Men, Trauma, and Homelessness: Paths to Recovery
Part II

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Welcome and Introduction

Amy Salomon

Hello, everyone. Welcome to our second in the two-part PATH technical assistant series on Men, Trauma and Homelessness: Paths to Recovery. My name is Amy Salomon and I'm from Advocates for Human Potential in Sudbury, Massachusetts. We're the technical assistance contractor for the PATH program.

We're delighted to have back with us two nationally recognized experts from Community Connections in Washington DC , Roger Fallot and David Freeman. Welcome to you both.

In addition, we have people participating on this call from all over the country, including staff from PATH funded service provider agencies and representatives of State and Federal government. Many are listening to the presentation over the telephone, and many others are listening via the Internet. Welcome to all of you.

Our format today is going to be a little different from our first call. We've divided the presentation into four sections and after each section you are going to have an opportunity for a question break.

For those of you who weren't part of the first call, we're going to start with a brief overview and review of the Part I presentation. We're then going to move on to the new material for today, which focuses on three areas: 1) Eight core assumptions about working with men who were trauma survivors, 2) critical trauma recovery skills and their implications for practice and 3) the application of these core assumptions and the recovery skills in a group intervention developed by Community Connections, called M-TREM, which stands for Men, Trauma, Recovery and Empowerment Model. There is a TREM for women; this is the M-TREM for men.

I want to quickly review some logistics with all of you for this call before we begin, and then invite Dr. Michael Hutner, who is the Director of our PATH program at the Homeless Services branch at the Center for Mental Health Services to say a few words of welcome.

There is a PowerPoint set of slides which accompanies today's call. If you want to access those slides, go to www.prainc.com/uploads/broadcasts and the file name there is Men Trauma and Homelessness Part II.ppt. Or to make life even slightly easier, you can contact Amy Sanborn here at AHP. Her e-mail is asanborn@ahpnet.com or you can reach Amy Sanborn at 978-443-0055 extension 411.

The audio recording and presentation materials from the first part of this series are posted on the PATH Web site at www.PATHprogram.samhsa.gov. The transcripts from Part I and all of the information from today's call will be available on the PATH Web site shortly. We also encourage everyone to visit the PATH Web site to view other training resources that are posted there, including the transcripts from last year's introductory teleconference on working with trauma survivors who are homeless.

Okay, at this time I'd like to turn it over to Dr. Michael Hutner, PATH Director at the Homeless Services branch, and an individual who has provided valuable guidance to all here on the topics and the techniques for PATH TA over the years. Thank you, Michael.

Michael Hutner

Thanks, Amy. I just want to thank Roger and David for their wonderful presentation last time. I was particularly impressed by the relevance and also by the detail of that first presentation. It was a primer about the importance of trauma and its relevance to outreach and to care management, which is, in fact, the substance of many of the PATH-related services and services generally, to people who are homeless. So thank you Roger and David.

We in the PATH program certainly recognize the complexity of homelessness, the understanding of that complexity, the importance of training and the contribution of both the understanding and the training to the professionalization in our field. One of our important next products, contributing, we hope,

to that, is the development of an outreach manual. We'll be developing that with practitioners and expert observers and interpreters such as Roger and David. Let me turn it over to Roger Fallot and David Freeman.

Amy Salomon

Thank you, Michael, for raising that issue of our increasing understanding about complexity of homelessness and the skills needed for providers. I wanted to take a moment to introduce our featured experts. Roger Fallot and David Freeman both work at Community Connections, which is a private not-for-profit agency, providing a broad range of human services in metropolitan Washington DC.

Roger Fallot is a clinical psychologist and co-director of Community Connections. The author of numerous clinical and research articles, Dr. Fallot is a contributing author to and co-editor of *Using Trauma Theory to Design Service Systems*. Dr. Fallot is principal investigator on a District of Columbia trauma study, a Federally funded research project examining the effectiveness of integrated services for women trauma survivors who have mental health and substance abuse disorders. Dr. Fallot has considerable experience with women and men trauma survivors. Dr. Fallot is on the adjunct faculty in pastoral counseling at Loyola College in Maryland and is a contributing author and editor of *Spirituality and Religion in Recovery for Mental Illness*.

David Freeman has worked with vulnerable and disenfranchised consumers at Community Connections for the past 13 years. He has been a case manager, a team leader, a program director and is responsible for quality improvement in the care of over 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, as well as the men's trauma recovery program. Dr. Freeman had directed the psychology training program at Community Connections for five years and has been adjunct faculty at George Washington University and Howard University. Let's start with a brief overview of the highlights from last month's call on Men, Trauma and Homelessness.

The Basics on Men, Trauma and Homelessness

Roger Fallot

Thank you, Amy and Michael. We're glad to be back for this reprise. If you have access to the slides, it may be helpful to follow along with those slides as we talk through in a *Reader's Digest* version of the last presentation.

First of all, why are we spending so much time talking about trauma? Why is it so important? First, trauma is much more pervasive than it previously was thought to be. Recent community surveys, for instance, have found nearly 90 percent of the individuals in those surveys report lifetime exposure to at least one traumatic event and that it's simply not the rare kind of event that we had, at times, thought.

Trauma's impact is broad and diverse. Rather than just a single or a pair of impacts, for instance, we know that in addition to PTSD and acute stress disorder, traumatic events raise the risk of many other kinds of mental health problems, substance abuse problems and physical health problems as well as raising the risk for a number of other social kinds of difficulties.

Third, trauma's impact is as deep as it is broad. We know that exposure to trauma can be life changing and life shaping. The kinds of assumptions that people bring about the nature of themselves and the world are challenged and often reorganized around histories of traumatic events, so that they come to see themselves as less competent, as guilty or shameful, and the world around them as dangerous and threatening.

Fourth, trauma, especially interpersonal violence, is often self-perpetuating. We know that exposure to trauma significantly increases the risk of becoming a perpetrator of violence.

Finally, trauma is insidious and it's differentially affecting the most vulnerable among us, including those who seek help. Poor and socially, economically disadvantaged populations, those with mental health problems, those with substance abuse problems, those with developmental disabilities, those with previous trauma histories are all exposed to higher risk of trauma.

We're going to talk today about trauma among men, so I want to refresh people's memory about the extensive survey literature in this area addressing the kinds of men who participate in PATH programs. Physical abuse is well over 50 percent in the childhood of most clinically identified populations. For adulthood physical assaults reach almost 80 percent and a lifetime history of physical abuse is over 85 percent. Sexual abuse is also much higher among men who have been diagnosed with serious mental illness; 30 to 35 percent in childhood and 25 percent in adulthood report sexual assault.

Why are we focusing on trauma among men? There are characteristics that distinguish the trauma experiences and responses of men from those of women. First of all, men and women are exposed to different types of trauma. Men are much more likely to be exposed to physical assaults and physical abuse, women to sexual assault and sexual abuse.

Even if the trauma is the same type, however, the exposure often involves different characteristics of the trauma. For instance, if we look only at sexual abuse in childhood, women are more likely to be exposed to sexual abuse that is negatively coercive, that is, is surrounded by threats and physical threats of violence. Boys are more likely to be exposed to sexual abuse that carries "positive coercion," the offer of rewards and of close relationships.

Men and women tend to make different attributions about trauma. Men are less likely to blame themselves than women, for instance. Men and women bring different coping styles. Men are more often characterized by the traditional fight or flight responses, whereas women are more likely to reach out to others as well.

There are different trauma sequelae that are most prominent for men and for women. For men, and boys especially, the trauma sequelae are often what are called "externalizing," the kinds of difficulties that bring boys to the attention of authorities and get men in trouble with the criminal justice system. They are also more likely to be aggressive and to be truant, if of school age, and to develop substance abuse problems. Women, on the other hand, tend to internalize, to develop classic symptoms of PTSD or depression, for instance, in response to traumatic events.

There are certainly exceptions to these general rules, but these are trends in the literature that are important to know about and that describe some of the differences between men and women and their experiences of and responses to trauma.

Very importantly, men and women live, to a certain extent at least, in somewhat different cultures. Trauma is not only a psychological and biological concern, but it's also a sociological and almost anthropological one. The experiences of trauma are thoroughly embedded in cultures and subcultures that reflect strong assumptions about men and masculinity. Before we turn to trauma among men, we need to understand more fully the gender-based culture that has shaped the lives and responses of many men.

In the Men's Trauma Recovery and Empowerment Group it became clear to us, for instance, that talking about what it means to be a man was absolutely fundamental to trauma recovery. So we developed an early session of this group that was focused on what we call the "male myths," which is our shorthand for gender role expectations. These are messages that boys and men get about being male, at least in the dominant parts of our culture. You will see some of those male myths listed on the slide that we've put together.

Imagine, if you would, coming into a room and seeing these 10 statements placed on newsprint, each on a separate sheet around the room. What we do in our group intervention is ask the men to talk about the messages that they've received, to tell us which of those have been most important in their own histories,

to talk about the source of those messages, to talk about the advantages and disadvantages of trying to live up to these various messages.

We actually ask men, as well, to tell us the one message they would most like to eliminate, because all of these messages carry with them a kind of a downside if they are to be adhered to very stringently and rigidly. We want to talk about both the advantages and disadvantages and get enough distance on those messages so we can place this response in a larger perspective.

Working with men who are trauma survivors involves reminding ourselves of what our culture tells us about how men are and how men should be, so that we take gender role expectation very seriously in understanding the place and the impact of trauma.

One of the other things we talked about last month was the relationship between trauma and homelessness. Probably everyone listening on this call already knows better than I, there are multiple risk factors for homelessness; some of them are structural and economic and have to do with the availability, accessibility, and affordability of housing, and others have to do with individual characteristics of persons. Childhood abuse and neglect has been well established as an individual risk factor for homelessness, especially strong among those with severe mental disorders.

Of course, the experience of homelessness is itself an additional trauma, so that when someone loses housing and is living on the streets or in shelters, it causes horrific fear and panic in many instances. Further, homelessness raises the risk factors for re-victimization. People who are living on the streets and shelters are much more vulnerable to re-victimization.

So what this leads to, then, is often a vicious cycle in which violence and trauma, substance abuse, mental health problems, and homelessness are constantly reinforcing each other in the lives of many of the men with whom we work. The kinds of experiences are often related to particular places, so that homelessness on the streets or in shelters or in other tenuous housing may be tied to mental health problems, substance use problems and, of course, the avoidance and/or perpetration of violence.

I'm going to turn this over to David to you for a little bit more on the stages of trauma recovery. David.

The Stages of Trauma Treatment

David Freeman

Thanks, Roger. I'll review a few more of the points that we made in our last presentation. I want to mention the stages of treatment, of our involvement in working with people that are trauma survivors: outreach and identification, engagement, active trauma recovery, and future orientation.

Outreach and identification is a central concern for PATH participants. It's very helpful to have a unique sensitivity to the stage that consumers are in when you approach them, so that you don't, for example, plunge into offering all kinds of services for trauma recovery when the individual is still in a stage of outreach and identification. If you are offering services that are out of the person's stage, your intervention is going to be mismatched. The intervention will either be overwhelming, ineffective, or rejected.

In the first stage of outreach and identification there are special problems that are unique to men and boys. For example, it's very common for men and boys to underreport traumatic experience. This shouldn't be too surprising, given men's proclivity to minimize problems, to want to experience themselves as in control, to have trouble acknowledging vulnerability and weakness. It's hard to demonstrate to another person that you've got a problem if you don't want to be vulnerable.

At the same time, clinicians have a difficulty because they often underrecognize problems that are presented by clients. For example, clinicians sometimes avoid the simple, straightforward question, leaving the trauma experiences and the trauma history sort of dangling out there in the air. It's important for clinicians to ask simple, straightforward, and direct questions.

Also clinicians often buy into the same male myths that cause the consumers to minimize their experiences, so that clinicians, too, underestimate the prevalence of traumatic experience. Clinicians will often minimize the impact of those traumatic experiences for the people that they're working with.

Also, of course, clinicians are often concerned about probing and asking questions about experiences that they feel uncomfortable following up with, either for personal reasons, or because follow-up services are not available once the original questions have been answered. If there isn't a service resource for male trauma survivors in your local community, you might be hesitant about asking questions about traumatic experience.

In terms of engagement, we talked before about the obstacles to connecting with men who are trauma survivors. We talked about different styles that men adopt when they have survived a horrible experience. One group of people tend to be prickly, hyper-vigilant and paranoid. Another group can adopt a coping style in response to a traumatic experience by being angry, overbearing, and intimidating towards others. We see this as a way of coping with terrible experience, as a way of keeping people at a distance, as a way to protect oneself.

A third group tends to be closed off, to be isolative, to avoid letting the helping person into their lives. We understand this is a coping style that makes sense given the traumatic experiences men have had. A fourth style is evidenced by somebody who changes unpredictably from one style to another so that the clinician or the helper is always off balance and unable to connect.

The central features of the trauma-informed approach to engagement focus, first of all, on ensuring physical and emotional safety. Now, homeless service providers are going to be uniquely sensitive to providing for peoples' basic needs and recognizing that the streets are unsafe, that some shelters can be unsafe and that it's important to help people move into places where safety and boundaries can be protected.

We always try to maximize the survivor's capacity to choose and control the direction of their treatment. While we are always questioning at the beginning, highlighting what we believe are difficulties with traumatic experience, we let people choose and direct their own treatment whenever possible.

We try to maintain a clear definition of our own role in helping others, of what we can do and what we can't do effectively, so that assumptions are clear and boundaries well defined. Both consumers and clinicians or providers are very powerful in the unfolding process of getting and giving help. So when possible, we want that power to be shared, not with a clinician coming in and saying, "I'm the expert and I know what you should do next and this is what you should do." The clinician should sustain collaboration and focus on empowerment and skill building.

In terms of training staff for working with survivors of physical and sexual and emotional abuse, remember, first of all, that we're all working in agencies where there is significant turnover. So training really needs to recur. Basic orientation, some essential training, ongoing supervision and support are essential to keep trauma services alive. It has been interesting to me to see how a program's focus can shift away from trauma, even though the impact of trauma is sustained.

So just in summary, we've talked before about how pervasive and often ignored traumatic experience is, especially amongst men. We've discussed gender differences and the impact of trauma, the prevalence of trauma, and the way that trauma unfolds over the lifespan. So are the fact that trauma and homelessness are often interwoven, that trauma can contribute to homelessness, that homelessness can leave people at risk for further traumatic experience, and that there are some central principles in outreach and engagement with homeless men where you should be mindful of trauma and recovery.

Roger Fallot

Let's see if there are questions at this point. Then we'll move onto the core assumptions of M-TREM.

Amy Salomon

We'd like to open it now for questions to our audience. Do we have any?

Caller

Thank you. In maximizing the survivor's choice and control, how does the practitioner recognize this ethic or this value when it conflicts with some of the suffering from substance abuse or chemical dependency and they're tending to make the wrong choices or to choose a treatment that is too lightweight for the severity of the problem?

David Freeman

I think it's a great question. I'd actually like to add to it by also discussing the potential of the individual being in danger and the risk of community safety being compromised.

We want to keep the safety of the individual and their freedom to make choices in balance so that if somebody is imminently suicidal or making a threat toward another person, we preserve the freedom to move in aggressively and give people less choice about the next step in the process. Whenever we propose an involuntary treatment we do so with great caution.

I'll give you a quick clinical example. We had to have somebody involuntarily hospitalized the other day —he was threatening to kill himself and others and had a significant history of violence, but we were able to work with the police, when they arrived, so that the restraint was just enough, but not too much. We encouraged the police to be gentle, by encouraging the police to ask the consumer in what way would they be most comfortable when escorted. For example, we asked if the consumer could be handcuffed with their hands in front of them instead of in back as he was requesting.

These are limited choices within the context of the fact that somebody's going to be carted away but, nevertheless, choices that we try to make available to people. Also, at least in the District of Columbia, there is a choice of which hospital you're going to go to if you are being involuntarily taken in for treatment. So we try to give people that choice as well.

Specifically, with regard to substance abuse, there are times when peoples' substance abuse is so severe that they really put themselves in terrible danger. For example, hanging out with a network of very dangerous people, being at risk of losing housing that they've established, being at risk of being kicked out of a shelter where everybody has worked hard to get them in. So, in these cases, we try to encourage aggressive treatment and we try to talk with people about the consequences of drug use on the unfolding course of their life. It is possible to feel terribly frustrated in the face of intransigent problems, but it is our job to emphasize sensitivity to the impact of trauma, to avoid re-traumatization, and to protect the safety of consumers and the community.

Caller

That was helpful. If I could follow up, suppose we have a case of a client who has late-stage chemical dependency, has failed in treatment before or relapsed, and rather than going into intensive treatment or longer-term residential, they want to try going to 12-step meetings one or two times a week? How can we encourage someone to get a more suitable intensity of treatment and still maximize the choice and control that they need as a survivor of trauma?

David Freeman

I was actually talking with a guy yesterday who had set up a life for himself that was really quite nice. He had been homeless for many years; he'd been incarcerated for years and been in our local hospital for a long time. After working with him for three years, we were finally able to help him establish a transitional apartment. He was clean for a year, and he had a little bit of control over his SSI check and he was beginning to get some transitional employment.

He lapsed and then had some initial drug use and then suffered the losses, which was a devastating blow, and he relapsed and fell into very intense episode of use. He invited some of the local dealers into his apartment and his apartment was overrun, causing the landlord to force him out.

When I sat down with him yesterday, I had in my mind that he should be in a detox facility—he was still using crack pretty heavily—so it seemed he should go from a detox facility to residential treatment where he would stay for 30 to 45 days and then go into a group home. So I'm thinking with a very intense intervention; and meanwhile, he's thinking what you're talking about, actually, once-a-week AA meetings, and a weekly meeting with his probation officer.

In talking to him, I just said, "You know, you've had several difficult losses—your sister, your sobriety, your apartment, your independent lifestyle. Just three months ago things were sailing along."

The conversation helped him focus, on the loss of what he had achieved and his feelings about that. It helped him come to terms with the idea that what he needed was more intense than what he was proposing for his own treatment. We compromised on daily meetings instead of once-a-week meetings.

We compromised on a different budget. Instead of getting four $100 checks each month, he sent some money to his mother. We set aside money for rent and food and we broke down the remaining amount of his check into two small amounts so that he wouldn't be as tempted to continue into heavy use. Budgeting money in a careful and thoughtful way is one way of helping someone with a drug problem.

Caller

Thank you very much.

Amy Salomon

Thank you. We're going to move forward to the new material on eight core assumptions that form the work that our experts today do with survivors of trauma.

Eight Core Assumptions

Roger Fallot

Thanks, Amy. We'll want to review them pretty quickly because they really are background for what we're going to talk about the rest of this call.

Let me begin with a story that risks any credibility I may have built up over the first 45 minutes. As you mentioned, there is a women's trauma recovery and empowerment model group that was begun here at Community Connections nearly 10 years ago, for which a manual has been published and widely disseminated. So when we decided to develop a men's trauma recovery group, we thought the easiest way to do that would be simply to use the women's model with men.

We did that and it failed miserably, abjectly and we all felt massively embarrassed by the rates of non-response to this intervention. This set us back to reading, talking, thinking, planning, conducting focus groups, and doing some re-analysis of what had gone wrong.

Out of that batch of focus groups and reading and talking with a lot of people came these assumptions. I'll just review them briefly. First is that many of the short-term and long-term sequelae of trauma may be similar for men and women. But the significant difference in gender role expectations affects not only the experience of trauma itself, but the survivor's understanding of and responses to trauma. So we placed an increased priority on the discussions that men need in order to be able to address trauma more directly.

In the women's group, the first 10 or 11 sessions of the intervention are focused on empowerment. The assumption is that women's experiences of abuse are primarily disempowering and that empowerment is necessary in order to talk more productively about trauma. For men, we found that a focus on emotions and relationships in those early sessions was absolutely essential to productive discussions later on in our intervention.

The implication of this, for people who are working with homeless men who may be trauma survivors, is that this emphasis on the emotional life and on the development of relationships are twin emphases of early relationship building. Now it's also very important to temper expectations about men's capacity for talking about feelings, for expressing feelings and for new relationships. I'll talk a little bit more about that as we go on with some of the other assumptions.

Secondly, male trauma survivors are faced with what we call a "disconnection dilemma." In order to retain feelings of fear, vulnerability, and powerlessness associated with the trauma experiences, they often disconnect from the sense of being masculine, the sense of being a "real man." Or alternatively, if they want to hang on to their sense of masculine identity and gender roles, survivors need to disconnect from unacceptable feelings of vulnerability, fear, powerlessness.

It's very important to respect the power of these gender role expectations because trauma recovery depends on their recognition and their incorporation. For example, one man was recently telling me about the almost physical pain that accompanied simply coming to a mental health agency, where he knew he had to be vulnerable and seek help. Seeking help was making him sick.

The capacity for all of us as providers to empathize with the struggle many men have with these experiences of helplessness or vulnerability is very important.

The third core assumption is that many trauma survivors who are men develop all-or-nothing responses, especially in the emotional and relationship worlds. For instance, David referred to the contrast between those men who are primarily characterized by anger and rage versus those who have withdrawn into a more passive, often almost interpersonally timid stance.

A key trauma recovery skill for men is the development of a broader range of options for expressing emotions and for being in relationships. That is certainly the goal of our group, to expand the range of those possibilities. We help men understand that feelings can be rated on a continuum, ranging from a small amount to a great amount of a particular feeling. Men with extensive histories of violent victimization have difficulties recognizing this.

The fourth core assumption is that trauma severs core connections to one's family, one's community, and ultimately to oneself. For men, these experiences of separation are colored by gender role socialization that supports at least the appearance of interpersonal self-sufficiency.

Human development, in the masculine realm, has been told primarily as a story of a move toward increasing independence, rather than a story of different kinds of interdependence. That emphasis on independence in men has often made it much more difficult for them to connect with sources of help and especially to other people, who may be able to collaborate with them.

Services relationships are extremely important avenues for male trauma survivors to establish renewed connections. It's very important for providers to maintain flexibility that is inviting and to increase collaboration in those relationships as well, so that power and decision-making are increasingly shared.

The fifth assumption we make is that people who experienced repeated trauma in childhood were deprived of the opportunity to develop certain skills for adult coping. One of the implications of this for people who are providing services is to have those services be skills oriented, as opposed to deficit or problem oriented.

To focus on skill development shifts the question, so we ask not "What's wrong with you and how can I, the provider, fix it?" but rather, ask the question "What has happened to you and how can we work together toward meeting your goals?" The shift in both parts of that, from "What's wrong with you?" or "What is your problem?" to "What has happened to you in your life?" is an invitation to talk about the kinds of experiences that may help make sense of deficits and skills. We'll talk in more detail about

some of specific recovery skills in the next section, as we move along.

The sixth core assumption is that while certain abilities may have been adversely affected by violence and abuse, trauma survivors bring an array of skills and strengths to the recovery process. It's important to realize that trauma survivors are, above all, often survivors. To build on the skills that men have is to build on the coping strengths that have gotten them through often absolutely horrific and frightening circumstances.

We try to especially build on what we call "bridge skills," those that help men build bridges from skills they already have into new areas. For instance, men who may have been able to retain friendships may be able to use that experience of friendship and closeness to explore the ingredients that are necessary to trust and to risk disclosure of their feelings in other settings.

The seventh core assumption is that some dysfunctional behaviors and/or symptoms may have originated as legitimate coping responses to trauma. We talked about this a bit last month. Providers should look for the story behind the story. There was, for instance, one of the men in one of our trauma groups who routinely pushed his dresser behind his door every night to block entry. Now, that behavior had sometimes been understood as a paranoid suspiciousness and an overly sensitized reaction to danger in his apartment building. It became such a routine that other people were seeing it as an obsessive compulsive disorder. We would argue, though, from a trauma-informed perspective, that this behavior was simply his adaptive response to the dangers of growing up in a very abusive context.

That someone who grows up with unpredictable violence around him responds by making plans to protect himself, and protecting himself every night, whether or not there was an imminent danger, made a great deal of sense given his personal history. So those behaviors that were labeled symptomatic in one context could be understood as extensions of a legitimate and understandable adaptive response from another perspective.

The final core assumption, number eight, is that all attempts to cope with trauma have advantages and disadvantages, benefits and costs. We are often able to engage men who are trauma survivors in a discussion of those advantages and disadvantages. The capacity to take a step back and think, "Is this working for you, what might work better for you, what are the alternatives you've considered?"

This cost-benefit analysis is something that can occur at any stage of trauma recovery for providers who are engaging in the usual discussions with men who are trauma survivors.

In fact, it may have been one of the discussions that could occur in talking with someone about the advantages and disadvantages of any proposed course of action, any proposed response to managing an identified problem. We build this in pretty much from the beginning, drawing on what we think are one of the points of engagement with men, that is, their willingness to engage in problem solving.

Amy Salomon

We're going to move on, just so that we get the real heart of the conversation, which is about to begin, this central section, that we can get through it and we can get your questions on that part.

Trauma Recovery Skills

David Freeman

Okay, Amy. I'm plunging ahead here. Now we want to talk about trauma recovery skills. Our interventions are skills based. As we move from engagement into active treatment, there is a standard set of recovery skills that we're promoting, that we're helping people develop, that we're helping people think about.

Let me go through the list and then I'll talk about some of them, and Roger will pick up the ball and talk about some others. Self-awareness, self-protection, self-soothing, emotional modulation, relational mutuality, accurate labeling of self and others, a sense of agency and initiative taking, consistent problem solving, reliable parenting, possessing a sense of

purpose and meaning, and developing better judgment and decision-making are the set of trauma recovery skills that we try to build.

At Community Connections we developed a tool we call the Trauma Recovery Empowerment Profile, where each of these skills is laid out across several different sorts of stages of development of the skill. So we have some specific behavioral anchors for people who would rate poorly on a specific skill and another set of anchors for people who are developing the skill, and then a third set of behavioral anchors for people who have the skill.

What we try to do when we complete these—we call them TREPs, the Trauma Recovery and Empowerment Profile—is to be realistic but tend towards a conservative position in our judgment.

So for example, people who would have trouble with self-awareness are people who are unable to articulate their needs or their desires. They are completely unaware of their motivation, have little sense of how behavior causes moods and unaware of how their own actions lead to poor self-care.

People who are developing this skill are able to identify how they feel, but remain unaware of the triggers for actions, so there is a sense of what one feels, but not a sense of how feelings affects one's life. For example, someone in this category is able to state their needs and intentions, but only some of the time, or under very specific circumstances.

With men, you can picture the difficulty with self-awareness when you think back on times that you've asked a guy how they feel. Sometimes, men freeze. The question is overwhelming. They're just unable to describe a feeling and convey it to you.

We can understand this because there is a prohibition against feeling. There's the idea that it's important to minimize how you feel, that feelings are associated with vulnerability, that feelings are not a manly kind of thing. So feelings are pushed away or devalued in important ways.

The same thing can be true for sensation. Men who have suffered from trauma experience can be cut off from awareness of bodily sensation and bodily needs. The intense disassociation from feelings and from sensation is easy to see in kids, for example, who have Asperger's. I'm not linking Asperger's to trauma experience, but that disassociation from feeling is often typical of trauma survivors.

There was a consumer that I was talking about earlier in response to Alex's question, the gentleman who had lapsed and then his sister died and he fully relapsed. When I was talking to him about the impact of his sister's death, he was unable to acknowledge the impact of her death on his life. This is a sibling that he had been close to, who had been available to him in times of distress.

What he said was, "I don't want to give that as an excuse. I relapsed; it's my own fault. It really has absolutely nothing to do with the fact that I've had this grievous loss." But in the conversation, there was an awareness that, although he could take responsibility for his lapse and his relapse and that there were things that he could do to help get himself back into recovery again, that it also help to talk about the feelings that he had about his sister's death.

A second skill is self-protection. With self-protection, people who are very low on this skill associate with people who are abusive, exploitative, and dangerous and have little understanding of how to preserve a physical boundary, an emotional boundary, and with really poor judgment about dangerous situations.

Again, you can see how the male myths intervene here. Guys feel like they can handle whatever comes along. They often feel like they can be tough and independent and that they're strong and capable. So to admit that they're hanging out with somebody who puts them in terrible danger, flies in the face of the male myths. So the male myths reinforce difficulty with this skill.

We sometimes try to help people develop a better sense of self-protection, to think about a network member and to evaluate them. On a scale of one to five, we ask, how safe is this person? And then

have people explain why they feel that way, how it is that they've come to that judgment. What are the behaviors that person is involved in? And in what way is that behavior related to their safety or to the lack of safety?

Another skill is self-soothing. We often work with men who have a hard time dealing with intense anger, the final common pathway of so many of men's experiences. We find paranoia can easily complicate the difficulties in developing capacities to self-soothe.

For some men, self-soothing is so difficult that there is just no way to contain an escalation, that the self-soothing that occurs is related to drug taking or, perhaps, indiscriminate sex. People who are better able to self-soothe engage in strategies that may interfere with functioning but are not life threatening.

One of the ways that we try to help people with self-soothing is to help them construct a comfort list. What is it that makes you feel comfortable? What is it that helps you feel more at peace? People often turn to spiritual resources as they develop these comfort lists, and we encourage that. But people might also think about safe places or safe people that they can be with or things that they can do, go for a walk or listen to music or enjoying a particular food, things that are really not at all self-destructive that they can engage in and that are self-soothing.

Emotional modulation is another skill that is often disturbed when people have a long history of trauma. People are sometimes very stormy, intensely angry, volatile, or alternatively, absolutely frozen, emotionally rigid, and unable to respond. So there are different ways that emotional modulation can have a negative effect on people.

So we might try to help them develop a timeline. You can do this informally in conversation or you can do it more formally with a pencil and paper. Ask people what was happening right before an explosion, 15 to 30 minutes before, earlier in the day, and what were the circumstances. What were the feelings that they had? What were they thinking about? What were they remembering? Who were they with? Where were they? So that people begin to get a sense of what contributes to control over intense emotional experience.

Relational mutuality is another important skill partly because of the male myths that intrude. If you're supposed to be tough, strong, and independent, being in a relationship flies in the face of that. Often we find men who have no relationships at all or the relationships they do have are superficial. There isn't a genuine sense of give and take.

So what we help people do is make an assessment of their relationships. We have somebody think about one relationship, not one based on substance abuse, but a relationship that's important to them and what the people do that is fun together. Can you discuss your problems with this person? Do you engage in activities or share interests with them? And how often do you get together? Give men some tools for how to think about relational mutuality and how to develop that skill.

Another important skill is accurate labeling of self and others. We find that men who are trauma survivors often labeled experiences inaccurately. People who have been raped in prison might not call it rape, for example. People who have been physically abused, even tortured, might say that they were appropriately disciplined. So the people don't have good judgment about things that have been done to them; they can't label things for what they are. As people improve in this capacity, they might be able to use some new labels, but inconsistently. The language begins to emerge, but not reliably so.

Roger, why don't I hand it over to you and you can talk about some of these other skills?

Roger Fallot

Okay. The next skill is the sense of agency and initiative. Here, the continuum ranges from one end, where men experience virtually no control. Certainly some of the men who are at that end are depressed. Here the learned helplessness paradigm is an important one to understand, in terms of coming to terms with really inescapable abuse and the sense that there was nothing that the boy or man could do

to avoid the abuse and the helplessness that abuse engendered.

At the other end of the continuum is a thoughtful controlled action. I'm thinking of one man who was in a trauma recovery group who had spent much of his adult life between living with his abusive mother and being homeless. His life was really experienced as if he were kind of a pinball being bounced back and forth between various places, with no sense of his capacity to exert any control. He simply did whatever was asked of him and ran errands for various people in the neighborhood indiscriminately, in a way that resulted in his being beaten when he took on, without quite recognizing it, a drug running errand.

For each of these skill domains we have developed a number of both formal and relatively informal kinds of strategies.

One thing we might do in this arena, for instance, is a timeline review, just asking the man to think of one thing he had accomplished in the last week and then asking him to reconstruct the things that led up to that action. If he looks to external events or behaviors of others as leading up to that action, then ask him to redirect his attention to his own behavior. By going through this with a number of events and, focusing on his role you can contribute to this increased agency and initiative.

Consistent problem solving is a complex ability; it combines thinking, feeling, and interpersonal skills in dealing with personal and interpersonal situations. The continuum ranges from men who just seem overwhelmed by even very simple problems to those at the other end of the continuum, who have developed considerable skills and are consistently able to follow a strategy that is effective for them, especially asking for help when appropriate.

The father of one man, for instance, had been physically abusive and threatening to him as a child, and later stole money from him, a disability check. The man, who at the time was about 35 years old, only saw two alternatives, to give up or blow up. That is, he would either cave and say nothing to his family about the theft, or he would go and confront them and end up in a physical brawl, usually with his father.

Both of those responses had significant disadvantages. In our cost benefit discussions with him, he was able to recognize those and come up with a new alternative which involved engaging his case manager as a go-between. Involving the case manager in a mutual negotiation with his family resulted in his regaining a significant part of the money they had taken from him. That kind of situation, where we can break down problems into smaller actions and then reconstruct a pattern of responses is the skill development we are engaged in.

Reliable parenting is often one that people are surprised to see in a list of men's trauma recovery skills because it is identified with the women's and mother's realm, but it is something that has been very important to many of the men with whom we've worked. We were very impressed, for instance, by the extent to which relationships with children could motivate abstinence from substance use, as well as job seeking and appropriate interpersonal behaviors.

One man told us how important it was to include this. He said he had grown up with a father who had been physically abusive and he had decided to be the precise opposite of his father. He would never, ever threaten his son physically and he would never, ever dream of touching his son in anger or discipline.

That kind of avoidance worked for him for many years, until his son became a teenager with teenage behaviors. His son antagonized him in some ways and one day, this man was walking out of the room and flicked the top of this son's head with his fingers. The man was absolutely distraught and overwhelmed with grief and remorse that he had touched his son in anger. That sort of rigid response to the opposite extreme of what he had grown up with was constraining his ability to deal with his son effectively and was a reminder to us about the importance of developing reliable parenting skills.

Another useful skill is a sense of purpose and meaning. Trauma survivors talk about losing sight of their goals so that they often feel aimless and are devoid of any real future orientation, trying to

get by moment to moment. It's certainly true that trauma survivors ask big questions about life. They ask questions of ultimate purpose and meaning, the questions of how they fit in the scheme of things are often very central. So a sense of purpose and goal setting, especially for the men in our groups, becomes a very important part of the activities.

Certainly, one of the dilemmas for many men is that in the usual gender role expectations, men are expected to have it all: real men have lots of money, they have important jobs, they are thoroughly independent, and they have it right away.

We work on breaking down long-term and short-term goals. We work on pacing and the necessity of clear, intermediate steps and achieving long-term goals. By allying with men on their long-term goals and then helping them to break those down into more achievable steps, we facilitate skill development in this arena.

Finally, the last dimension is judgment and decision-making, where many of these skills are used in new situations to form reliable judgments that are based on thoughts, feelings, perceptions and then to use those judgments to make beneficial decisions. For many men this involves a slowing down of their usual pace, where impulsive reactions can get in the way of making good decisions.

This skill is a close cousin of the problem-solving skill. Here we work with men to assess alternatives, to weigh pros and cons, to make short-term plans, to act on those plans and then to talk with us about whether or not the plans worked. Failure to meet a particular short-term goal is just an opportunity to come up with another short-term goal and to make that next one more achievable and practical.

One of the ways that is sometimes carried out in concrete terms is by an exercise that we call "stopping the action." Simply, when men feel that they've made a decision to do something and they have not yet actually done it, we ask them to take a step back, literally. We ask them to take five deep breaths, to count to 30, to stand up and literally take five steps backwards and then ask themselves, "Do I still want to make the same decision that I made a few minutes ago?" And if so, why? And if not, why not?

Those are the core recovery skills. They provide us an opportunity, really, to ally with consumer strength in service planning. We will often sit down with this skill dimension list and review them with the individuals we're working with so that we can come to some judgment together about what their priorities are in terms of their development. Which area do they think is most important for them to work on of these 11 skill domains? Which comes to mind for them as the most important?

Emphasize that skill development in those priority areas as often as possible, and find some way to build on those skills so that each contact becomes an opportunity for skill development. And then, support the application of those skills in new circumstances.

That's the set of trauma recovery skills that we've developed and have compiled in a manual that is available from Community Connections, if people are interested in finding out more about these exercises and strategies.

We'll take a break for questions.

Amy Salomon

That's terrific, to know that there is such a manual. I want to open the floor to questions right now.

Coordinator

At this time there are no questions.

Amy Salomon

All right. I'd actually like to ask a quick question because I know our providers are always interested in getting their hands on good screening and assessment instruments in this area. When you started talking about the trauma recovery and empowerment profile tool, I wondered how that's actually used. Is it used as an assessment instrument? Is it used in relationship to enrolling in the M-TREM groups? Does it have some applicability more generally for providers working

with individuals experiencing homelessness who have potentially traumatic histories?

Roger Fallot

Yes, we've used it in a number of ways, Amy. Certainly we've used in some ways as an outcome measure for participants in our trauma recovery groups. That is, we will have people who know the participants in these groups very well complete this profile at the beginning and at the end of the groups.

It has also proven to be useful, more generally, for people who are providing services here at Community Connections, and in a number of other places, as one tool to use early on in service planning rather than being focused entirely on specific services that someone may want. That is, consumers may want housing, they may want help getting benefits, they may want to get into some other kind of group therapy or see a physician.

In addition to those kinds of service orientations, this tool provides an opportunity for clinicians to sit down with someone and identify skills that they may want to develop, which will help them achieve whatever goals they have. So we encourage clinicians to use them and use them in general in service planning and prioritizing.

Coordinator

At this time we have no further questions.

Amy Salomon

All right, then we'll move into our final section of the presentation.

Men, Trauma, Recovery and Empowerment Model (M-TREM) Methods and Goals

David Freeman

Okay, Amy. What we want to do now is talk a little bit about M-TREM, which is a specific intervention that we have developed at Community Connections. M-TREM is in the active stage of treatment. You know, we're engaged with people, we're quite sure that they're interested in coming to groups, that they're willing to come to groups, and that they'll be able to tolerate the group experience.

It is okay for men to come to the group and simply listen. For example, we ran a six-month group several years ago. This one particular gentlemen did not say more than three words in the course of the six months, and that's okay; we don't insist that anybody, any one person say anything in a group. But we were wondering if he was getting anything out of it. When we had some discussion at the very end about people's experience he said, "All I want to know is when does the next group begin?" And he sat through the next round of six months and was much more active the next time around.

We do look for people who can sit in a group; there will be content areas or triggers for people that will prompt them to leave a group temporarily. We try to have extra group leaders available so that people can go out and give individuals support if they've had a hard time. But for the most part, our experience with these groups has been that people come in and they like it and they stay. Our success rate for holding on to people is good.

Let me just say a couple of things about the development of the group. Our approach is psycho-educational in nature. This requires the clinician to adopt a different stance than most group leaders have grown to use. It's a psycho-educational position: people are very active, the group leaders are very active, giving feedback to people, really emphasizing the good points that they make and being sure to highlight the trauma-specific information and

education that we can get across to people. Also offering more general substance abuse and mental health education as we find it necessary to do that.

We're not interested in drawing out peoples' stories in the group; we're more interested in helping people develop specific skills and responding to a structured intervention. This is different for clinicians; it's a different model. We avoid questions that follow up on an individual's contribution, but we tie contributions to general shared experience.

So each session is very structured. We have a rationale, we have specific questions, and we have specific goals that we're trying to accomplish. We have specific questions that we put up on a flip chart, on the board, in advance, and we move through those questions and then we have an exercise at the end.

Then, in our manual, each session has some themes that have developed in response to the particular group content, notes for the leaders to prepare for the direction that we expect that group participants will take.

Amy Salomon

David, just for clarity, I wanted to make sure our listeners understand the length of this intervention and the times per week, the hours involved. I thought I heard you say six months?

David Freeman

Yes.

Amy Salomon

Okay, that's six months that people attend weekly? One time?

David Freeman

It's a 24-session model and we devote one week to each session. So you can expect the group to run for six months. We really try to keep the momentum going, so we move through the agenda of the overall six-month curriculum rather aggressively. We set aside 75 minutes for each group session and you need to really add 10 to 15 minutes before and after each group for group leaders to talk to each other.

Amy Salomon

Okay, and are there multiple leaders? Two facilitators?

David Freeman

Yes, we realized that there are sometimes funding constraints, which make this impossible, but our strong preference is to have three group leaders.

There is one person to manage of the session, to introduce the session, to structure to the session, to move through the questions and to be in a position of obvious leadership. Then there's another person who is busy writing up people's responses on the flip chart. The third leader is available to monitor the emotional tenor of the group and to respond to individual's distress, should it emerge.

So we write a question on the flip chart and we try to capture, in the consumer's and participant's own words, exactly what their response is to the question. Group leaders are encouraged to give their own answers to these questions. What we come up with at the end of a session is an amazing amount of material.

A typical session has usually between 5 and 10 large, newsprint-size pieces of paper filled with consumer's comments and answers to the questions. People get to see, first of all, that everything that they say is valued. They also get to see that there is a tremendous amount of material that has come out of the group.

It is rewarding for people, especially, who are diagnosed with more severe mental illnesses like schizophrenia, to see the volume of content that is generated from the discussion and to see how we value the material.

The third leader is there to stay tuned into the emotional process of the group. For somebody in the group who may be overwhelmed, that person is there to offer support. If somebody leaves the room because the content was too provocative for them, then we have somebody who can go out and attend to that person and bring them back into the group or at least

make some plan with them for their re-engagement with the group.

Now, as I say, three people is not always possible. Certainly, we have done the group with two group leaders. But sometimes what we've also done is have the third person be a trainee, somebody who is getting a feel for the flow of the group, because the content can be very difficult. People are making reference to traumatic experience, which has really been overwhelming to them and which is overwhelming to the listener.

So we want trainees to have an experience of being in the group room, with people who have run through the curriculum before and who are able to manage the emotional intensity and experience of running the group.

Amy, I hope that helps give you a sense of some of the nuts and bolts of it.

Amy Salomon

Absolutely, thanks.

David Freeman

The intervention that unfolds over the six months is really divided into three sections. The first section focuses on feelings and relationships. We really spend the first 12 weeks, actually, of M-TREM focusing on relational issues and feeling domains that we think have been particularly damaged or impaired by traumatic experience. We do this because men need help in developing a shared feeling language and a shared understanding of relationships.

Traumatic experience makes the discussion of feelings even more difficult than it already is for men. At the same time, traumatic experience makes relationships that much more difficult than it already is, based on upbringing and socialization.

So the sessions in this first section include discussions of the male myths that Roger has made reference to and friendship, trust, sex, and intimacy. These are the relationship topics. And interspersed with each of these sessions are topics on anger and fear, loss and hope, and shame.

Because the guys in the group can be overwhelmed as they get in touch with the intensity of their fears or the intensity of their experience of loss, we frequently remind people that we have some strategies for dealing with the problems that we're discussing and that participation in the group over the full six months will give people skills for dealing with the problems that they struggle with in the feeling and relational domains.

What I want to do is just discuss one session from this first section of M-TREM in a little bit more detail, and then talk a little bit about the session on anger.

What we find for men who are trauma survivors is that anger is often a predominant and the defining emotion. If men can't identify any other feeling that they have—sadness or grief or hope or mistrust—they can talk about anger. In fact, anger is almost like the final common pathway for all kinds of feelings. So the guy will say, "I was really upset about the fact that something was stolen from me the other day and I was so angry about that." We're off and running with anger.

Also, it often seems to men that anger is the one emotion that they're able to express, that the more vulnerable feelings, the softer feelings, are less accessible and less rewarded. Our goal here is to help men to appreciate that anger is really a complex emotion, that it's not an all-or-nothing phenomena, and it can be a screen for less accessible emotions. There are advantages and disadvantages to expressing anger. The therapeutic goal is not simply to help people be more comfortable expressing anger, but to be able to talk and think about the expression of anger and the feeling of anger and also to introduce men to a range of strategies for dealing with angry feelings. Not all anger has to be dealt with in, for example, a violent way, or for example, in a way where people withdraw from the interaction.

We ask men in this session to talk about situations where they've felt angry, to describe other emotions that somebody might feel in that same situation. Again, we're writing all of the men's responses up

on the board so that people can see the total group contribution to these questions and people can begin to identify with material that they, themselves, were not in touch with at the moment.

We talk about what were some of the negative consequences that people experienced as a result of being angry and what were the benefits. Again, we're always talking with people about the pros and cons. And are there ways that people have to handle anger more effectively?

Let's just zip right along. Roger, do you want to talk a little bit about part two?

Roger Fallot

Okay. Yes, after these first 11 sessions, we've hoped for two things: First that men have developed, in this group, a sense of safety and trust with each other and can now talk about things that they would have been reticent to talk about when the group started. And secondly, that they can reflect on their own behaviors and feelings, to share those in a way that enables us to talk more fully about them.

So in addition to the psycho-educational emphasis that has characterized the intervention thus far, we added, increasingly, cognitive behavioral interventions and skills-building exercises throughout this portion of the group.

In the second section we talk most directly about trauma experiences. Now, it's not that we haven't talked about those in the first 11 sessions. But in sessions 12 through 17 or 18, it's a focused attempt to help group members understand trauma in general, and its impact in their lives, in particular. So the sessions talk about trauma as a whole, and how trauma may work in general, as well as about emotional abuse, physical abuse, and sexual abuse as categories of violent experiences. Then we spend three sessions fleshing out some of the relationships between these histories of abuse and psychological or emotional symptoms, addictive substance abusing, compulsive behavior, and the impact of abuse on interpersonal relationships.

Let me say something briefly about topic 16, which makes it clear what we do in terms of those relationships. Imagine a newsprint with three columns, labeled A, B and C. In this session we try to start a discussion about the experiences in column one, which are experiences of abuse; column two, which are coping responses; and column three, which are behaviors of feelings that get labeled as symptomatic.

We start with column-three experiences by asking men to talk about things that have been labeled symptomatic for them and we often get responses like depression, paranoia and those kinds of things. And then we work backwards to understand the relationship between those symptomatic experiences and some potentially earlier experiences of abuse and their coping responses.

For instance, physical beatings may lead to distrust, which then may be generalized into a broader symptom that someone will call paranoia. Helping men understand that these experiences that are labeled by the mental health system as problematic may help them, develop skills that are responsive.

David, why don't you talk briefly about the third section and then we'll move to wrap this up?

David Freeman

Okay. Let's see, the second part that Roger was describing is where we try to talk specifically about trauma experience. In the third part, we're beginning to apply the understanding of trauma's impact to a whole variety of life domains, to develop and practice recovery skills, and to deepen the supportive function of the group. The sessions here have to do with revenge, acceptance and forgiveness, negotiating family relationships, communication skills, and with managing feeling out of control.

I want to talk about the idea of the sessions and self-soothing and managing feeling out of control. Often men don't have a range of options for easing stress and comforting themselves, and sometimes don't even regard this as a legitimate goal.

So we try to, in this session, help men understand some of the triggers that cause them to feel out of control and to consider that there are many feelings, besides anger, that will serve as a trigger for that. We're trying to broaden people's appreciation of their experience and the range of emotions that affect their lives. We're trying to help men to consider some ways that they could modulate those feelings to soothe themselves.

So some of the questions that we ask are "What does it feel like to be out of control? How do you behave when you feel that way? And how would others describe you at those times?" We're trying help encourage men distinguish between how they felt and what they did when they felt that way, and also try to help them take some perspective on their behavior so that they begin to look at themselves from the perspective of somebody else. Then also, "What are the triggers that provoke those very feelings of being out of control? And how do you respond when you felt out of control? What are some of the positive things that you've done to restore control afterwards?"

Sometimes men are going to talk about some really unproductive ways of restoring a sense of control, like controlling another person or getting into a fight, or getting involved in some behavior that leads to a hospitalization or heavy binge of substance use. But we're really focusing on the positive ways that have worked and for men to share these experiences with each other. And then just to say when you feel bad, how do you take care of yourself? What can you do to feel better, calmer and less upset? And giving men the opportunity to talk about that range of things that they can do to help themselves.

Roger, do you want to go ahead?

Roger Fallot

Sure. I think it should be clear that we're hoping for the ultimate development of a future orientation: a sense that the future is hopeful, that goals can be set and can be met, that the skills that have been developed are going to be adequate to meeting those goals. We hope for a more realistic appraisal of relationships and what it takes to sustain relationships, as well as a more realistic assessment of the services and sources of help for sustaining recovery.

The process we've tried to incorporate here, then, is for men at each stage to recognize what's going on with them, to understand some of the connections between their current experiences and their histories of violent victimization, to be able to choose among a range of responses, to practice those responses, and then to evaluate how well these work.

If they're not working out well, you go back to the beginning and get attuned to yourself, trying to understand, and choose an alternative and practice a second way of coping with a particular problem. Hopefully, in all of these sessions we have been working at those skills.

Sustaining Trauma Recovery

David Freeman

Then, finally, I want to comment on sustaining trauma recovery. You know, it's one thing to have a background knowledge that is shared by a few people in an organization or to have a few trauma-specific interventions. But really, in order to sustain the recovery, we find that you really need to build a community of staff and of consumers who understand the importance of trauma in men's lives, who have a shared value for addressing some of these male myths, for questioning them, for exposing them as inaccurate and unproductive, for developing a set of skills that allows men to be in touch with a much broader range of experience and feelings, a much broader capacity for relationships, and a shared understanding of the impact of traumatic experience on people's sense of themselves, people's experience of psychiatric symptoms and substance abuse and a shared understanding of the impact of trauma on relationships with families and the impact of trauma on people's capacity to engage in services, and also a shared commitment to addressing these concerns, for keeping them alive in the life of an agency and the life of communities so that trauma recovery can be sustained and so that trauma recovery still can be learned and so that people can lead fuller lives.

Amy Salomon

Thank you, David. Thank you, Roger. That was fascinating and I think your final comments, David, certainly make us understand how transformational this kind of work is on many levels: staff, supervisors, agencies and the broader community. We have about six minutes left. I'd like to open this once again for questions.

Caller

Yes, I had some questions about the logistics. First, what is the size of the group that you recommend for this model? And you mentioned having three group leaders, a facilitator, someone writing on the flip chart, and could you repeat the role of the third leader?

Also, could you address the issue of bringing structure to a population that is, by definition, unstable? How do you get the same people to come back to the group every week for six months? Do you have it in the shelter? Do you serve a meal before or after the program or how did you deal with that?

David Freeman

What we do, actually, Alex, is we have a target of having 8 to 12 people in the group. In order to get to that target, we need between 15 and 20 initial referrals. So, as you're looking around and talking with colleagues and bringing referrals in, we're very clear that we're going to be talking about men's issues, trauma recovery issues, the impact of physical and sexual abuse, from the very beginning, but that we're doing it in such a way that people are made to feel very comfortable and that people are able to develop skills for recovery.

We interview everybody and find that out of that initial group of 15 to 20, we often get between 12 and 14 people who are interested. We end up with 8 to 12 people that attend the initial group. Once we get people through the initial three to four groups, we find that the stick rate is excellent and we have a very low attrition rate. But we do find that going from the initial referral to the third group is a little bit trickier, so we try to go for a little larger number at the beginning.

In terms of the three roles, we have the person who is providing the overall structure and leadership, the person who is taking notes and then the third person, who is available to attend to people who are not participating and may be in distress.

Amy Salomon

Does that answer all of your questions? Oh, I think some other things you were asking had to do with, are there any particular strategies that you're using?

David Freeman

We do serve food. We have donuts, chips, soda, coffee.

Remember that this is an active treatment stage, so that it's not appropriate for people who are in the engagement phase of treatment, but for people with whom you are engaged and who you have moved through the persuasion stage. So the people are connected with the idea that change might be a good idea and that substance abuse and trauma and perhaps mental illness are important factors in their life, and they are willing to address those issues. This is the group for them.

We have offered the group in people's homes, we have offered groups like M-TREM in off-site settings and that's totally legitimate.

Coordinator

At this time there are no further questions.

Amy Salomon

All right. I'd like to thank our featured presenters, Roger Fallot and David Freeman of Community Connections. I'd like to thank Alex, who asked both questions, and to remind our listeners that you can continue to send in e-mail questions and ask for any kind of information that you might need on this topic and we'll refer them to our speakers.

I'd like to thank Michael Hutner for participating today, Margaret Lassiter, our colleagues at Policy Research Associates, who have helped enormously on the Internet access to this presentation and Amy Sanborn here at AHP for coordinating the call so beautifully.

With that, our call is concluded. Thanks so much to all the listeners for being with us today. Thank you.