Helping Men Heal from Addiction and Trauma:
Understanding and Treating Men in Addiction Treatment

Michael F. Barnes, Ph.D., MAC, LPC
Chief Clinical Officer
Foundry Treatment Center
Steamboat Springs, Colorado
• May 2013, first Males, Trauma and Addiction Summit was held at the West Coast Symposium in La Quinta, California.

• 23 men and women, leaders in addiction, trauma, community mental health and education.

• Developed 8 Agreements. A document on how society & culture impact how males experience addiction and trauma.

• MATRIC is consortium of likeminded treatment providers, administrators, educators, and advocates.

• Goal: promote 8 Agreements and to educate treatment providers, consumers, and the society at large of the need for gender responsive, trauma informed and culturally aware addiction treatment.
MATRIC (Males, Addiction and Trauma Recovery International Consortium)  www.menstrauma.org

- Miles Adcox, (Onsite)
- Michael Barnes, Ph.D., MAC, LPC (CeDAR)
- Richard Bebout, Ph.D. (Green Door Mental Health)
- Allen Berger, Ph.D.
- Lou Cox, Ph.D.
- Judy Crane (The Refuge)
- Richard Dauer (River Ridge Treatment Center)
- Tian Dayton, Ph.D.
- Teresa Descilo (Trauma Resolution Center)
- Eduardo Duran, Ph.D.
- Norma Finkelstein, Ph.D. (Institute for Health & Recovery)
- William Ford, Ph.D., (C4 Recovery Solutions)

- Rawly Glass
- Dan Griffin (Griffin Recovery Enterprises)
- William Pollack Ph.D. (Harvard Medical School)
- David Powell, Ph.D. (International Center for Health Concerns)
- Pat Risser (Males for Trauma Recovery)
- Jaime Romo, Ed.D. (Males for Trauma Recovery)
- Cheryl Sharp (National Council for Behavioral Health)
- Brian Sims, MD., (Correctional Mental Health Services)
- David Washington (Males for Trauma Recovery)
- Rob Weiss, LCSW (Elements Behavioral Health)
- Jacquie Wheeler (Jaywalker Lodge)
The 8 Agreements (MATRIC)

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

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

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

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

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

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

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

8. Effective treatment of male trauma will help to interrupt cycles of violence, abuse, neglect, and addiction.
Helping Traumatized Men Receive Recovery Messages!

- The goal is to create a treatment process where trauma symptoms do not interfere with recovery messages and addiction.
- It is critical that clients are able to hear, receive, and implement the recovery messages throughout treatment.
- Must provide opportunities to work on trauma symptoms, that prevent client from engaging in treatment.
- Now not the time to work on resolving the trauma itself.

Shame, Trauma Issues and gender socialization serve as a barrier to insight and acceptance of need for change!
### Lifetime Substance Use
**Ages 12 & Older**
(HHS, SAMHSA, OAS, 2009)

<table>
<thead>
<tr>
<th>Substance</th>
<th>% Men</th>
<th>% Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>85.5</td>
<td>79.3</td>
</tr>
<tr>
<td>Cocaine (any form)</td>
<td>18.0</td>
<td>11.8</td>
</tr>
<tr>
<td>Smoked cocaine (i.e., crack)</td>
<td>4.4</td>
<td>2.3</td>
</tr>
<tr>
<td>Heroin</td>
<td>2.1</td>
<td>1.0</td>
</tr>
<tr>
<td>Inhalants</td>
<td>11.6</td>
<td>6.4</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>17.8</td>
<td>11.6</td>
</tr>
<tr>
<td>Marijuana</td>
<td>45.6</td>
<td>36.9</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>5.2</td>
<td>3.1</td>
</tr>
<tr>
<td>Pain relievers (non-medical use)</td>
<td>16</td>
<td>12.3</td>
</tr>
<tr>
<td>Sedatives</td>
<td>4.2</td>
<td>3.1</td>
</tr>
<tr>
<td>Tranquilizers</td>
<td>9.3</td>
<td>8.2</td>
</tr>
</tbody>
</table>

