

BASED ON TIP 56

Addressing the Specific Behavioral Health Needs of Men

KAP KEYS FOR CLINICIANS



KAP KEYS BASED ON TIP 56

Addressing the Specific Behavioral Health Needs of Men

Introduction

KAP Keys were developed to accompany the Treatment Improvement Protocol (TIP) Series published by the Substance Abuse and Mental Health Services Administration (SAMHSA). These KAP Keys are based entirely on TIP 56 and are designed to meet the need of the busy clinician for concise, easily accessed “how-to” information.

For more information on the topics in these KAP Keys, see

TIP 56: Addressing the Specific Behavioral Health Needs of Men

Other TIPs relevant to these KAP Keys:

TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment

TIP 48: Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery

TIP 47: Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

TIP 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders

TIP 36: Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues

TIP 35: Enhancing Motivation for Change in Substance Abuse Treatment

TIP 25: Substance Abuse Treatment and Domestic Violence

Men's Trauma Recovery and Empowerment Model (M-TREM)

The Trauma Recovery and Empowerment Model (TREM) was designed to facilitate trauma recovery among women. The developers who adapted TREM for male clients formulated eight basic assumptions about how trauma treatment for men should differ from that provided to women. M-TREM appears promising in its ability to engage male clients and improve their coping skills. Assumptions and adaptations of the model for male clients are presented below.

Assumption	Adaptation
Men and women understand and respond differently to traumatic experiences.	The TREM model emphasizes empowerment for women; M-TREM focuses on emotions and relationships (areas in which men have difficulties).
Male trauma survivors must either disconnect from male gender role expectations to feel the fear, vulnerability, and powerlessness associated with trauma, or else disconnect from those feelings to retain their sense of masculine identity.	M-TREM focuses on exploring the relationship between trauma experiences and masculine gender role expectations.
Many male survivors develop all-or-nothing responses, especially emotional responses (e.g., rage or timidity), or ways of being in relationships (e.g., dependence or emotional distance).	M-TREM teaches men a wide range of options for expressing emotions and being in relationships.
In spite of the appearance of independence that results from trying to fill masculine roles, men with trauma histories feel cut off from their families, communities, and selves.	M-TREM uses reconnecting skills of emotional, cognitive, and behavioral self-recognition and teaches relational mutuality to improve men's understanding of how to be in relationships.
Men who were traumatized early in life lost the opportunity to develop important skills necessary for adulthood.	M-TREM uses a psychoeducational and skills-oriented approach to treatment for trauma.

2 KAP KEYS BASED ON TIP 56

Addressing the Specific Behavioral Health Needs of Men

Men's Trauma Recovery and Empowerment Model (M-TREM) (continued)

Assumption	Adaptation
Men with trauma histories have skills and strengths that can help them in recovery.	M-TREM uses a strengths-based approach.
As with women, men's dysfunctional responses to trauma (or its symptoms) may have begun as useful coping strategies.	M-TREM helps clients reframe problematic behaviors as attempts to cope with trauma.
Any attempt to cope with trauma is likely to have advantages and disadvantages.	M-TREM helps clients look at the costs and benefits of their coping strategies in an objective fashion and reframe problems so they can choose the best coping strategies.

Adapted from Fallot, R. D., Harris, M., Affolter, H. U., Anglin, J., Arledge, E., Bebout, R., et al. (2001). *Men's Trauma Recovery and Empowerment Model (M-TREM): A clinician's guide for working with male trauma survivors in groups*. Washington, DC: Community Connections.

Overview of GATE, a Screening and Intervention Process With Clients Who May Be Suicidal

G: Gather information. There are two steps to gathering information: (1) screening and spotting warning signs and (2) asking follow-up questions. Screening consists of asking brief, uniform questions at intake to determine if further questions about suicide risk are necessary. Spotting warning signs consists of identifying telltale signs of potential risk. Counselors should ask follow-up questions when clients respond “yes” to one or more screening questions or whenever they notice a warning sign. Asking follow-up questions elicits as much information as possible so that counselors and their supervisors and/or treatment teams can develop a good plan of action. Counselors should provide as much information as possible to other providers upon referring clients to them.

