to the On-Star button, because it was so incompatible with his image of himself as someone who was strong and independent. Those kinds of helping relationships that stand as reminders of vulnerability are particularly problematic. So clearly, providers should minimize the extent to which the nature of that relationship is understood as a one up, one down relationship.

Another thing we know about trauma is that it tends to elicit all-or-nothing responses—fight-or-flight, hyper-vigilance, or inattention, acute sensitivity or emotional numbness, depression and helplessness, or rage and expressed powerfulness. For clinicians, especially with men who are not articulating these feelings, this often seems like you're walking through a mine field, not knowing which step is going to trigger which emotional or behavioral extreme.

Extremes tend to elicit extremes, and providers either become overcautious or overly bold. They either overreact or underreact to the survivor's experiences. So providers should find a way of being flexible and emotionally engaged, but not intrusive, not in a position that is rigid.

The same sorts of principles apply to these engagement phases that apply to the outreach phase. In fact, we consider these to be core principles in any aspect of trauma-informed services. So how do we ensure physical and emotional safety and give people as many choices as possible?

For instance, when someone has already established a relationship, ask a series of questions and give the person a wide range of options about how they want to be contacted, where they would like to be contacted, if they would like to be contacted, or if they would like to contact the service provider. Ask how they prefer to be addressed. Give them as a broad a range of choices in the most mundane, everyday kinds of activities as possible. Even the ones that seem trivial to providers are often important to survivors.

Maintaining clarity about boundaries is especially important as providers start offering services. Be very clear about what services can be offered and those which cannot, so that there's real clarity about the sorts of promises that are being made. Trauma survivors are sensitive to misleading or ambiguous kinds of communication, to what's going to happen next and why it's going to happen next. You can never provide too much information for trauma survivors about why things work the way they work with this particular agency or program.

This is another way of saying that you can collaborate and share power by simply sharing your thinking. Providers can let men in on what's going through their mind as they're thinking through the various options that are open to them and constantly checking out

the responses to those options by the men with whom they're working. When we prioritize empowerment and skill-building, we try to find in every contact with consumers a potential opportunity for building skills.

Building on Men's Strengths

You can also appeal to men's strengths. I think one of the things we have tried to do in getting men involved in our trauma recovery groups is to appeal to these kinds of strengths. One thing that men can identify with is the strengths that go with being survivors. They can really take pride in the resilience that is evident in their having lived through physically and emotionally threatening circumstances.

Men in our groups have said, in essence, "Look what I've made it through. If I can survive that, I can survive anything." The self-esteem that is associated with that kind of recognition of survival is often a bridge to more involvement. So in trying to have men feel more comfortable and connected in relationships, build on that kind of self-esteem.

It's also become common to talk about the limitations that go with men's tendencies to think more than they feel and to live in their heads rather than their hearts. But this analytical approach brings with it certain skills. Men who are trauma survivors can sometimes be challenged to think, to analyze, to pick apart their experiences and their attempts to cope. They can be given new information, new ways of connecting experiences of violence to current problems. These kinds of new explanations fit with many men's tendencies to look for patterns, causes, and links.

For instance, as David would say, what began as understandable, thoroughly reasonable coping attempts can be related to later behaviors that get labeled symptomatic. Being mistrustful and wary is not only predictable, but is a very intelligent and adaptive response to unpredictable physical abuse. It makes good sense not to trust because not trusting is basic self-protection.

But, if this "not trusting" response becomes too general, it begins to look like paranoia to some observers. And discussing this pattern—abuse to mistrust to paranoia—is often just the kind of connection that appeals to the analytical side of men's approach to problems.

The third strength, briefly, is men's tendency toward problem solving. I was thinking of this the other day when I saw one of those joke lists of "Things women need to know about men." One of the items on this list, which was clearly written by a male writer to presumed women readers, said something like, "If you tell me about a problem, I will try to solve it. That's what men do. If you want sympathy, talk to your girlfriend." Now these are admittedly exaggerated stereotypes, but they carry a grain of truth. Men can often be engaged in trying to fix a problem—taking action, trying solutions, evaluating outcomes, and trying something else to find the thing that works.

Men who are survivors, given the right encouragement, are often willing to try new things that just might make a difference. Especially if they find the right kind of support, they can feel right at home developing what we call a recovery tool kit, a classic male image if there ever was one.

Training a Trauma-Informed Staff

Amy Salomon

Thank you. Taking all of what we've been talking about today into account, I'm sure there are listeners who are feeling, "How am I going to digest and learn this and then actually turn it into practice? What are the implications from the information that you've provided today for staff training, both ongoing staff training and new staff training? How do you transform a workplace into a trauma-informed workplace?