### Treatment Admissions by Primary Substance of Abuse
(SAMHSA, OAS, 2008)

<table>
<thead>
<tr>
<th>Substance</th>
<th>% Men</th>
<th>% Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>74.6</td>
<td>25.4</td>
</tr>
<tr>
<td>Alcohol with another substance</td>
<td>73.7</td>
<td>26.3</td>
</tr>
<tr>
<td>Smoked cocaine (i.e., crack)</td>
<td>58.4</td>
<td>41.6</td>
</tr>
<tr>
<td>Other cocaine</td>
<td>65.0</td>
<td>35.0</td>
</tr>
<tr>
<td>Heroin</td>
<td>68.3</td>
<td>31.7</td>
</tr>
<tr>
<td>Other opioids</td>
<td>53.8</td>
<td>46.2</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>54.2</td>
<td>45.8</td>
</tr>
<tr>
<td>Inhalants</td>
<td>67.0</td>
<td>33.0</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>72.7</td>
<td>27.3</td>
</tr>
<tr>
<td>Marijuana</td>
<td>73.8</td>
<td>26.2</td>
</tr>
<tr>
<td>Sedatives</td>
<td>42.7</td>
<td>57.3</td>
</tr>
<tr>
<td>Tranquilizers</td>
<td>46.4</td>
<td>53.6</td>
</tr>
</tbody>
</table>

In 2006, 68.2% of admissions to Substance Abuse Treatment Programs (receiving state funding) were men!
Significance of trauma for men

- According to the National Center for PTSD:
  - 61% of men and 51% of women report having experienced at least one traumatic event (lifetime)
  - 10% of men and 6% of women report having experienced four or more traumatic events (lifetime)

- Of these trauma victims, 8% receive diagnosis of PTSD
- 1% of American population (New England Journal of Med)

- Women are twice as likely to be diagnosed with PTSD as Men!

  10% of Women and 5% of men who experience traumatic event will be diagnosed! (Tolin & Foa, 2006)
Males are biologically influenced to minimize or deny traumatic life experiences

Hypothalamic-Pituitary-Adrenal Axis (HPA Axis)
- Functions include:
  - Stress response, increase blood sugar for quick burst of energy, Suppress the immune System, Aid with, protein & carbohydrate metabolism
- **Cortisol is a stress hormone** that is released when the individual experiences threat/stress and the HPA Axis is stimulated. It is a steroidal hormone – **Glucocorticoid**!
- **Cortisol and Oxytocin** are vital in maintaining biological homeostasis in response to chronic stress.
- Lower Cortisol levels following traumatic event is associated with increased risk for PTSD.

Gender differences:
- **Men experience stable/higher cortisol levels** following experience of trauma memories.
  - May stimulate avoidance & increased fight/flight in men, which may mediate PTSD development.
- **Women’s cortisol levels stay the same** following experiences of trauma memories (Lower than men = higher risk of PTSD)
  - May be associated with differences in how testosterone & estrogen interact with Oxytocin, which is also released during stress response

Tolin & Foa, 2008; Verma, Balhara, & Gupta, 2011
Significance of trauma for men

• Men experience significantly higher rates of the following Potentially Traumatizing Events (PTE) (Tomlin & Foa, 2006):
  • Accidents, Nonsexual Assaults, Combat, War, Terrorism, Disasters or Fires
  • Men and Women experience the same number of Nonsexual child abuse or neglect events.
  • Women experience more child and adult sexual abuse

• 1 in 20 boys experience child sexual abuse (National Center for Victims of Crime)

• 5%-10% of adult men can recall childhood sexual abuse event.

• 1 in 71 (9%) men raped in adulthood (National Sexual Violence Resource Center)
Prevalence of PTSD and Substance Use Disorders

Bride (2007) - of treatment seeking substance abusers:
- 60% to 90% have history of physical or sexual abuse.
- 30% to 50% meet criteria for PTSD.

Among persons who develop PTSD, **52% of men and 28% of women** are estimated to develop an alcohol use disorder. **35% of men and 27% of women** develop a drug use disorder  
(Najavits, 2007)

The numbers are even higher for veterans, prisoners, victims of domestic violence, first responders, etc.  
(Najavits, 2004a, 2004b, 2007)

Individuals with PTSD are **3 to 4 times more likely to develop SUD’s** than individuals without PTSD have earlier histories with A & D, more severe use, and poor treatment adherence.  
(Khantzian & Albanese, 2008)

Clients with PTSD/SUD more vulnerable to poorer short & long-term outcomes, more likely to Relapse!
Significance of trauma for men

CeDAR Primary Residential Program – Admission TSI-2 (July 1, 2014 to April 28, 2016)

TSI-2 Admission Scores for **Men** with Problematic and Clinically Significant Trauma

- Normal: 14%
- Trauma (Problematic): 20%
- Trauma (Clinically Significant): 66%

TSI-2 Admission Scores for **Women** with Problematic and Clinically Significant Trauma

- Normal: 31%
- Trauma (Problematic): 23%
- Trauma (Clinically Significant): 46%
Significance of Trauma for Men

CeDAR Primary Residential Program – Admission TSI-2  (July 1, 2014 to April 28, 2016)

Gender Comparison Total Population TSI Scales/Subscales
Men n=312/Women n=91

Depression

Trauma Reducing Behaviors
Significance of Trauma for Men

CeDAR Primary Residential Program – Admission TSI-2 (July 1, 2014 to April 28, 2016)

Scores for Men: Problematic Trauma (n=43) & Clinically Significant Trauma (n=61) Scores
Women with Clinically Significant Scores Added for Comparison (n=27)
When does society start imposing gender rules?

“The stage is set at an early age for the induction of “boy code” where boys are taught to keep emotions in check, violence is acceptable as a response to emotional unrest, self-esteem is based on power, and all “feminine qualities” must be rejected”~ (Pollack, 1999).

• Trauma symptoms, painful memories and emotions, facing consequences, relational conflict all experienced by the brain as threat? Initiate control behaviors!
• Control behaviors can be either passive or aggressive.
• They ALWAYS attempt to prevent thoughts, feelings, & behaviors similar to traumatic event.
Under stress, the human system tries its newest system first. Humans will initiate Social Engagement first. If that doesn’t reduce stress, it will initiate fight/flight. If that doesn’t reduce stress, it will initiate immobilization as a survival strategy!

Hierarchical relationship among three subsystems of the autonomic nervous system.

3.) Immobilization: Dissociation, behavioral shutdown
- Most primitive – shared with most vertebrates
- **Dorsal Vagans** nerve (from brain stem to dorsal motor nucleus). Connected to all organs below the heart. (See Red on 1st Picture)

2.) Mobilization: Fight/Flight behaviors
- Dependent on sympathetic nervous system (increased metabolic activity & cardiac output)

1.) Social Communication or Social Engagement: Facial Expression, vocalization, listening
- Dependent on **Ventral Vagal** (myelinated) nerve.
- From brain stem to nucleus ambiguus. Fosters calm behavioral states by inhibiting the influence of the sympathetic Nervous system on the heart. (See yellow on 1st picture)
Males are biologically and culturally influenced to minimize or deny traumatic life experiences

- Little boys are programmed to feel shame associated with their experience of and sharing of feelings, especially feelings associated with weakness, vulnerability, fear, and despair.

- **Shame-Hardening Process (Pollack, 1998)**
  - Use of shame to control boys expressions of emotions.
  - Boys are disciplined, toughened up, to be “Real Men” which is foundation of self-identity, gender-identity, etc.

- Shame the foundation of societal maintenance of identity of masculinity.
- Shame also frequently responsible for emotional injury and cultivation of rage and violence as defensive behavior. (Mejia, 2005)
Males are biologically and culturally influenced to minimize or deny traumatic life experiences

• “Gender politics are deeply embedded in the fabric of our society. They profoundly influence the course of our psychological and social development, and how we see ourselves as men and women.” (Laidlaw & Malmo, 1991)

• The essential features of masculine ideology are toughness, fearlessness, and denial of vulnerability. (McCreary et al., 1996)

• “The schema of men as essentially synonymous with masculinity is still well entrenched. It is therefore very difficult for people to be cognizant of the contradictory view of men as tough and invulnerable on the one hand and hurt and suffering on the other.” (Mejia, 2005)
The paradoxical nature of being a man in recovery

Man Rules
- Don’t be weak
- Don’t show emotion
- Don’t cry
- Don’t ask for help
- Don’t care about relationships

Recovery Rules
- Admit powerlessness
- Speak openly about your emotions
- It’s ok to be vulnerable
- Ask for help
- Get a sponsor/support network

Across the lifespan, how do the man rules impact attachment in relationships with family, friends, intimate relationships, addiction & recovery?
How the Unconscious Mind Influences What is Normal

- A recent study indicates that 80% of the thoughts that we have today are the same thoughts that we had yesterday, the day before, etc.
  - Thoughts, feelings, defensive responses happen outside of conscious awareness are called procedural memory!

- Thoughts, experiences and emotions cause specific neuro-pathways to fire.
  - The more we have the same thoughts, experiences and emotions, the strong and faster this neuro-pathway develops.
  - The neurons that fire together, wire together!
  - Repetition, increase pathways, Repetition, increase pathways, etc.

- The vast majority of “normal” family thoughts, feelings, and behaviors are proceed in procedural memory system.

Conscious Thought
Declarative Memory

Unconscious Mind
Procedural Memory

- Sensory Triggers
- Multigenerational Epigenetics
- Attachment Relationships
- ACES
- Covert Rules, Roles, Routines, Boundaries
Trauma and the Autonomic Nervous System

- Somatic Experiencing (Peter Levine, Ph.D.)
- Containment and Autonomic Regulation (CAR) Eric Wolterstorff, Ph.D.)
Primary Conflict – Self-Development vs. Association

“Sam he said, there are two questions a man must ask himself: The first is ‘where am I going?’ and the second is ‘who will go with me?’ If you ever get these questions in the wrong order you are in trouble.”

Statement made by philosopher Howard Thurman to Sam Keen
Fire In The Belly, 1991

- Thurman was talking about man’s consistent focus on intimate and sexual relationships and developmental focus on getting the right partner and being enough to fulfill and maintain the marriage/committed relationships.
- Men are also highly desirous of other critical relationships with friends, clubs, athletic teams, combat units.

- Statement is especially relevant for young boys and adolescent males, who are struggling with childhood trauma, neglect, poor attachment with parents.
- Young boys who are experiencing childhood trauma/ACES, or not getting attachment and developmental needs met due to family addiction, mental health issues, will often shift focus from self-development, to safety.
- For some, safety is to develop avoidant or anxious attachment.
- For some, safety is found by affiliation with like minded peers. Can begin association within the culture of addiction.
• Children do NOT have the ability to understand concepts such as “Powerlessness” and “Turn It Over.”

• We know that the adults in our lives are supposed to be taking care of us.

• When children experience abuse (physical, sexual, emotional), neglect, anger, blaming, bullying, unpredictability, they come to believe that the only way to make the pain go away is to believe that the issue/problem is ME!

• This results in growing belief that we are bad, stupid, inadequate or unlovable.

• Constant experience of fear, anxiety, threat associated with being ourselves alters our brains and is the beginning of low self-esteem, anxiety, reactivity, dissociation, shame based identity and a deep fear of trust and attachment!
Relationship between Childhood Trauma & Addiction – Being Me is Really Dangerous!

• Deep fear of trust and attachment is based on foundational beliefs of inadequacy! Important!

• Being myself is dangerous. Must take on a role that will allow me to maintain some sense of control in their lives.

1. “I have to be a perfect Family Hero! I will be what/who they want me to be. This may be very different with different people in my life. I can’t risk being myself with others that have power or can judge/punish me.”

2. “I need to be wary of all other people and I must learn to use distance, anger to create control of my own safety. People can not be trusted!” Scape Goat, always in trouble. Identified as troubled!

3. “I have no power to impacting the events of my life, so I keep my head low and survive day to day. There is no use in setting goals or making long-term plans, because I will never be able to make them happen.” May be highly anxious and focused on other’s feelings (Mascot) or quiet and alone (depressed) (Lost Child).

If this is how you survived as a child and throughout your years of active addiction, what are the implications for playing each of these roles in treatment?
- William White: Need to Shift from Culture of Addiction to Culture of Recovery!

- What we don’t get in our family of origin, we will seek to fill in our social groups at school, work, etc.

- We almost always seek out people who are similar to us in terms of sense of self, how they experience and manage emotions, how much they trust, level of openness, honesty, and intimacy.

- We seek out friends who are similar to us, so if we are unable to trust, we will find relationships with people who are also struggling with trust, honesty, and being themselves.

- As children and adolescents, this makes us feel more normal.

- It also maximizes the likelihood that our social group will respond to the experience of drugs and alcohol is similar ways.
  - Childhood friends fall away as we feel drawn to others that behave in similar ways that we do!
Phase four: Drink/Drug to feel normal

Must start wherever His/her chronic depression is and comes off to a worsening emotional position.