A: Access supervision and/or consultation. Counselors should never attempt to manage suicide risk alone in clients, even if they have substantial specialized training and education. With suicidal clients, two or three heads are almost always better than one. Therefore, counselors should speak with a supervisor, an experienced consultant who has been vetted by their agency, and/or their multidisciplinary treatment team when working with a suicidal client. It is a collective responsibility, not the counselor’s alone, to formulate a preliminary impression of the seriousness of risk and to determine the action(s) that will be taken. Accessing supervision or consultation provides invaluable input that promotes the client’s safety, gives counselors needed support, and reduces personal liability.

T: Take responsible action(s). A counselor’s action(s) should be responsible and make good sense in light of the seriousness of a client’s suicide risk. Some of the potential actions (which cover a range of intensity and immediacy) that counselors and their supervisors or teams may take include:

- Gather more information from the client to develop an accurate clinical picture and treatment plan.
- Gather additional information from other sources (e.g., spouse, other providers).

Overview of GATE, a Screening and Intervention Process With Clients Who May Be Suicidal (continued)

- Arrange a referral:
 - To a clinician for further assessment of suicide risk.
 - To a counselor for behavioral health counseling.
 - To a provider for medication management.
 - To an emergency provider (e.g., hospital emergency department) for acute risk assessment.
 - To a mental health mobile crisis team that can provide outreach to a client at his or her home (or shelter) and make a timely assessment.
 - To a more intensive substance abuse treatment setting.
- Restrict access to means of suicide.
- Temporarily increase the frequency of care, including more telephone check-ins.
- Temporarily increase the level of care (e.g., refer to day treatment).
- Involve a case manager (e.g., to coordinate care, to check on the client occasionally).
- Involve the primary healthcare provider.
- Encourage the client to attend (or increase attendance at) 12-Step meetings.
- Enlist family members or significant others (selectively, depending on their health, closeness to the client, and motivation) in observing signs of a return of suicide risk.
- Observe the client for signs of a return of risk.

Upon a return to acute suicidality, create a safety card with the client. TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (Center for Substance Abuse Treatment, 2009, p. 21), describes this process.

Overview of GATE, a Screening and Intervention Process With Clients Who May Be Suicidal (continued)

E: Extend the action(s). Too often, suicide risk is dealt with once, in acute fashion, and then forgotten. As with substance abuse, vulnerable clients may relapse into suicidality. Thus, counselors need to continue to observe and check in with clients to identify any possible return of risk. Another common problem is referring a suicidal client but failing to coordinate or follow up with the provider. Suicide risk management requires a team approach, and a client's substance abuse counselor is an essential part of this team. A counselor should document all actions taken to create a medical and legal account of the client's care: what information was obtained, what actions were taken and when, and how follow-up on the client's substance abuse treatment and suicidal thoughts and behaviors was conducted. This record can be useful for supervisors, consultants, the counselor's team, and other providers.

Source: Center for Substance Abuse Treatment. (2009). *Addressing suicidal thoughts and behaviors in substance abuse treatment*. Treatment Improvement Protocol (TIP) Series 50. HHS Publication No. (SMA) 09-4381. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Time Out! For Men (TOFMEN)

This eight-session group intervention for male clients in substance abuse treatment:

- Promotes the reexamination of gender stereotypes, social pressures, and sexual misconceptions.
- Aims to help men improve their relationships with their partners.
- Is designed to be run by a behavioral health counselor.
- Has an online training module available at <http://ibr.tcu.edu/time-out-for-men-a-communication-skills-and-sexuality-workshop-for-men>.

Session 1: This session focuses on creating a bond among group members and exploring male and female gender roles. Specifically, group members examine what they need and want in their intimate relationships and what role socialization plays in their values and choices. The counselor asks each man to create a list of the characteristics that make an ideal man and woman; group members use these lists to look at how gender role stereotypes affect their relationships. Men are challenged to implement and discuss what they have learned via a take-home assignment. After session 1, group members are given worksheets to help them identify their needs and how they can meet the needs of their spouses or partners.

Session 2: Men start by reviewing their homework from the day before. After, they concentrate on building communication skills to achieve and maintain an assertive attitude. They discuss the disadvantages of aggressive and passive communication styles and the differences between “I-statements” and “You-statements.”