David Freeman

I think it's very useful, first of all, to identify the leadership in your program. Who is going to take responsibility for shepherding through some of the changes that may need to take place and some of the information distribution?

In most programs, there is somebody who can really champion trauma principles—somebody who's respected by the leadership of the program, if not one of the program leaders themselves, somebody who can be identified as bringing in important information and having it be respected within the program as a whole.

Of course, an important step is training and having the staff trained in basic trauma principals. There are many different kinds of trauma interventions that are available on the market. M-TREM is certainly one of them. There are training opportunities in M-TREM. We do have publications and materials that people can gather, and many of them are available through the Community Connections Web site, for example. So training is a piece of it.

Ongoing supervision is essential to bringing understanding and appreciation of the trauma dynamics into an agency. It's not enough to get some basic ideas out on the table, and then expect people to digest the information and to apply it independently. The team leaders, the supervisory staff, and/or the program leadership need to adopt these ideas and be sure that they're worked into assessments, into treatment plans that are developed, and into action plans that are put in place.

At every stage of an employee's participation in a trauma-informed system, the idea of trauma training and trauma-informed services needs to be worked into their experience. So, for example, in the hiring process, it's important to identify the agency as one that's trauma-informed. It's something that potential employees should know the agency cares about, that the agency will be paying attention to, and about which the agency will be offering training and supervision.

It's really important for people to develop evaluative systems to see if they really have brought trauma-informed ideas into their day-to-day practice. Another thing that's really crucial is for people to think about the generations of clinicians that move through systems. Good programs will have some people that have been around for a long time, but they'll also have large numbers of people who come in for a year or two and then move on. Although you may be fully trauma-informed for a year or two, when you look again at your program, another year later, you may find that 50 percent, 60 percent, or 70 percent of your clinicians are really not aware of what you're talking about. Sometimes, the leadership believes that the agency is trauma-informed when in fact there are a lot of people who have never really been exposed to the idea.

Revisit trauma training again and again so that new staff are brought into the loop. Think through clinical practice, think through administrative practice to see in what ways services are trauma-informed, and evaluate the outcome of those trainings by talking with staff and with consumers about the extent to which they feel the program is trauma-informed.

Amy Salomon

Thank you, David. We're going to open up our discussion to the listeners, but before we do so, can one of you leave us with some concluding thoughts or highlights from the presentation today that you feel are particularly important to underscore and leave with our listeners?

Roger Fallot

David told me a while back a story about how in any kind of presentation of this length, no matter how many things you say, people will only remember three of them.

I knew we would have a very sophisticated audience today, so I put four things on our final summary slide. First is basically how pervasive trauma experiences are among men and how diverse those experiences are. Second, there are gender differences between the way men and women in this culture are socialized to respond and understand trauma experiences. We need to understand some of those differences to understand the kinds of coping styles and interpersonal relationship styles that characterize men and women who have had experiences of childhood physical and sexual abuse.

Third, there are multiple connections between trauma and homelessness, and childhood abuse is a risk

factor for adult homelessness. Homelessness is itself traumatic for many people, and homelessness indeed increases the risk of revictimization. Finally, there are several key principles in outreach and engagement with homeless men that take into consideration what we know about trauma and recovery.

I realize we didn't really talk about the distinction between trauma-specific and trauma-informed services. So let me just conclude with that. When we talk about trauma-informed services, we're talking about the fact that any kind of human services can be informed and enriched by what we know about trauma, its impact, and patterns of recovery. When we incorporate that understanding and our knowledge about trauma fully into the way we offer services and develop relationships with the people we serve, then we are offering a trauma-informed service.

A trauma-specific service, by contrast, is often an individual or group intervention that focuses on recovery and healing. So homeless outreach and engagement can easily be more trauma-informed, even though they do not take as their primary task trauma recovery work. By taking into consideration what we do know about the impact of trauma on people's lives, we can adjust the way services are offered, in both outreach and identification stages particularly, to be more sensitive to the needs of people who have had experiences of trauma, and especially of men who are homeless.

Questions and Answers

Amy Salomon

Thank you, David. We're now going to begin the question and answer period.

Someone e-mailed in a question that I'm sure a lot of us are wondering about. "In a short-term shelter situation, is there a tool that can help us identify a trauma victim when the individual's reluctant to disclose this history?"

David Freeman

Well, the thing that providers should keep in mind is that in a homeless shelter system, traumatic experience really has to be the expectation. You can safely assume, without doing anybody any harm at all, that people who are recently homeless are at substantial risk of traumatic experience. If there's a history of substance abuse and mental illness, these interrelated factors increase the risk of recent trauma experience. As you're talking with people, you can use that as an initial assumption.

Roger Fallot

There are also a number of what are called trauma screening instruments. Even for people who are reluctant to disclose trauma histories, it's often very important to ask the questions. It's very important to ask whether they've ever had an experience of physical abuse, or whether they've been sexually abused in some way. There are a number of ways that those questions can be phrased so that you are most likely to get a positive response if someone does have a trauma history.

But even if they are not willing at the time of the first questioning, it communicates something very important about the shelter situation itself. It says that we understand how common these kinds of experiences are. We are interested in hearing about them. We know they have an impact on people's lives, and we want to take them into consideration as we offer our services.

That kind of message is very important, because if the person may not want to talk about it at the first questioning, they may decide later on that they are interested in talking about it. And I think especially for men, with whom denial and minimization are very common, it's important to have been asked the question because it sets the stage for follow-up. Men may come back a day or two days or a week later and say, "You asked about this. Let me tell you about something."

David Freeman

Let me add that often times clinicians who haven't had previous training or support in working with trauma issues are reluctant to ask these initial questions because they feel that they'll be overwhelmed by the response or that they'll actually injure somebody by asking the question. But more and more, part of my job at Community Connections is to do intakes with people who are coming off the street or out of the forensic system, and more and more people are asking me if we have trauma services. They're taking the initiative to pursue these concerns themselves. So it would be a dereliction of duty if I wasn't asking the questions, because trauma is on the forefront of people's minds.

Amy Salomon

Let me make sure I understand. David, what you seem to be saying is that we should ask about trauma right from the start, and that it isn't a matter of somebody being in your shelter for a certain period of time or going through a certain set of other kinds of intake questions and later asking this, but actually integrating that immediately into an intake.

David Freeman

Yes. We think that it's very important to get the questions on the table from the very beginning of the initial contact. There are, of course, many people who only stay in contact for a very brief period of time. So you want to capture everybody from the beginning, and you want to be sensitive to people's response. If people say, "I don't want to talk about that right now," you can say, "That's okay," because again, you want to be very respectful of people's efforts to manage their own boundaries.

Part of being a trauma-informed system is getting the questions out there at the beginning. Another part is being aware of people's responses to the questions you're asking and adjusting as you go.

Roger Fallot

There are other ways also to keep this on the table in shelter situations. Having brochures that are available that talk about it, along with other things that talk about the pervasiveness of trauma and its importance, often provide a nudge toward talking about it when the person is ready.

Gigi Belanger

Roger, if you have people who do intakes in shelters who are not trained in mental health or substance abuse, do you recommend that they approach this topic with people?

Roger Fallot

What we've found in a wide range of both research studies and clinical work is that, in the vast majority of cases, these questions can be asked and answered in pretty straightforward ways. What's important to do is to respect the person's response. I was talking with a member of our staff a while back who was doing an intake with someone on the street and asked him whether he had ever been sexually abused, and the man's response was, "Not when I was a kid." The follow up question was simply, "Well, then I assume you were as an adult." The answer was, "Yes, but I don't want to talk about it."

Respecting that as an appropriate end to the conversation and saying, "If at any time in the future you do want to talk about it, we would be glad to hear more about your experience because we think it's important," is enough. Honoring and respecting the person's right to not answer a question is as important as it is to ask a question.

Al Peak

Yesterday, I was in a situation with a homeless fellow who is a Vietnam vet and I probably made the mistake of trying to help him engage the system; currently, he is in the VA system and he's also trying to see about disability. I think the mistake I made was he had first presented about six months ago with what I perceive were symptoms of possible PTSD. I know there's a history of violence with him, but, unfortunately, we got oriented toward the PTSD.

I sent him in for an evaluation with a psychiatrist, and now the patient is somewhat convinced that he's doing

better and everything is okay. Yet, he's still living in the woods. He's isolated. He does admit to some depression, but how can I keep him engaged? I don't want to give him a symptom, but I feel like sometimes when we send people to professionals, they're not really trauma-informed. So how would I go about handling a situation like this?

Roger Fallot

Let me respond briefly first, and then David can jump in. One of the things that is often very important in that first kind of connection and moving toward engagement is to, and this falls under choice and control, ask questions about what, if anything, this person may want or gain from being in connection with your program.

I think if you can find a goal, a purpose, or something he wants to accomplish that he's missing, you can use that to build a beginning alliance around something he wants, whether it's a better disability program or a particular outcome in the VA system or something that the two of you are collaborating on. Trauma survivors are so sensitive to a kind of vulnerability that goes with these helping stances. So to say, "What can you and I work together on?" is the best invitation you can offer.

David Freeman

Increasingly, communities are developing programs that both have trauma-informed and trauma-specific services. They don't always get the word out about their existence as they could, but many cities have had Federal grants to address issues related to trauma experience.

So it is important to find resources or places that will address chronic complex PTSD, because I think there are a lot of clinicians out there who are very effective with single-incident trauma. But often, when you're working with people who are homeless, or have multiple chronic problems, you're not dealing anymore with single incidence PTSD at all. You're dealing with a pattern of experiences in childhood and adulthood, in institutions, and sometimes in war that are really very complex. So it becomes important to identify the community resources where people are sensitive to that range of trauma-related problems, and can think about it and talk about it comfortably, as you make your referrals.

I've had the same experience that you've just described. Sometimes, you put a lot of effort into the initial outreach and engagement with somebody. You make the connection with a provider agency. The referral is established. The person trusts you enough to follow through with the referral. What you get is a response that doesn't really feel like it gets to the heart of the matter, and then you feel stranded, because the person walked away saying, "Well, I got everything that they had to offer," and you have to start all over again.

Al Peak

How do you determine between a group approach and an individual approach once he wants to go further? Is that one of the choices?

David Freeman

Yes. In order for people to really take advantage of a group, they need to show up. Often, when people are not settled in their lives, it's really hard for them to show up consistently. I'll give you an example. Our M-TREM group runs over a six-month period. We find if people miss once in a while, it's okay, but if people are missing huge chunks of the group, they can't take advantage of it. It's hard to participate in the group, and it's hard to feel comfortable. So it's really important for people to be settled, to have enough of a trusting relationship to come in consistently over a period of time to really take advantage of an established group intervention.

Roger Fallot

We'll talk more about this next month when we get into some of the lessons we've learned from our group intervention, but I think the strong advantage of a group is that very early on, if the group is properly constructed, it offers a bridge to further engagement. It doesn't ask a lot of men in terms of difficult disclosure. It focuses on the kinds of experiences they have in common so that they understand they're not

alone and they can build on their shared experiences, and that it doesn't require necessarily a lot of openness and talking.

In one of our groups, the 24-session group, one of the men probably participated in only 8 to 10 of the sessions. The other 14 to 16 sessions he was silent. We were going around the room at the end of the group, and his only question was, "When does the next group start?" He had used that first six months as a testing ground to see if the group was really going to be safe enough to join. That was fine with us. So he signed up for the next group and became a public relations expert for our group intervention with other men at the end of the second time through. To maintain that kind of long-term perspective and not expect too much too quickly is very important.

Al Peak

Good. Thank you.

Amy Salomon

I have one more question from one of our Internet listeners. "Greetings from Chicago," she says. "This question can be answered by either presenter. What is your opinion of women clinicians treating men with trauma?"

David Freeman

Great question. We think there's definitely room for women to work with male trauma survivors. The issues are complicated. Men are often the perpetrators of violence against men, so that if you restrict yourself to male clinicians in working with male trauma survivors, for some men, you will be creating an unsafe environment.

Also, there may be significantly more women than men on staff in an agency. So if you restrict the provision of services to only male clinicians, you're simply not going to have enough services provided.

You have to be careful about a couple of issues. I have run M-TREM groups with women present where the issues of competition for a woman's attention disrupted the capacity of the men to discuss their vulnerabilities. Once a woman was in the room, what got activated was, "I'm in control." All of the male gender stereotypes, the myths that guide and shape male gender identification got activated when this woman was in the room.

So the men in the group would not let their guard down. They could not connect with each other, because they perceived each other only as competitors. And the fact that there was a woman in the room interfered with the unfolding process of the group.

Amy Salomon

Thank you. We are running out of time, and I'm going to need to conclude today's program.

I'd like to thank our featured presenters, Roger Fallot and David Freeman of Community Connections. I'd also like to thank Gigi Belanger of the Homeless Programs Branch, Margaret Lassiter and our colleagues at Policy Research Associates who have been helping enormously on the Internet access of this presentation, and Amy Sanborn who has been coordinating the call today.

Thank you all for participating, and we look forward to the second call on June 15th. Our call is now concluded.

End