No longer able to start here as in the past and drink to Feel “Good”.

Pain  Normal  Euphoria

-7 -6 -5 -4 0 1 2 3 4 5 6 7

X X X X

X

Teen drinker with childhood trauma history!
• **Tribes and the Culture of Addiction provide members:**

  • For those who struggle to meet needs in larger society, tribes provides opportunity to **address the needs of all human beings.**
  • **Enhanced identity through membership, social acceptance, self-esteem, purpose, and order to daily life.**
    • For many males, this is the **most significant experience of acceptance & belonging in the individual’s life!**
    • No skills required. **Mentorship in how to use, reduce risk, etc.**
    • Allows opportunity for sexual expression.
    • **Identity enhancement meets more needs than the actual use of drugs do**

• Membership supports **new worldview and a code of values** that support drug use & rejection of society that rejected them.

• Allows members to maintain the **illusions of normalcy & controlled drug use.**
Embrace the social stigma.
Society & its values ridiculed & rejected

Rules

Roles

Rituals

Routines

Relationships

Values + Goals = Identity

Loyalty - Stick together or hang alone
Denial, minimizing, projection
Intimacy = vulnerability & stupidity
No real moral codes, rip-offs OK
Sex is a commodity
Mentor will teach proper technique and etiquette of drug use.
Work works, until it gets in the way

Where, When, How & With whom a drug is used
Observe other/more experienced users prepare drug for use.
Routinize procedures & method
Autonomic response when triggers are experienced

Loyalty to tribe 1st, family 2nd
Family shifts from safety net to controllers
Tribe relationships codependent on drug use
Tribe relationships serve as constant triggers
Family & coworkers opportunity for hustles

Dealers
High priests
Storytellers
Medicine men/Midwives
Jailhouse lawyers
Pledges (New users)
Gangsters

Hustling
Copping
Getting Off
Avoiding busts, rip-offs & hassles

Mentor will teach proper technique and etiquette of drug use.

Work works, until it gets in the way

Many addicts have found it easier to break the physiological relationship with their drug of choice than to break the relationship with the culture in which the drug was used!!!
Key Treatment Objectives – Create a New Tribe Within Culture of Recovery

• Most important factor in treating clients from different tribes, is to assess what they were getting from their association with that social group, in a non-judgmental way.

• How we refer to their friends, mentors, etc. play a key role in demonstrating your competence and your safety.

• From a caring and curious perspective.
  • What do they get emotionally, socially, relationally, from an addiction perspective.
  • What role did you play in your tribe?

• Client MUST find that they can get the same needs met through their relationship with you, the helping community, 12 Step/Recovery Support, and within the culture of recovery.

If we can not convey this reality in a convincing way, there is no hope for lasting recovery.
Key Treatment Objectives – Creating Therapeutic Relationship

• Client/Therapist factors that most influence change process:
  • 40% client factors such as motivation, emotional capital, recovery capital
  • 30% therapeutic relationship
  • 30% client and therapist expectations (i.e., past treatment success, biases, etc.)
  • 15% clinical model, therapeutic interventions, etc.

• 1\textsuperscript{st} session is the most important when working with male clients

• No such thing as an unmotivated client! Many clients motivated to stay the same!
• It is our job to assess client motivation, without judgement!

• Male clients with trauma and addiction will be assessing the therapist more than the therapist is assessing the client!
  • Think in terms of trauma and attachment info discussed earlier!
Initial goal is to establish “emotional contact” with client.
• Welcome struggle, predict times of frustration and conflict
• Reinforce & welcome fear, pain, discomfort, loneliness, sadness, etc.
• Can the patient hang in there with you and stay in treatment. Learn to trust and begin process of adult relationships?
• Introduce fact that we will be having some difficult discussions that may challenge the relationship, including continuing care.

I like to predict that the patient may feel the need to pull away at times and that I will hang in there with the patient. Seek out comfort with other’s struggling to be in the culture of recovery!

“You will abandon me before I will abandon you!”
• What are the implications of this statement in addiction treatment?
• Program must be able to tolerate and address dysregulation and rejection of treatment!
Key Treatment Objectives – Engaging Men in Early Treatment

• Emphasize options and free choice, even when choices are limited.

• Roll with resistance. Confrontation about behaviors and right/wrong will escalate resistance behaviors.
  • Spend as much time processing what is happening right now, in the present moment. Often it helps to process behavioral issues, not as a past event, but on the fact that you are discussing it right now. How does that feel? What are you experiencing?

• Challenge “man rules” and traditional views of masculinity by reframing coming to treatment as a success and sign of strength and courage.

• Support male clients as they struggle to get in touch with emotions. Remember that many clients may have incredibly painful memories that elicit extremely difficult emotions.

• Remember that many males have spent the majority of the lives trying to hide their pain, fears, shame and uncertainty.
  • Counselor who demonstrated great empathy and insight into the client’s feelings, can make men feel exposed and vulnerable
  • Client may recoil and seek comfort in the rules, roles, relationships with other clients living in culture of addiction.
  • Recognize importance of pace, make the covert processes more overt by being curious and asking about them.
Key Treatment Objectives – Be Aware of Countertransference

• Critical that Counselors have done their own work!
  • Resolved their own trauma issues.
  • Resolved own biases in terms of with Gender Socialization, Man Rules, Need for competition, etc.

• While working in therapy, clients will often demonstrate or play out one or more of the roles that they played in their family of origin or addiction culture.
  • Clients may then projecting other roles out onto the therapist in the form of transference.
• Roles intended to manage anxiety for various participants!
  • **Savior**  “Assume expert role. Caretaker. Protector”
  • **Perpetrator**  “Bully other patients. Critical of staff.”
  • **Bystander**  “Only care about self. Not my job to support others”
  • **Victim**  “You broke my trust. I can’t trust anyone here.”

• It is critical for therapists to understand how these roles played out in their own life/family and recognize countertransference issues that could cause conflict or slow down the therapeutic process.
Key Treatment Objectives – Identifying Treatment Goals For Males

- **Constructing a New Self** - work on acceptance of addiction and ultimately acceptance of self as an addict, and self as a human being. Work on schemas and shifting.

- **Identification of & Grieve Losses** - begin with losses associated with addiction, move into familial and other interpersonal losses.

- Work towards **inner feeling of security and independence**.

- Initiate & **promote interaction** with counselors, peers, other 12 stem members, family, etc. Begin to **engage in meaningful conversations and activities**. New Affiliation, New Tribe

- **Focus on Feelings, current here-and-now experiences** with counselor, staff, peers, etc.

- Client **learns emotional regulation**. Identify triggers and coping strategies for dysregulation, such as feelings of vulnerability, fear, rejection, etc.

- Begin to **build new recovery tribe**. Client begins to accept that needs that were met in addiction tribe can also be met in recovery. Begin to experience new affiliation within culture of recovery. Begin to give and accept social support.
• Use Psychoeducation for men who emphasize rationality over emotionality. Can reduce problems related to feeling and expressing emotions.

• Work with men during individual and group therapy to apply feeling words to their internal/physical experience.

• Help clients identify emotions that are more comfortable and support efforts to manage the emotions.

• Intervene if other group members shame or strongly confront his inability to express certain emotions.

• Help the client set goals for group participation, particularly in terms of learning about and expressing emotions.

• Provide homework assignments to help him express his emotions within a highly structured context (e.g., expressive writing).
Key Treatment Objectives: Mindfulness, ANS Regulation Skills

Teaching Autonomic Nervous System Regulation Skills and Anger Management Skills:

- Mindfulness Meditation

- Trauma Reducing Protocol (Formerly Containment and Autonomic Reduction Therapy)
  - Resourcing Skills
  - Relational Abilities (Stressed Yes & Stressed No)

- Dialectical Behavior Therapy and the 12 Steps
  - Develop coping skills in:
    - Mindfulness
    - Distress Tolerance
    - Emotion Regulation
    - Interpersonal effectiveness
When someone is starting to exhibit affect change or when you observe signs that they are not listening, becoming fidgety or dissociated. Stop the session and ask everyone present to consider the following four questions:

I have found that men are often more open to working on emotions when become aware that they are not emotionally deficient, but that their training in emotional awareness was deficient!
Michael F. Barnes, Ph.D., MAC, LPC

• Email: mike.barnes@foundrytreatmentcenter.com
• Phone #: 303-885-1846
• Website: http://foundrytreatmentcenter.com/

Foundry Treatment Center
Steamboat Springs, Colorado