Session 3: This session focuses on listening, a key skill for maintaining good relationships. Group members participate in listening exercises to help them decipher common listening problems and identify good listening habits. In one exercise, an item (e.g., a mug) is passed to the participant who has the floor. The next group member to receive the item then restates what he heard the previous speaker say.

Time Out! For Men (TOFMEN) (continued)

Session 4: Participants discuss feelings and how to accept and express them. After making a list of feeling words, group members identify and discuss which feelings are hard or uncomfortable for them to talk about.

Session 5: Men discuss how to resolve conflicts. They are encouraged to seek solutions instead of assigning blame when conflict arises and are taught how to fight fairly with others.

Session 6: This session uncovers misconceptions about sexual and reproductive health and how they can affect attitudes and values about sexuality. Clients are taught how unnecessary concerns about normal body functions, sexual responses, and sexual feelings can cause undue stress on relationships.

Session 7: This session continues the discussion of sexuality as the men address common concerns about, and the effects of substances on, sexual functioning. They also examine stereotypes concerning the man's role in sexual relationships and try to devise self-help solutions for sexual problems in relationships.

Session 8: The last session focuses on increasing self-esteem (e.g., by writing affirmations) and reviewing communication skills covered in previous sessions. The men are encouraged to keep building these skills. The workshop closes with a graduation celebration; group members are awarded certificates for completing the intervention.

Source: Bartholomew, N. G., & Simpson, D. D. (2002). *Time Out! For Men: A communication skills and sexuality workshop for men*. Fort Worth, TX: Texas Christian University, Institute of Behavioral Research.

Goals and Techniques for Working With Male Clients in Couples and Family Therapy

GOAL—Develop perceptual and conceptual skills:

- Clarify your own values concerning gender socialization.
- Become aware that all men are not alike—they are in various stages of transition along a continuum, with some men being open to change and others being more resistant.
- Define family as inclusive of all the many types of families in America (e.g., traditional families, single-parent families, extended families, gay or lesbian families).
- Become aware of and challenge any tendency to protect men in the system.
- Familiarize yourself with men's writing about men.
- Focus on the anxieties that underlie men's defensiveness.
- Be aware of patterns of power assertion on the part of male clients.

GOAL—Promote mutual responsibility:

- Ask couples historical questions on the formation and development of responsibility in the presenting family.
- Have couples evaluate their options for changing the division of responsibilities.
- Determine who initiates sexual interaction.
- Use direct teaching to introduce the reciprocal nature of gender interactions and the constraints of the larger sociocultural context.
- Design interventions that are directed at all parts/ members of the involved treatment system (e.g., helpers, members of the extended family).

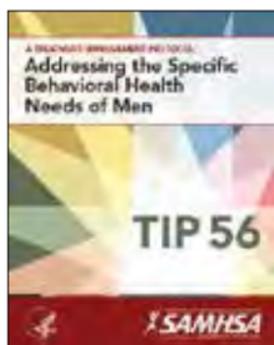
Goals and Techniques for Working With Male Clients in Couples and Family Therapy (continued)

GOAL—Challenge stereotypical behaviors and attitudes:

- Teach men to ask for help.
- Discuss the benefits that men can get from changing stereotypical behaviors and adopting new attitudes, roles, and behaviors.
- Encourage father–daughter and mother–son bonding, especially during adolescence.
- Discuss problems men with absent fathers have in being fathers to their own children.
- Examine couples' experience of socioculturally supported behaviors in their own relationships (e.g., Are men satisfied with working long hours? Do they long for more time with their children?).

Source: Dienhart, A., & Avis, J. M. (1994). Working with men in family therapy: An exploratory study. *Journal of Marital and Family Therapy*, 20(4), 397–417.

Ordering Information



TIP 56

Addressing the Specific Behavioral Health Needs of Men

TIP 56-Related Product:

**Quick Guide for Clinicians
Based on TIP 56**

Publications may be ordered or downloaded from SAMHSA's Publications Ordering Web page at <http://store.samhsa.gov>. Or, please call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

Do not reproduce or distribute this publication for a fee without specific, written authorization from the Office of Communications, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

HHS Publication No. (SMA) 14-4881
Printed 2014

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment