Trauma informed care for women who use substances

A TRAINING CURRICULUM FOR SERVICE PROVIDERS

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We Would Like to Thank:

All members of the SHEWAY team, Dr. Amy Salmon and Dr. Ron Abrahams for their collaboration on this project and for sharing their knowledge.

Patti Zettel and Dana Clifford for supporting further ideas and projects related to this topic.

Isabelle Aube Linden, Diane Smylie, and Dr. Francois Noël for their contributions to the workshop and this manual.

Dr. Michael Krausz for his ongoing and generous support.

This project was supported by a grant from the Canadian Institutes of Health Research CIHR, Funding Reference Number 124775. Dr. Iris Torchalla and Dr. Verena Strehlau have no conflicts of interest.

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A. Background

Women in the Downtown Eastside (DTES) of Vancouver

The Downtown Eastside (DTES) of Vancouver, a small geographical area of about 18,000 people, is one of the poorest neighbourhoods in Canada. Many community habitants experience poverty, unemployment, substandard housing, violence and crime. Involvement in sex work and the drug trade are common means for the DTES residents to make ends meet, and many struggle with mental illness, substance use disorders (SUDs), and medical diseases.[1]

About 38% of the DTES population are women,[2] and almost 30% of the DTES residents are injection drug users, of which a high proportion are also women.[1] A Vancouver based study indicated that female injection drug users have mortality rates almost 50 times that of the province's general female population[3]. Women from the DTES also have high rates of pregnancy and poor pregnancy outcomes,[4,5] and report alarming rates of gender-based violence.[6]

Such results suggest that women residing in the DTES face multiple burdens related to social determinants of health, and that psychological trauma is an unfortunately common experience. In our own study of homeless women and men from Vancouver, Victoria, and Prince George – the BC Health of the Homeless Survey (BCHOHS) - 73.0% reported having ever experienced a traumatic event; 20.5% met criteria for current PTSD, and rates were almost twice as high in women than in men (28.0% versus 15.5%).[7] International studies also indicate that the co-occurrence of substance use disorders and trauma experiences or PTSD represents a growing area of concern. Histories of traumatic events have been reported by as many as 90% of some samples of substance users,[8,9] and estimates of PTSD prevalence rates among individuals with substance use disorders were between 20% to 38%.[9,10] Research suggests that the co-occurrence of SUD and trauma/PTSD is associated with adverse health outcomes and behaviours. For example, in a study among 1437 intravenous drug users from the DTES, among whom 68% reported a history of sexual violence and 33% reported childhood sexual abuse, sexual violence at any age was strongly associated with a variety of high-risk behaviours.[11] Individuals with concurrent trauma/PTSD and SUD also presented with more severe psychiatric symptoms[12] and higher rates of additional psychiatric disorders[13] than people without this comorbidity.

> **"A Vancouver based study indicated that female injection drug users have mortality rates almost 50 times that of the province's general female population.**

Despite such findings, the majority of research and services in the DTES have focused on drug use and infectious diseases whereas mental health issues and disorders have often been neglected.[14] This focus may partly be the result of the HIV/AIDS rates reaching epidemic level in the 1990's which prompted the opening of the BC Centre of Excellence for HIV/AIDS in 1992, and of the Four Pillar Strategy that the City of Vancouver adopted in 2000 in response to the high rates of drug use, infectious diseases and other problems visible in the city. The Four Pillars include 1) Prevention, 2) Treatment, 3) Harm Reduction, and 4) Enforcement; the approach was developed to prevent harm from psychoactive substance use.[15] It led to the establishment of North America's first supervised injection site and other harm reduction programs, and subsequent research projects to evaluate their effects.

The goal of our own research program was to complement this work with studies exploring trauma and mental health issues

in the experience of addiction in the DTES population, in order to develop treatment and training programs that are adapted to the complex concurrent conditions these individuals face. Researchers have also observed gender differences among individuals with PTSD-SUD comorbidity. For example, women tend to report more multi-type abuse and/or sexual victimization than men,[16,17] and appear to have a greater risk than men for developing PTSD following trauma.[18] Our own study of homeless people from British Columbia indicated that, among participants with SUDs, PTSD comorbidity was associated with greater current suicidality, psychological distress, and somatic symptoms. Gender was also associated with the study outcomes, and the most severe pattern of psychopathology was found among women with PTSD.[7]

The Addiction in Maternity Study

There is evidence that trauma experiences such as childhood maltreatment, sexual assault and intimate partner violence have a negative effect on mothers with substance use problems. For example, childhood abuse was associated with current psychological distress and drug use severity in urban low-income mothers.[19] Furthermore, histories of trauma exposure appear to be associated with current parenting behaviour.[20] Studies among low-income mothers showed that a history of abuse and/or maltreatment was related to low parenting satisfaction, physical punishment and neglect of their own children.[21,22] In order to provide a more comprehensive understanding of the experiences and the interplay of trauma, substance use, and mental health problems in the lives of women, our team conducted the 'Addiction in Maternity Study' with women who struggled with substances during pregnancy and/or early motherhood, and who accessed community programs that provide harm-reduction services for these women: 'Sheway' is a drop-in centre in the DTES that offers prenatal and postnatal care, sexual health counselling, addiction counselling and methadone maintenance treatment, practical support, food and nutrition counselling, parenting classes, and First Nation specific services for about 120-160 women. Sheway works in close partnership with 'Fir Square', a residential program at BC Women's Hospital to providing care for substance-using women and their newborns in a single unit. The program helps women and their newborns stabilize and withdraw from substances, while keeping mothers and babies together and continuing to provide care from antepartum to postpartum and between hospital and community. Furthermore, 'Crabtree Corner Housing' is located in the DTES and provides transitional housing for pregnant and parenting women who use substances. The centre also offers meal programs, child care, support groups, and programs related to parenting, family activities, health prevention, and child development. The overall goals of these programs are to improve pregnancy outcomes, support mothers in their capacity as parents and caregivers, provide education and support to help them reduce risk behaviours and improve social conditions, and promote the health and development of their children. Trauma and mental disorders are not systematically addressed.

We interviewed 31 women using quantitative and qualitative measures to assess the areas of childhood experiences, experiences of abuse in adulthood, symptoms of PTSD, psychological distress, and substance use. The study showed that these women faced complex concurrent health conditions. Polysubstance use was common, and levels of current general and PTSD-related distress were moderate to high in this group. Furthermore, all women reported at least one type of childhood abuse or neglect, but multi-type maltreatment was the norm. All of the women indicated traumatic experiences of sexual, physical, and emotional abuse in adulthood as well.[23] Key themes that emerged from the qualitative interviews highlighted the ubiquity of multiple and continuing forms of adversities and trauma - often in form of gender-based violence - from early childhood to adulthood, in a variety of contexts, and through a variety of offenders. Both personal factors and structural/environmental conditions (e.g., related to homelessness and street-based sex work) mutually intensified each other, interfering with a natural resolution of trauma-related distress and substance use. Women were also concerned that trauma can be passed on from one generation to the next.[24] The results underscore the vulnerability of this population, and reinforce the need for increased and continued services for pregnant substance using women. Following the "Addiction in Maternity" study, our team has partnered with Sheway to collaboratively develop a training workshop aimed at promoting trauma-informed care. The materials and instructions for holding the workshops are included in the current manual.

"Studies among low-income mothers showed that a history of abuse and/or maltreatment was related to low parenting satisfaction, physical punishment and neglect of their own children.

B. Overview of the Program

The workshop is designed to be delivered in an interactive way by involving the participants whenever possible. For example, the facilitators could introduce a new topic by asking the participants about their own observations and experiences with the topic. The content has a strong focus on issues that are relevant for the everyday work at harm reduction services that serve women with substance use issues who have concurrent trauma issues. Such facilities often have multidisciplinary, non-hierarchical teams, consisting of a variety of health care professionals and workers with different levels of training and experience. Thus, our goal was to create one curriculum for all levels of training and experience to be beneficial for all staff members and provide them with the knowledge and clinical skills to address trauma in the context of addiction. The original workshop was designed to be delivered in 7-8 sessions; each of which is about 60 minutes in length. However, the materials can be used flexibly for seminars, workshops, and lectures of different length and duration. Table 1 provides an overview of the treatment.

TABLE 1: CONTENT OF WORKSHOP BY SESSION

1	• **Introduction to workshop** • **Introduction to concurrent substance use and trauma/PTSD** o Epidemiology o Possible pathways o Clinical impact o Gender (women's) issues • **Review of PTSD: DSM-diagnostic criteria**
2	• **General assessment strategies of traumatic experiences and PTSD** • **Self reports and interviews for trauma and PTSD assessment** o Assessment of trauma exposure o Assessment of trauma- and PTSD-related symptoms o DSM based clinical interviews for establishing a PTSD diagnosis
3	• **Treatment approaches for individuals with concurrent substance abuse and trauma/PTSD** o Pharmacotherapies o Evidence-based treatment for PTSD o Integrated psychotherapy treatment programs o Example: Seeking Safety o Effectiveness of integrated treatment programs • **General trauma-informed practices (TIPS) and strategies** o Intake practices and engagement o Making contact, empathic listening and responding o Specific examples of TIP
4-6 (7) Or even more needed for practicing techniques	• **Focus on practice: Therapeutic strategies and techniques to cope with trauma related symptoms** o Introduction of distress rating scale o Breathing exercise o Progressive muscle relaxation o Grounding exercises o Safe Space o Trauma Box • **Practice in small groups** • **Discussion of experiences** • **Sleep and nightmares** o The relationship between sleep, substance use, and trauma o Nightmares in the context of PTSD o Treatment of PTSD related nightmares
8 Last session	• **Concurrent trauma and SUD in relationships** o Transgenerational trauma, parenting issues of trauma survivors o Video (20 minutes) o Feedback/Debrief on video, discussion • **Feedback, and wrap-up of the workshop (Leave enough time!)**

C. Description of Sessions

Session 1

SESSION 1
General information on trauma, PTSD and its comorbidity with SUD

- **Introduction to workshop**
- **Introduction to concurrent substance use and trauma/PTSD**
  - o Epidemiology
  - o Possible pathways
  - o Clinical impact
  - o Gender (women's) issues
- **Review of PTSD**
  - o DSM-5 diagnostic criteria for PTSD
  - o Complex PTSD

INTRODUCTION TO WORKSHOP

- Greeting, introduction of lecturers and participants
- Discuss issues of confidentiality (e.g. for case examples)
- Provide an overview of the workshop by presenting table 1

INTRODUCTION TO CONCURRENT SUBSTANCE USE AND TRAUMA/ PTSD

Definitions

A trauma is a major event that is disturbing and overwhelms an individual's ability to cope. (e.g., sexual abuse, physical assault, accidents, witnessing someone else being seriously injured or killed, etc.). Many individuals respond to a traumatic event with intense psychological distress. Some may develop post traumatic stress disorder (PTSD), a mental health condition that is a direct result of experiencing a traumatic event. People with PTSD may re-experience the trauma in intrusive memories or nightmares, avoid anything that reminds them of the trauma, have persistent negative thoughts and feelings, and be irritable, hypervigilant, or easily startled. We will discuss the specific features of trauma and PTSD more explicitly when we talk about assessment procedures.

Epidemiology

? *"Based on your own experiences and estimates, how many of the clients that you serve have histories of trauma?"*

Trauma exposure:

In representative national surveys, 81.7% of US Americans [25] and 76.1% of Canadians [26] reported lifetime exposure to a traumatic event. Histories of traumatic events have been reported by as many as 90% of some SUD samples. [8,9]

PTSD rates:

Current prevalence rates for PTSD were 3.5% in the US [27] and 2.4% in the Canadian [26] general population. Estimates of PTSD prevalence rates among individuals presenting for SUD treatment range from 20% to 38%,[9,10] with lifetime prevalence rates are between 30% and 52%.[9,28,29] In our own study of homeless women and men from Vancouver, Victoria, and Prince George, 73.0% reported having ever experienced a traumatic event; 20.5% met criteria for current PTSD and 18.8% had concurrent PTSD and SUD.[7]

We also explored trauma experiences during childhood and adulthood among clients who accessed Sheway, a service for pregnant and postpartum women with substance use issues in Vancouver's DTES. All of the women reported histories of abuse and neglect both during childhood and adulthood; multi-type maltreatment was common.[23]

Possible pathways

? *"Why do trauma and substance use co-occur so often? What do you think is the relationship between trauma and substance use?"*

Instruction: Show the slide that illustrates the different theoretical models, but explain the different models one by one. Refer to the responses generated by the participants when explaining the models.

Several mechanisms have been proposed to explain the co-occurrence of SUD and trauma/PTSD.[30]

a. The "High-Risk" model proposes that individuals with SUD are at an increased risk for exposure to traumatic events due to the risky behaviors and conditions associated with their substance use (e.g., intoxication, prostitution, illegality, etc.).

b. According to the "Increased-Susceptibility" model, individuals with SUD are more likely to develop PTSD

following exposure to a traumatic event, due to functional and/or neurobiological impairments associated with their substance use (e.g., chronic hyperarousal, sensitization of the neurobiological stress system, lack of healthy coping strategies, etc.)

c. The "Self-Medication" model assumes that individuals who have experienced a traumatic event use psychoactive substances to relieve the psychological distress resulting from trauma exposure.

d. The mutual maintenance hypothesis, a bidirectional model, suggests that substance use increases when PTSD symptoms worsen, and at the same time the substance use may interfere with recovery from trauma-related distress, by preventing habituation to traumatic memories or by interfering with the processing of the traumatic experience.

Clinical impact of trauma experiences on women who use substances

? *"Do you have the impression that the trauma experiences affect the mental health and the behaviours of your clients? Do you think, people who have both substance use and trauma issues differ in some way from people who have substance use problems but do not have histories of trauma?"*

Research suggests that the co-occurrence of SUD and trauma/PTSD is associated with adverse health outcomes and behaviours. For example, in a study among 1437 intravenous drug users from Vancouver's DTES, among whom 68% reported a history of sexual violence and 33% reported childhood sexual abuse, sexual violence at any age was strongly associated with a variety of high-risk behaviours, such as sex work, suicide attempts, overdosing, needle-sharing with HIV infected persons, alcohol and drug bingeing.[11] In international studies, individuals with concurrent trauma/PTSD and SUD presented with more severe psychiatric symptoms[12] higher rates of additional psychiatric disorders,[13] and poorer physical health[31] than people without this comorbidity. Histories of trauma exposure also appear to be associated with current parenting behaviour.[20] Studies among low-income mothers suggest that a history of abuse and/or maltreatment relates to low parenting satisfaction, and physical punishment and neglect of their own children.[21,22] Furthermore, clients with concurrent PTSD and SUD appear to benefit less from standard SUD interventions; they demonstrated poorer treatment outcome and higher relapse rates than substance using individuals without PTSD.[32] Among clients accessing SUD treatment programs, the persistence of PTSD symptoms predicted substance use over the follow-up period.[36] On the other hand, studies following SUD-PTSD clients in a SUD treatment program found that attending PTSD treatment following discharge was associated with long-term SUD remission.[37,38]

Gender (women's') issues

In both general and clinical populations, men have typically higher rates of substance use (both alcohol and drugs) and SUDs.[39–41] Researchers have also observed gender differences with respect to trauma and PTSD. For example, women and men report different types of traumatic events (e.g., women tend to report higher rates of sexual assault whereas men tend to report higher rates of physical assault), women have a greater risk for developing PTSD than men.[18] Other clinical issues associated with PTSD-SUD differ between women and men, e.g. additional comorbidities, symptom type and severity.[42] Some studies indicated that substance use was more likely to precede trauma in men than in women.[43,44]

REVIEW OF PTSD

Explanation: **The Diagnostic and Statistical Manual of Mental Disorders (DSM)** is published by the American Psychiatric Association (APA). The manual provides standard criteria for the classification and diagnosis of mental disorders. It reflects the current scientific knowledge of mental disorders and is regularly being revised and updated (e.g., by modifying diagnostic criteria, adding new disorders and removing those that are no longer considered a mental disorder). The current version is the fifth edition (DSM5).

Ask if they have heard of the DSM or if they are using it at their service.

> **"Sexual violence at any age is strongly associated with a variety of high-risk behaviours, such as sex work, suicide attempts, overdosing, needle-sharing with HIV infected persons, alcohol and drug bingeing.**

DSM-5 diagnostic criteria for PTSD

A. The person has been exposed to one or more traumatic event(s) in form of actual or threatened death, serious injury, or sexual violence, either through a) direct exposure, b) witnessing in person the event as it occurred to others, c) indirectly by learning that the event occurred to a close relative or close friend (with the actual/threatened death being either violent or accidental), or d) repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., professionals repeatedly exposed to details of child abuse, but not through indirect non-professional exposure through electronic media, television, movies, or pictures).

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring.
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked psychological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s)
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s)

D. Negative altercations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury or substance use)
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous,")
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others
4. Persistent negative emotion state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities
6. Feelings of detachment or estrangement from others
7. Persistent inability to experience positive emotions.

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidence by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance
4. Exaggerated startle response
5. Problems with concentration
6. Sleep disturbance

F. Duration of the disturbance (symptoms in Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.
Specify if:

- With dissociative symptoms: In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:
  - Depersonalization: experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).
  - Derealization: experience of unreality, distance, or distortion (e.g., "things are not real").
- With delayed expression: Full diagnosis is not met until at least 6 months after the trauma(s), although onset of symptoms may occur immediately.

To note: Individuals who have experienced trauma may not develop any psychological problems at all following the event. They may or may not develop PTSD, or symptoms of distress that do not fully meet the criteria for PTSD, or they may develop other mental disorders (e.g., major depression, substance use disorder, panic disorder, etc.).

Session 2

SESSION 2 - ASSESSMENT

- **General assessment strategies of traumatic experiences and PTSD**
- **Self reports and interviews for trauma and PTSD assessment**
  - o Assessment of trauma exposure
  - o Assessment of trauma- and PTSD-related symptoms
  - o DSM based clinical interviews for establishing a PTSD diagnosis

INTRODUCTION

- Greeting
- Provide an overview of today's agenda

GENERAL ASSESSMENT STRATEGIES OF TRAUMATIC EXPERIENCES AND PTSD

Sample question for the group to start discussion: *"What are your own experiences with asking clients about trauma? Do you find it easy to ask about trauma? Do you have any concerns about trauma assessment?"*

Does trauma assessment and research have lasting negative effects on the client's well-being? How can we conduct trauma assessment that is ethical and minimizes the risk to our clients? Research indicates that 1) only a minority of study participants experience distress when participating in trauma-focused research projects, 2) the distress tends to dissipate quickly, and 3) the majority of study participants found that participating studies that explore trauma was a rewarding experience.[45] Other authors even suggest that the society tends to overemphasize trauma survivors' vulnerability and ignore the costs of avoiding trauma assessment; thus, harming the survivors.[46]

We are presenting slides with various examples for PTSD assessment. This is not to encourage that every patient/client should be assessed with these scales. We acknowledge that especially in low-threshold, front-line services that would be even inappropriate, but we still feel that these measures should be part of this workshop to inform participants about them. It may be necessary to remind participants that not everything in this workshop is applicable to every client/patient nor to every workplace.

SELF REPORTS AND INTERVIEWS FOR TRAUMA AND PTSD ASSESSMENT

As already discussed in our first session:

- A trauma is a major event that is disturbing and overwhelms an individual's ability to cope. (e.g., sexual abuse, physical assault, accidents, witnessing someone else being seriously injured or killed, etc.).
- Many individuals respond to a traumatic event with intense psychological distress.
- Some may develop PTSD, a mental health condition that is a direct result of experiencing a traumatic event. People with PTSD may re-experience the trauma in intrusive memories or nightmares, avoid anything that reminds them of the trauma, have persistent negative thoughts and feelings, and be irritable, hypervigilant, or easily startled.
- Some may not show a distress response following a traumatic event. There is also evidence that trauma exposure may have psychiatric sequelae other than PTSD [47].

> **People with PTSD may re-experience the trauma in intrusive memories or nightmares, avoid anything that reminds them of the trauma, have persistent negative thoughts and feelings, and be irritable, hypervigilant, or easily startled.**

➔ Discuss the different types of assessments and their procedures. The slides contain examples for each of the measurement types. Be aware when using

any psychometric scale or questionnaire to check the copyright before, some authors charge for the use of their scale(s).

EXAMPLES OF MEASURES OF TRAUMA EXPOSURE

- Brief Trauma Questionnaire (BTQ)
- Childhood Trauma Questionnaire – Short Form (CTQ-SF)
- Childhood Traumatic Events Scale (CTES)
- Evaluation of Lifetime Stressors (ELS)
- Life Stressor Checklist (LSC)
- Potentially Stressful Events Interview (PSEI)
- Stressful Life Events Screening Questionnaire (SLESQ)
- Trauma History Questionnaire (THQ)
- Traumatic Events Questionnaire (TEQ)
- Traumatic Life Events questionnaire (TLEQ)
- Traumatic Stress Schedule (TSS)

Note: Provides information whether or not exposure to potentially traumatic events has occurred, but does not provide any information if the exposure has resulted in any distress.

ASSESSMENT OF TRAUMA AND PTSD RELATED SYMPTOMS

- Davidson Trauma Scale (DTS)
- Impact of Event Scale - Revised (IES-R)
- Minnesota Multiphasic Personality Inventory (MMPI: PTSD Subscale)
- National Women's Study PTSD Module
- Posttraumatic Stress Diagnostic Scale (PSDS)
- Posttraumatic Stress Disorder Symptom Scale– Self Report (PSS-SR)
- Posttraumatic Symptom Scale (PSS)
- PTSD Checklist (PTSD-CL)
- PTSD Interview
- Self-Rating Scale for PTSD
- Symptom Checklist-90 (SCL-90; PTSD Subscale)
- Trauma Symptom Checklist-40 (TSC-40)
- Trauma Symptom Inventory (TSI)

Note: assessment of trauma related symptoms are not the same as establishing a PTSD diagnosis.

DSM-BASED CLINICAL INTERVIEWS FOR ESTABLISHING A PTSD DIAGNOSIS

Examples of assessments for establishing a diagnosis of PTSD based on DSM diagnostic criteria are structured clinical interviews such as the following:

- Clinician Administered PTSD Scale (CAPS)
- Structured Interview for PTSD (SIP)
- Anxiety Disorder Interview Schedule (ADIS)
- Structured Clinical Interview for DSM-IV (SCID-I)
- Composite International Diagnostic Interview (CIDI)
- MINI-Plus Neuropsychiatric Interview (MINI-Plus)

Session 3

SESSION 3

- **Treatment approaches for individuals with concurrent substance abuse and trauma/PTSD**
  - o Pharmacotherapies
  - o Evidence-based treatment for PTSD
  - o Integrated psychotherapy treatment programs
  - o Example: Seeking Safety
  - o Effectiveness of integrated treatment programs
- **General trauma-informed practices (TIPS) and strategies**
  - o Intake practices and engagement
  - o Making contact, empathic listening and responding

INTRODUCTION

- Greeting
- Provide an overview of today's agenda

TREATMENT APPROACHES FOR INDIVIDUALS WITH CONCURRENT SUBSTANCE USE AND TRAUMA/ PTSD

Pharmacotherapies

Pharmacotherapy for PTSD is not a focus of today's workshop; therefore it should only be presented briefly with the idea to show that there are also some pharmacotherapeutical options available. Although especially selective serotonin reuptake inhibitors (SSRIs) are used in clinical practice for the treatment of PTSD, the efficacy of medications in PTSD treatment is not clearly established. In addition to SSRIs, there are also some initial findings for venlaxafine, rispericdone, and prazosine for the treatment of PTSD (Inser & Stein, 2012).

Medications

The U.S. Food and Drug Administration (FDA) has approved two medications for treating adults with PTSD:

- Sertraline (trade name - Zoloft)
- Paroxetine (trade name- Paxil)

Both of these medications were originally used as antidepressants, but they are also used to treat anxiety and other things. They may help control PTSD symptoms such as sadness, worry, anger, and feeling numb inside. Taking these medications may make it easier to go through psychotherapy, which

is another important treatment component for PTSD.

Evidence- based treatment for PTSD

Show slide with table of recommendations from different PTSD treatment guidelines. Then explain the level 1 recommendation in detail:

- **Exposure therapy** includes in-vivo exposure or imaginal exposure or both. It aims at reducing avoidance of trauma related internal (e.g., memories and thoughts) and external (e.g., people, places, situations) stimuli. During in-vivo exposure, clients seek out safe situations that they tend to avoid since the trauma. During the exposure, the client uses emotional regulation skills that they have learned previously to cope with anxiety. During imaginal exposure, the client talks about the traumatic event repeatedly with the therapist. The therapist helps the client to stay with the memory despite of emerging distress. PTSD symptoms are believed to resolve through habituation, emotional processing, increased mastery, and differentiation between safe and unsafe situations, and between the trauma and the present (i.e., memories of the trauma).

- **Cognitive therapy** aims at modifying maladaptive cognitions (e.g., guilt, shame, anger, etc.) that have developed following a traumatic event. The therapist helps the client to identify thoughts about the world and the self that are unhelpful and result in anxiety and distress. Cognitive restructuring is used to replace these thoughts with more accurate and less distressing thoughts. .

- **Stress inoculation training** aims at reducing PTSD symptoms by increasing anxiety management skills to better cope with anxiety stemming from trauma reminders. Psychoeducation is used to inform clients about the nature of stressors, the stress response, and the role of appraisal. The therapist helps the client to identify triggers for anxiety and PTSD related distress, and teaches the client a variety of coping skills for managing and reducing anxiety (e.g., progressive muscle relaxation, deep breathing, etc.) as well as problem solving skills. Cognitive strategies are used to modify unhelpful thoughts related to the stressors. Stress Inoculation Training is effective for coping with PTSD symptoms as well as "inoculating" individuals to future and ongoing stressors.

- **Cognitive processing therapy** aims at modifying maladaptive cognitions (e.g., about the trauma, oneself, or the world) that have developed following a traumatic event. These cognitions are the result of a conflict between pre-trauma beliefs (e.g., the belief that I am a strong person and that the world is a safe place) and post-trauma information (e.g., that I am weak and the world is dangerous). The clients are instructed to write about the traumatic event in detail, and subsequently read the narrative aloud in and outside of the therapy session. The therapist and the client identify the maladaptive cognitions. Cognitive restructuring techniques are then used to challenge these cognitions and develop more balanced appraisals. It is assumed that this directly results in dissolving of PTSD symptoms.

- **Eye Movement Desensitization and Reprocessing (EMDR)** aims at changing how clients react to memories of their trauma. The therapist and the client identify and discuss reminders of the trauma. After that, the client focuses on these upsetting memories while following the therapist's finger which that is moving back and forth with their eyes. This is repeated until the client's distress declines. The client is then instructed to think of something positive that the therapist and the client have identified at the beginning of the treatment.

Integrated psychotherapy treatment for concurrent trauma and substance use

Our own meta analysis has shown that integrated treatment programs effectively reduce PTSD symptoms and substance use over time.[48] In several intervention studies targeting women, integrated trauma-informed services resulted in superior clinical outcomes compared to standard community care . Thus, IT programs are being highly recommended for women with SUD-trauma comorbidity by Health Canada and other experts.[52–54]

> **During in-vivo exposure, clients seek out safe situations that they tend to avoid since the trauma. During the exposure, the client uses emotional regulation skills that they have learned previously to cope with anxiety.**

In view of such findings, a number of integrated treatment programs have been developed that address both conditions simultaneously within the same service by the same team of clinicians. Such programs are typically based on cognitive behavioural therapy and also include use motivational interviewing strategies. The interventions focus on psychoeducation about trauma and concurrent substance use, stabilization, safety, social support, development of affect regulation and other coping skills, and relapse prevention. Women-specific issues addressed in some treatments included: female therapists, family strengthening, family reunification, parenting, empowerment, discussing sexual abuse, stigma, and domestic violence.

First we will introduce one quite well known treatment manual, called 'Seeking Safety' with the following slides. After that, there are three – optional (depending on the audience of this workshop) - slides that show a quite busy table on 'Integrated Treatment (IT) Control Group studies targeting Women' and one summary slide. This may be appropriate/of interest for a more research oriented audience and/or if you as the workshop facilitator would like to show this for a specific discussion or learning experience.

Example: Seeking Safety (slide)
Seeking Safety is an example for an integrated treatment program by Judith Herman, although there are several other IT (integrated treatment) programs that are based on similar or joint ideas. Seeking safety as a treatment has been evaluated in a number of studies. The intervention consists of 25 group or individual sessions that are administered twice weekly. The slides provide an overview and introduction into seeking safety, but for using it therapeutically, training is recommended. More information on seeking safety can be found on seekingsafety.org or other publications available on this program.

Show slides on 'Seeking Safety' and introduce the topic. Facilitate discussion along the way – there may be individuals in the workshop audience who have had training in seeking safety or utilized principles and techniques of this program in their work.

Seeking safety as a treatment program is based on five principles, two of them are shown in more detail with slides (as examples, but feel free to go over and discuss all principles if time allows and/ or the audience is interested and/or if you would like to have a specific teaching point here).

Seeking safety's underlying principles are: (1) Safety as the priority of treatment. (2)Integrated treatment.(3) A focus on ideals. (4) Four content areas: cognitive, behavioral, interpersonal, and case management. (5) Attention to clinician processes. Beside the principles, seeking safety include other features which are: simple, human language and themes (i.e., accessible language that avoids jargon); treatment methods based on educational strategies to increase learning; a focus on potential; emphasis on practical solutions; and an urgent approach to time. Seeking safety's principles are not only protecting the client/patient but also the therapist in the therapeutic process.

- Judith Herman also describes 'stages of healing' after recovering from (a) traumatizing event(s), being Stage 1: Safety, Stage 2: Mourning, and Stage 3: Reconnecting. Again, it is vital that SAFETY is the important underpinning in treating both trauma and substance use for both client/patient and therapist/ provider. 'Safety' as the concept in Seeking Safety includes discontinuing* substance abuse, decreasing suicidality, gaining control over extreme symptoms, stopping* harmful behaviors. (* discontinuing/ stopping of substance use and harmful behavior are at times not achievable, especially with individuals who have a severe substance use disorder – therefore it may stay a goal for some individuals, and 'decrease' of substance use or less risky behaviours may be the achievable first steps.)

You as the facilitator: Decide if you would like to end this section of the workshop with the discussion about 'Seeking Safety' or if you like to add the two slides with the (quite busy) table on 'IT (integrated treatment) Control Group studies targeting women' and the subsequent slide that summarizes the table. This depends of the groups learning objectives and how much research background you like to provide.

After the component on 'seeking safety' and integrated treatment programs, move on to the next topic of the workshop with is about 'TIP' – trauma informed practices (and

> **'Safety' as the concept in Seeking Safety, includes discontinuing* substance abuse, decreasing suicidality, gaining control over extreme symptoms, stopping* harmful behaviours.**

* discontinuing/stopping of substance use and harmful behavior are at times not achievable, especially with individuals who have a severe substance use disorder – therefore it may stay a goal for some individuals, and 'decrease' of substance use or less risky behaviours may be the achievable first steps.

TRAUMA INFORMED PRACTICES (TIP)

First there are slides on general Trauma-informed practices related to the intake process or 'first encounter' with a client who may or may not have had traumatizing events in his/her past – but it is assumed that everyone has the possibility to have traumatizing events in his/her history: These principles are based on recommendations of several British Columbia addictions and mental health providers focus groups who convened in 2011. Overarching ideas – not only but also for the trauma-informed intake – are to create safety for clients/patients and providers, to actively engage with the goal to establish a therapeutic and meaningful relationship, to leave room for disagreement (versus 'pressing for compliance'), to screen for present/imminent/acute concerns and symptoms, to normalize the client's/patient's experiences (if appropriate), to set boundaries with the goal to protect both client/patient and provider.

The following three slides are on TIP-principles 1) Emphasis on safety & trustworthiness, 2) Engagement of clients and avoiding re-traumatization, and 3) opportunity for choice, collaboration & connection. Each slide on principles 1, 2, and 3 is giving discussion points and examples. They should be used as 'conversation starters' with the workshop participants to facilitate a discussion. They also can be used – if the audience has only limited experience with TIP – as teaching points. All three slides that discuss TIP-principles also have a box with the invitation to the audience to 'please share your experiences' – as the interactive component is very important in this workshop, please use the slides to introduce the topic and thoughts about TIP and move on to a discussion with the workshop audience.

TIP Principle 1 – Emphasis on safety and trustworthiness

Trauma Survivors:

- Likely have experienced boundary violations and abuse of power
- Need to feel physical and emotionally safe
- May currently be in unsafe relationships

Safety and trustworthiness are established through:

- Welcoming intake procedures (such as the ones presented in the slide at the beginning this topic)
- Adapting the physical space (examples to follow on a slide, but please invite discussion)
- Providing clear information and predictable expectations about programming and services
- Ensuring informed consent (consent is seen a process not as a signature on a document)
- Creating crisis plans . . . (preparing for adversity and therefore normalizing it)

TIP Principle 2: Promote safety and trustworthiness by:

- Acknowledging and attending to immediate needs (therefore establish what is important 'now', in addition what may be important of the patient's/client's history)
- Being transparent, consistent & predictable
- Being clear about role and boundaries (to protect yourself and the client)
- Explaining confidentiality (including limits and why they are important)
- Obtaining informed consent (on an ongoing basis)
- Asking what works if feeling upset or anxious – how do they want you/program to support them if this happens?

TIP Principle 3: Opportunity for choice, collaboration and connection:

Create safe environments that foster a client's sense of efficacy, self-determination, dignity, and personal control.

Service providers are encouraged to:

- communicate openly (goes along with transparency and trustworthiness)
- equalize power imbalances (without crossing boundaries/limits set)
- allow the expression of feelings without fear of judgment
- provide choices as to treatment preferences, and
- work collaboratively

After presenting and discussing the TIP-principles, move on to discussing practical implications. Again, workshop participants' feedback, experiences and examples should be encouraged to facilitated discussion. These TIP-ideas cover some important areas, such as 'making contact with the client' or 'responding to trauma disclosure', but there are other areas that are not covered with slides here – workshop participants may bring up other areas where trauma-informed principles may be applicable.

> **"It is assumed that everyone has the possibility to have traumatizing events in his/her history.**

TIP-IDEAS on 'Making contact with the client':

Promote collaboration & choice by:

- Asking how would they like to be contacted
- Are they comfortable working with female/male?
- Asking if there is anything that might prevent their participation – work together to problem solve

Sample phrases:

- *"what is most important for you that we should start with?"*
- *"it is important to have your feedback every step of the way"*
- *"this may or may not work for you – you'll know best"*
- *"you can choose to pass on any question"*

TIP-IDEAS on 'Responding to Trauma disclosure':

- Acknowledge and express empathy: *"I appreciate your honesty"*
- Offer a larger context for the trauma - not alone
- Validate: *"I appreciate your courage to share"*
- Address time – being respectful of person's story and supporting containment: *"This is very important, we only have 10 minutes, so I wonder about dedicating time in next apt"*
- Offer hope: *"This will help with their care and healing"*
- Work together to create a self-care plan for after they leave: *"People respond differently to talking about upsetting memories, I encourage you to check-in with yourself and notice how you are feeling after you leave"*

Another slide with sample phrases is provided, how a provider COULD respond constructively to trauma disclosure and related statements. As always, this should be used as a discussion-starter and discussion should be encouraged to facilitated joint, collegial learning:

"I don't know why I respond like that...it's like I lose my mind."
Practitioner: "Given everything that you have described, it sounds like a pretty normal response to abnormal events."

"I feel like such a failure. Here I am back in the hospital again."
Practitioner: "No matter how bad things get, you don't give up. You know what you need to do to keep yourself safe."

"I don't know why I freak out like that when my partner is late. I hate myself afterwards."
Practitioner: "Based on what you have described, your childhood experiences of never knowing if your parents were going to follow through, it makes sense that it is important to you that people are reliable and dependable. You are doing the best you can, based on what you know, and trying to communicate this with others...(pause)... I wonder if you'd be interested in looking at some other options for how you might express this to your partner and others."

TIP-IDEAS to work with people who identify as Aboriginal, summarized by Menzies in 2012.

- Recognize diversity (learn about background, history, identity & culture)
- Provide opportunities for longer engagement process given history of oppressive policies
- Be prepared to offer clients a larger social context for problems – link to colonial history
- Partner with cultural helpers/cultural teachers
- Be open to [Aboriginal] traditional or complementary healing practices

TIP-IDEAS on trauma awareness:

- Acknowledge common, connections between substance use and trauma
- Recognize range of responses people can have (normalizing the range of responses)
- Recognize that because of trauma responses, developing trusting relationships can be difficult
- Disclosure of trauma is not required (client decides if he/she likes to do that)
- Recognize when someone is triggered or experiencing the effects of trauma & support

TIP-Ideas and Examples on Physical Environment:

If you are facilitating this workshop in a service providers physical environment, look around and positively reinforce the physical environment examples that are relating to TIP:

- Signage with welcoming messages and avoid rule based language; with "do not" messages
- Making waiting areas comfortable and inviting
- Lighting in outside spaces
- Accessibility and safety of washrooms
- In counseling rooms – choice about whether door is open or closed

TIP-Ideas in Counselling Work:

Maximize – as an ongoing (therapeutic) process:

- consistency
- follow through - if you say you will do something
- honesty and transparency

Consider:

- avoiding unnecessary disappointment
- whether people are fully informed of risks during consenting & have choice for partial consent or withholding consent

As the facilitator, summarize the discussion that evolved when presenting the slides. The last slide can help with the summary. It outlines that TIP can be seen as part of a shift and change how providers perceive, see and talk about people, e.g.: "What is wrong with her?" to "What happened to her?".

TIP can help change in language away from:

- Controlling
- Paranoid
- Manipulative
- Uncooperative
- Untreatable
- Masochistic
- Attention seeking
- Drug seeking
- Bad mother
- Not believable, etc. Towards a more helpful, constructive language.

Session 4

SESSION 4

- **Therapeutic strategies and techniques to cope with trauma related symptoms**
  - o Introduction of distress rating scale
  - o Breathing exercise- Example slide and group practice
  - o Progressive muscle relaxation - Example slide and group practice
- **Practice in small groups**
- **Discussion of experiences**

Note: Session 4 and onwards are focused on large and small group practice. The slides should be discussed to introduce practice but the mainstay of the session should be hands-on practice, feedback and sharing experiences of the participants!

INTRODUCTION

- Greeting
- Provide an overview of today's agenda

THERAPEUTIC STRATEGIES AND TECHNIQUES TO COPE WITH TRAUMA RELATED SYMPTOMS

Distress Scale

The Distress Scale (also: Subjective Unit of Distress Scale, SUDS) is a simple, easy to use scale for measuring your current level of psychological distress and discomfort. Zero represents no distress at all. Ten represents something that bothers you as bad as possible. The distress scale can be used before and after a relaxation exercise to measure its effectiveness.

If participants need further instruction for the rating:

Zero: Complete relaxation, no distress at all, feeling absolutely calm.

DISTRESS SCALE

One: Alert and awake, concentrating well.

Two: Alert, not quite fully calm.

Three: The amount of tension and stress needed to focus and keep your attention from wandering. This tension and stress is not experienced as unpleasant; no interference with performance.

Four: Mild distress such as mild feelings of bodily tension, mild worry, mild apprehension, mild fear, or mild anxiety. Somewhat unpleasant but easily tolerated.

Five: Mild to moderate distress. Distinctly unpleasant/uncomfortable, but insufficient to produce many bodily symptoms; you can continue to perform.

Six: Moderate distress. Unpleasant feelings of fear, anxiety, anger, worry, apprehension, and/or substantial bodily tension such as a headache or upset stomach. Distinctly unpleasant sensations that affect your attention; but you're still able to think clearly and do routine work.

Seven: Moderately high distress that makes concentration hard. Emotional pain and fairly intense bodily distress.

Eight: High distress. High levels of fear, anxiety, worry, apprehension, and/or bodily tension that are taking over your attention. These feelings cannot be tolerated very long. Thinking and problem-solving is impaired. Bodily distress and emotional discomfort are substantial. Ability to work, drive, converse, and so on is difficult.

Nine: High to extreme distress. Thinking is substantially impaired.

Ten: Extreme distress, panic-stricken, extreme bodily tension. The maximum amount of fear, anxiety, and/or apprehension you can possibly imagine.

Discuss and list (on flipchart) measures to manage acute distress, e.g.,

- Breathing techniques
- Relaxation exercise
- Sport
- Talk to a friend
- Go for a walk
- Have a hot tea, etc.
- Have a bath/shower
- Give yourself a foot-massage
- Etc. Facilitate a discussion

We will start practising bodily exercises first (e.g., breathing exercises and progressive muscle relaxation) before moving to the more cognitive (thought related) techniques. We would like to practice the first exercise with the entire group before splitting up in smaller groups.

When people are highly distressed or anxious, their breathing often becomes rapid and uneven, and their body often becomes very tense because they are in constant fight-or-flight mode. It is important that we learn to relax and breathe in a calming way, in order to relieve feelings of stress and anxiety. Rapid shallow breathing may produce

unpleasant physiological symptoms such as dizziness, light-headedness, tingling, etc. Breathing exercises aim at calming down and regulating our breathing. Progressive muscle relaxation involves a series of exercises where you first tense and then release various muscle groups in your body. The idea is that that people can calm their minds by relaxing their bodies.

Note: All the exercises can be found in the Appendix starting on page 49 of the manual for easier photocopying purposes

Breathing

When people are highly distressed or frightened, their breathing often becomes rapid and uneven. But rapid breathing increases our distress even more because it prepares our bodies for a fight-or-flight response and produces physical arousal. It is very important that we learn to relax and breathe in a calming way, especially when we are upset and distressed. I will now introduce you to a technique that can help you to produce a noticeable decrease in your distress and bring you back into a more balanced state.

The key to calming breathing is to take your breath from your abdomen, not from the chest. When you inhale, take a normal breath, at your own pace, not a deep breath. Exhale it slowly.

Short Breathing Exercise

- Make sure that you sit comfortably in your chair.
- Breathe in evenly through your nose - one – two – three – four (4 seconds).
- Hold the breath.
- And exhale slowly through your mouth - one – two – three – four (4 seconds).
- And pause slightly before breathing in again.
- Continue to breathe in evenly through your nose (one – two – three – four), hold the breath, and breathe out slowly through your mouth (one – two – three – four).
- Exhale all of your tension and anxiety. Relax your entire body as you exhale.
- Whatever feelings, sensations, images, thoughts, or memories arise, pleasant or unpleasant, gently acknowledge them, and let them go. (...) Allow them to come and go, and keep your attention on your breath. (...).
- So inhale evenly - one – two – three – four (4 seconds).
- ... hold ...
- And exhale slowly - one – two – three – four (4 seconds).
- And pause slightly before breathing in again.

Practice the breathing exercise every day, and use it whenever you feel distressed, or at night before you go to sleep.

Breathing Exercise

- Find a comfortable position in your chair with as much support as you need. And close your eyes if you like.
- Breathe in evenly through your nose. Gently rest your hands on your stomach, and notice how the stomach rises as you inhale. Hold the breath for 2 seconds.
- Exhale slowly through your mouth, until your lungs are empty. Notice how the stomach drops as you exhale. And pause slightly before breathing in again.
- Continue to breathe in evenly through your nose, hold the breath for 2 seconds, and breathe out slowly through your mouth.
- And you may find it helpful to associate your breathing with a word that has a calming effect on you.
- So inhale evenly ... hold ...
- And exhale slowly and say to yourself silently "... calm and relaxed."
- Exhale all of your tension and anxiety. Relax your entire body as you exhale.
- And pause slightly before breathing in again.
- Inhale evenly ... hold ...
- And exhale slowly "... calm and relaxed."
- Imagine the muscles of your body becoming more and more relaxed with each breath you take.
- Whatever feelings, sensations, images, thoughts, or memories arise, pleasant or unpleasant, gently acknowledge them, and let them go. (...) Allow them to come and go, and keep your attention on your breath. (...).
- Inhale evenly ... hold
- Exhale slowly "... calm and relaxed."
- Exhale all of your tension and anxiety. Relax your entire body as you exhale. And pause slightly before breathing in again (...)
- And every time your attention gets caught up in your thoughts, gently acknowledge it, and return your attention to your breath. (...)
- Inhale evenly ... hold
- Exhale slowly "... calm and relaxed."

Practice the breathing exercise every day, and use it whenever you feel distressed, or at night before you go to sleep.

> **"It is very important that we learn to relax and breathe in a calming way, especially when we are upset and distressed.**

Progressive muscle relaxation

When people are highly distressed or anxious, their body often becomes very tense because they are in constant fight-or-flight mode. It is important that we learn to relax, in order to relieve feelings of stress and anxiety. I will now introduce you to a technique named progressive muscle relaxation that will help you to achieve a state of relaxation. The idea is that people can calm their minds by relaxing their bodies. To attain this goal, progressive muscle relaxation involves a series of exercises where you first tense and then release various muscle groups in your body. During the exercise, I will ask you to tense each muscle group tightly and hold the tension for about 5 seconds. Note that the tension should be tight but not painful. I will then ask you to release the tension and focus your awareness on the relaxation for about 10 seconds, before progressing to the next muscle group. We will begin with the hands and works our way down to the feet.

- So find a comfortable position in your chair with as much support as you need. And close your eyes if you like.
- Take some time to focus on your breathing, noticing your abdomen rise and fall with each breath (...). Breathe in evenly through your nose, notice how your abdomen rises as you inhale, and hold the breath for 2 seconds.
- Exhale slowly through your mouth, until your lungs are empty. Notice how your abdomen drops as you exhale. And pause slightly before breathing in again.
- And imagine how, with each exhalation, the tension is flowing off your body.
- And as your breathing becomes more restful, turn your attention to your right hand. Clench your right hand into a tight fist; feel the tension in the muscles of your hand and lower right arm. Hold it (5 seconds). And then release the tension (5 seconds). Let your hand and fingers relax, and experience the transition from tension to relaxation in these muscles (5 seconds).
- Make a fist with your right hand again, raise it towards your shoulders, and tighten your biceps as if you are lifting weights. Feel how the muscles contract, and experience the tension. Hold it (5 seconds). Then release the tension (5 seconds), and notice the difference between the tension and relaxation (5 seconds).
- Now clench your left hand into a tight fist; feel the tension in the muscles of your hand and lower left arm. Hold it (5 seconds). And then release the tension (5 seconds). Let your hand and fingers relax and experience the transition from tension to relaxation (5 seconds).
- Make a fist with your left hand again, raise it towards your shoulders, and tighten your biceps. Feel how the muscles contract and experience the tension. Hold it (5 seconds). Then release the tension (5 seconds), and notice the difference between the tension and relaxation, as you continue to breathe evenly and calmly (5 seconds).
- Now turn your attention to your face. Raise your eyebrows as high as you can; feel the tension in your forehead and hold it (5 seconds). Then release it (5 seconds). Notice the transition from tension to relaxation, and how your forehead muscles become smooth and soft as you relax (5 seconds).
- Close your eyes tightly, and at the same time bring every part of your face toward your nose and hold it there (5 seconds). Feel the tension in your face. Then release it, and experience the relaxation (5 seconds). There is no tension around your eyes, your eyelids are gently closed, and your face is still, as you continue to breathe (5 seconds).
- Now clench your jaw and bite your teeth together. Hold it (5 seconds), and release (5 seconds). Feel how your jaw is completely loose, your lips are slightly parted, your cheeks are deeply relaxed, your eyelids become heavy, your forehead and scalp are smooth and soft (...), and enjoy the peace and calmness that arise from relaxing the muscles in your body (5 seconds).
- Continue to breathe in and out freely and evenly, letting go of all the tension (5 seconds).
- Now direct your attention to your neck. Bring your head forward, pressing your chin against your chest and at the same time working against it. Focus on the tension in your neck muscles. Hold it (5 seconds) and release (5 seconds). Relax, and let your head return to a balanced and comfortable position (5 seconds).
- Now tighten your shoulders by rising then up as far as you can. Feel the tension in your shoulders. Hold it (5 seconds). Then release (5 seconds), and notice

> **When people are highly distressed, their body often becomes very tense because they are in constant fight-or-flight mode. It is important that we learn to relax, in order to relieve feelings of stress and anxiety.**

the difference between the tension and relaxation. Feel the relaxation spreading through your shoulders and neck. Let it spread into your arms and hands and down to your fingertips, and feel how your body and mind becomes more and more relaxed (5 seconds).

- Now turn your attention to your chest. Take a deep breath in, hold the breath for 5 seconds, and feel the tension in your chest (5 seconds). Exhale slowly, until your lungs are empty (5 seconds). Notice how your chest relaxes as you exhale (5 seconds). Repeat the deep inhalation and feel the tension in your chest as you hold your breath (5 seconds), and enjoy the relaxation as you slowly exhale (5 seconds). Now, just observe your breath and the air streaming in and out, and how, with each inhalation, you breathe in calmness, and with each exhalation, the tension is flowing off your body (5 seconds).
- Now direct your attention to your abdomen. Tighten all your abdominal muscles, and focus on the tension in these muscles. Hold it (5 seconds). And then release the tension (5 seconds), and notice the difference between the tension and relaxation, while you continue to breathe evenly and calmly (5 seconds).
- Tighten your lower back by arching it up. Hold it, and study the sensation of tension (5 seconds). Release (5 seconds), and notice the difference between the tension and relaxation (5 seconds).
- Tighten your buttocks and thighs, hold it, and focus on the sensation of tension (5 seconds). Release (5 seconds), and notice the difference between the tension and relaxation (5 seconds).
- Press your heels firmly into the ground, curl your toes toward your face and tense the muscles of your calves. Feel the tension in your feet and lower legs and hold it (5 seconds). Release (5 seconds), and enjoy the difference between tension and relaxation (5 seconds).
- Take some time again to focus on your breathing, just noticing how your abdomen evenly rises and falls with each breath (...). Notice your abdomen rise and fall, and enjoy the pleasant sense of relaxation. Feel all of your muscles be loose and heavy, relaxing further and further as you feel the relaxation spreading through your body. Let the relaxation proceed on its own.
- I will now count backwards from 5 to 1. And when I get to one, you may come back into this room, relaxed and refreshed. 5 – 4 – 3 – 2 – 1.
- And now open your eyes, move your hands, arms, legs, and feet, rotate your head, and stretch a bit.

This is a technique that, with regular practice, will enable you to relax your entire body within a few minutes. And with each cycle, you will notice it becomes easier and easier to relax. So find a quiet place to practice this technique every day, and use it whenever you feel distressed, or at night before you go to sleep.

Ask them to rate their distress again (SUDS)

Feedback round

Session 5

SESSION 5

- **Therapeutic strategies and techniques to cope with trauma related symptoms**
  - o Grounding
  - o Safe Space
  - o 'Trauma Box'
- **Practice in small groups**
  - o Discussion of experiences

INTRODUCTION

- Greeting
- Provide an overview of today's agenda

THERAPEUTIC STRATEGIES AND TECHNIQUES TO COPE WITH TRAUMA RELATED SYMPTOMS

Grounding

Grounding as a distress coping strategies to focus the attention on the present moment.

Background information for the facilitator (does not have to be presented in detail to group):

Grounding is a tool to cope with negative emotions and emotional distress. It consists of an active effort to focus attention on external stimuli with a shift away from internal stimuli. The focus during grounding is connecting to the world around us in the present moment and distracting oneself to detach from intense emotional pain. It differs from relaxation in that eyes are kept open. It differs from dissociation in that it is an *active* and *intentional* strategy. The goal is to detach oneself from emotional pain and hence reduce it to a manageable level.

The session will be centered on an experiential grounding exercise, followed by discussion about it. The goal is to help you identify which methods of grounding work best for you, in which situations to apply grounding, and address your concerns about grounding. Think about audiotaping the safe space practice, so you can use it on your own later on, to assist you in doing grounding.

➔ Use three general 'GROUNDING' Slides to introduce the topic to the group and for definition of and rationale for grounding.

Divide group into small groups of three (instructor, 'client'/recipient, and observer) and hand out worksheet with examples of a variety of grounding exercises. Also encourage participants to experiment with other examples they may know. Use 'GROUNDING: PRACTICE' slide and handout 'grounding practice' from this manual or other examples you have available.

Handout Grounding (copy and paste this text and make a handout for participants)
Grounding is a distress coping strategy to focus the attention on the present moment

Examples for physical grounding

- Press your feet on the floor. Notice how they connect you firmly to the ground.
- Push your legs up. Notice how your muscles tense ... and let them relax again.
- Tighten your fists and flex your arms. Feel the tension.
- Hold on to your chair. Feel everywhere your body touches it. Feel what material it's made of, how hard or soft it feels. How smooth or rough the surface feels.
- Pick up an object around you and touch is with both of your hands – feel it. How heavy or light, how cold or warm, how big or tiny it feels in your hands.
- Pick up an ice cube. Feel how cold it is, how it melts.
- Run water over your hands, feel the water pressure, notice the temperature.

Examples for mental grounding

- Use a safety statement, e.g.;

  'My name is _____. I am safe right now. Today is _____ and it is _____ o'clock. I am at/ in_____). I am in the present moment, neither in the future or the past.'
- Notice and describe the things around you. Notice and describe how many there are, what colors or shapes do you see, what are they made of, etc.) You can do this with objects, images, the weather outside. Try to describe every detail as if you're seeing this object for the first time in your life.
- Play a category game. Try to think of types of animals, sports, cars or plants. Try to make a list in your head of all the words that start with the letter 'H'
- Count numbers or the alphabet v..e..r..y.. s..l..o..w..l..y..
- Spell words backwards

After the grounding exercise, use 'GROUNDING – FEEDBACK' slide and encourage and facilitate group discussion and feedback around grounding in general, participants' previous experiences with grounding in their work and also about the grounding exercise just done

The following questions will help facilitating the feedback discussion:

- Questions or concerns about grounding?
- What works best for you?
- What would you change?
- In which specific situations could this tool be handy for yourself/with clients?
- How could you become better at grounding? How could you help clients use this technique more frequently and successfully?

Wrap up grounding exercise by summarizing the feedback provided by the group.

Safe Space

Safe Space is a technique that can help clients to cope with their negative emotions by creating and imagining an internal safe and secure place.

Use the general SELF SPACE slide to introduce the topic. Safe space is a self-soothing skill that helps clients regulate their emotions 'travelling' to an internal safe space. Remind the group that safe space skills need practice (more than grounding) by both the client and the therapist/provider and may not be useful when the client is an acute, distressing situation without previous practice. Also remind participants, that safe space as a technique should be used with caution with clients who have a tendency to dissociate or detach from reality with physical and emotional experiences.

Use SAFE SPACE – PRACTICE slide to introduce the two practice sessions. If you are running out of time, consider skipping practice #2 (small group safe space).

One facilitator reads a safe place text to the group and group members are encouraged to participate in the exercise. As a second practicing step, group can be split into small groups of 2 or 3 people, practicing another safe place example, one person reading out the text, another person being the 'client', a third person (if small groups of 3) being the observer.

> **The focus during grounding is connecting to the world around us in the present moment.**

pages, you will find the text for Safe Space practices, which can be copied and distributed to the group as handouts.

The text for grounding exercise #2 is generously shared by the group *Integrative Medicine for the Underserved - A Collective of Health Care Providers and Educators*

Safe Place #1
To go to your safe place, lie down and make yourself totally comfortable. Close your eyes....or leave them open, whatever your prefer. In your mind, walk slowly to a quiet place...Your place can be inside or outside.... It needs to be peaceful and safe.... Picture yourself unloading your anxieties, your worries...Notice the view in the distance.... What do you smell?.... What do you hear? Notice what is before you.... Reach out and

touch it.... How does it feel? Smell it.... Hear it.... Make the temperature comfortable.... Be safe here.... Look around for a special spot, a private spot.... Find the path to this place.... Feel the ground with your feet.... Look above you.... What do you see?.... Hear?....Smell?.... Walk down this path until you can enter your own quiet, comfortable, safe place. You have arrived at your special place.... What is under your feet?.... How does it feel?.... Take several steps.... What do you see above you? What do you hear? Do you hear something else? Reach and touch something.... What is its texture? Are there pens, paper, paints nearby, or is there sand to draw in, clay to work? Go to them, handle them, smell them. These are your special tools, or tools for your inner guide to reveal ideas or feelings to you.... Look as far as you can see.... What do you see? What do you hear? What aromas do you notice? Sit or lie in your special place.... Notice the smells, sounds, sights.... This is your place and nothing can harm you here.... If danger is here, expel it.... Spend three to five minutes realizing you are relaxed, safe and comfortable.

Memorize this place's smells, tastes, sights, sounds.... You can come back and relax here whenever you want.... Leave by the same path or entrance.... Notice the ground, touch things near you.... Look far away and appreciate the view.... Remind yourself this special place you created can be entered whenever you wish. Say an affirmation such as "I can relax here" or "This is my special place. I can come here whenever I wish."

Safe Place #2

Sit comfortably, with your back and neck completely supported. Allow the floor, or chair, or whatever you are sitting on to hold you. Let tension melt away as you bring your attention to your breath. With each breath in . . . feel your diaphragm moving down toward your feet. . . and your lower abdomen beginning to expand. . . With each breath out. . .as your abdomen relaxes. . . feel the muscles in your neck and shoulders drifting down with gravity. . . and relaxing even more deeply. . .

Take a mental journey now, through your body, beginning at the bottom of your feet. Tighten the muscles of your feet, your toes, then let them relax and release the day's tension. . . Next tighten your calves and thighs, then loosen them. Move your attention slowly to the top of your head in this way, letting go of any tightness or restriction you find. (Pause about one minute.)

Your mind has just moved through your body, connecting with it, giving it attention, soothing the tense, tired places. Now let your mind move to a still point, a place of pure peace and calm. In your imagination, think of a place that is safe and comfortable . . . a place where you can retreat and care for yourself . . . a place where you can go to replenish your body and spirit . . . a place that is absolutely your own, secure and private. The place that you choose will be uniquely yours . . . It can be a place you have been to before, or somewhere you would like to find . . . It may be a beautiful outdoor scene . . . a beach, a meadow, an ancient forest. . . or it may be a special room. . . a childhood bedroom, a music room, a chapel. . . it may be a bubble in the clouds. You may decorate this place any way you wish. Imagine it with all your senses, smelling the fragrance of flowers, incense, or the ocean breeze . . . Feel the texture of the surface under your feet and against the skin of your hands, your arms . . . Hear all the sounds of this place . . . birds singing, wind blowing, waves on the beach or beautiful classical music or jazz. See the colors and shapes as you turn full circle to get a complete view. Let this place be a safe and nurturing hideaway, full of color, music. All the things that you need to feel sheltered and cared for.

Find a place to sit, on an old hollowed-out log or a rock that feels as if it were contoured just for you, in a billowy cloud-chair, or whatever fits in your special place. Make yourself very comfortable. For in this place of safety, only you are allowed. In this place of safety, no one can come without your invitation. In this place of safety, you are always at peace.... Allow the images to come.... Notice the color of the sky at your favourite time of day. And in this place, at this most perfect time of day, at the season and the temperature that you like on your skin, allow your senses to become more and more alive. Look around at the surroundings and allow yourself to see; if not with your eyes, then sense with your heart.... Each time you come to your safe place, you may develop it and allow it to become more and more beautiful. Allow yourself to see, feel and hear what is here today.... Let yourself bask in the safety and the peace....

Allow yourself to walk around, to be in this place, to notice more and more, to create more and more in this place.... Perhaps you would like to build a shelter of some kind, a cottage, a cave, a tent, a tree house. And if it's already there, you may add to it.... Plant flowers, adding a splash of color. Add special places or rooms to your safe place.... Create special places for special kinds of feelings that need to be healed, special places to wash away fear and pain.... Create a waterfall or a pool of healing water. Stand under the waterfall to wash away the fear.... Let the healing waters wash away what you'd like to be finished with. Each time you come to the waterfall or the healing pool of water, you can wash away more and more of the past.... Each time you come, you are cleansed and rejuvenated, shame is washed away. Wash away the pain. Wash all of it away, as you are ready. [Long pause.] When you are finished, step out of the water and you will find a robe or a towel to dry and warm yourself.

Now allow yourself to continue walking around your safe place.... You find a place for a healing garden, a place that is just for your healing. You can plant anything you would like.... You can plant wishes and dreams for the future. You can plant seeds of your healing. And you can weed out what you want to be finished with. Take some time to work with your garden now. [Long pause.]

And now, find your favorite place in all of safety. Walk around until you find just the right place. [Long pause.] Sit down, and get comfortable.... Breathe in the safety and the peace. Breathe out the fear.... Breathe in the safety and peace. Breathe out the fear.... Breathe in the safety and peace. Breathe out the fear.... And just be in this place as you breathe and heal.... Stay in this

place as long as you would like.... And when you are ready, simply count yourself out by counting from one to five. When you reach the number five, your eyes will open. And you will be awake and alert, and feeling safe and at peace. One ... two... three... take a deep breath ... four.... and five.

➔ AFTER the Safe Place practice: Make sure to leave time for feedback and discussion on grounding in general, participants' experiences in their work with clients as well as feedback about the practice of 'safe place' you just did.

The following questions may help you to facilitate the discussion:

- How easy/ difficult did you find the exercises?
- What was helpful (not helpful)?
- What happened to your body?
- What happened to your thoughts?
- What happened to your feelings?
- Any other observations or comments?
- What to do if a person cannot imagine a safe space?
- What other techniques do you already use to help clients cope with distressing thoughts and emotions?
- Are there any techniques you use to obtain control over things that seem uncontrollable (e.g. flashback, nightmares)?

Wrap up by summarizing some key learnings the group brought forward in the discussion/feedback round
Handouts for the Safe Space and grounding exercises will be provided as well as tangible materials that clients can take home (e.g., stress balls, candles, gemstones etc.).

Trauma Box

➔ Use slide TRAUMA BOX to briefly introduce Trauma Box as one example of 'other techniques' to obtain control over things that your participants' clients perceive as uncontrollable. In the feedback round after 'safe space practice' your workshop participants may ask how to work with clients who are presenting with myriad traumatic experiences, which cannot be dealt with right away or in the very near future. In this case, it may be specifically helpful to spend a bit more time with the topic 'trauma box' as one (out of many) examples how to 'contain' traumatic experiences, distressing memories and thoughts in an either imaginary or real box to store distressing memories and thoughts, until the person feels ready to 'open' it together with the therapist/provider.

➔ There is only one slide for trauma box, but feel free to open another discussion round in the group, if the participants would like to explore the topic of 'containment of traumatic thoughts/feelings' more
Wrap up today's workshop by summarizing key learnings of today and also by providing a short overview on the upcoming session.

Session 6

SESSION 6

- **Sleep and nightmares**
  - o The relationship between sleep, substance use, and trauma
  - o Nightmares in the context of PTSD
  - o Treatment of PTSD related nightmares

INTRODUCTION

- Greeting
- Provide an overview of today's agenda

SLEEP AND NIGHTMARES

What is the association of substance use, trauma, and sleep problems?

- Substance use/withdrawal may result in sleep problems (including nightmares)
- Sleep problems increase the risk for subsequent alcohol and drug use disorder
- Trauma exposure and PTSD may result in sleep problems.
- Sleep problems in individuals with PTSD are associated with drinking alcohol.
- Sleep problems may interfere with recovery from PTSD

The majority of individuals with PTSD report nightmares. Nightmares are considered to be a component of the intrusive/re-experiencing symptom cluster. Even when PTSD resolves, PTSD-associated nightmares sometimes persist. Multiple processes are proposed to explain the ways in which nightmares can interfere with natural recovery from trauma exposure, contribute to the development of PTSD, and compromise response to evidence-based

PTSD treatments. Some of these include neurobiological alterations, compromised generalization of fear extinction, disruption of sleep-dependent processing of emotional experiences, and repeated resensitization to trauma cues during nightmares.

Treating sleep disruption in PTSD is important because nightmares and insomnia are associated with significant distress and daytime impairment. Trauma-related nightmares can impair the quality of life, resulting in sleep avoidance and sleep deprivation, which in turn increase in the intensity of the nightmares. Nightmare disorder can result in insomnia, daytime sleepiness, and fatigue, and development or exacerbation of psychiatric distress and symptoms such as depression and anxiety. It may increase reactivity to emotional cues and impair a person's social and

occupational functioning. Furthermore, sleep impairment is associated with negative psychiatric outcomes, including increased suicidal ideation, while sleep fragmentation and deprivation are correlated with neuro-cognitive deficits and neuroendocrine abnormalities. Thus, effectively addressing the nighttime PTSD symptom profile may contribute to improved functional outcomes and overall well-being. However, first line psychological and pharmacological interventions for PTSD frequently fail to fully treat insomnia and nightmares.

➔ Show slide on best practices for treating PTSD related nightmares.

Imaginal Rehearsal Therapy – [overview given for participants information only, this will not be practiced. You may choose to abbreviate this, as it is not part of the main learning objectives of this workshop, but participants may be interested in learning about it].

Imaginal Rehearsal Therapy (IRT) is a modified CBT technique that utilizes recalling the nightmare, writing it down, changing the theme, story line, ending, or any part of the dream to a more positive one, and rehearsing the rewritten dream scenario so that the client can displace the unwanted content when the dream recurs. IRT acts to inhibit the original nightmare, providing a cognitive shift that empirically refutes the original premise of the nightmare. This technique is practiced for 10-20 minutes per day while awake. Participants are instructed to change a nightmare they had had in any way they want, and to rehearse one or two new dream scenarios during the daytime, at least three times per day, for a minimum duration of 5 min. Participants are also instructed to implement the new sleep schedules and behaviors for the following 6 weeks.

Treatment assumptions that are discussed with the patients:

1. nightmares which were caused by traumatic events may have beneficial purposes (e.g., providing information and emotional processing);
2. persisting nightmares do no longer serve useful purposes and are considered as a sleep disorder and are habit-sustained;
3. working with waking imagery can successfully affect nightmares, because the contents of dreams (and nightmares) are related to events and issues that happened during the day;
4. thus, the content of nightmares can be modified to include new images and a positive ending;

Instructions:

1. Select a single nightmare.
2. Write down your disturbing dream.
3. Change the nightmare anyway you wish and write down the changed dream.
4. Use imagery to rehearse your "new dream" scenario for 10 to 15 minutes.
5. Briefly describe your old nightmare and how you changed it.
6. What are the issues/problems/difficulties that emerged?

7. Rehearse a 'new' [re-scripted, more positive/constructive] dream for at least 5 to 20 minutes per day.
8. Do not work on more than two "new dreams" per week.

Descriptions of traumatic experiences and traumatic content of nightmares are discouraged throughout the program to minimize direct exposure. To facilitate this, participants are instructed to select a nightmare of low intensity for their first practice, and, if possible, one that is not a "replay" or a "reenactment" of a trauma.

Sleep hygiene

➔ Present as a blank slide and complete it during the session by asking the group about do's and don'ts for healthy sleep behaviours vs. unhelpful sleep behaviours.

Do:

1. Go to bed at the same time each day.
2. Get up from bed at the same time each day.
3. Get regular exercise each day, preferably in the morning. There is good evidence that regular exercise improves restful sleep. This includes stretching and aerobic exercise.
4. Get regular exposure to outdoor or bright lights, especially in the late afternoon.
5. Keep the temperature in your bedroom comfortable.
6. Keep the bedroom quiet when sleeping.
7. Keep the bedroom dark enough to facilitate sleep.
8. Use your bed only for sleep and sex.
9. Take medications as directed. It is helpful to take prescribed sleeping pills 1 hour before bedtime, so they are causing drowsiness when you lie down, or 10 hours before getting up, to avoid daytime drowsiness.
10. Use a relaxation exercise just before going to sleep. Muscle relaxation, imagery, massage, warm bath, etc.
11. Keep your feet and hands warm. Wear warm socks and/or mittens or gloves to bed.

Don't:

1. Engage in stimulating activity just before bed, such as playing a competitive game, watching an exciting program on television or movie, or having an important discussion with a loved one.
2. Have caffeine in the evening (coffee, many teas, chocolate, sodas, etc.) .
3. Read or watch television in bed.
4. Use alcohol to help you sleep.
5. Go to bed too hungry or too full.
6. Take another person's sleeping pills.
7. Take over-the-counter sleeping pills, without your doctor's knowledge. Tolerance can develop rapidly with these medications. Diphenhydramine (an ingredient commonly found in over-the-counter sleep meds) can have serious side e ffects for elderly patients.
8. Take daytime naps.
9. Command yourself to go to sleep. This only makes your mind and body more alert.

Session 7

SESSION 7

- **Parenting issues**
- **Feedback, and wrap-up**

Note: Today's focus is feedback, reflection and wrap up. Make sure to leave plenty of time to debrief and allow also for informal discussion, feedback and wrap up. For the first half or today's session – as a last workshop topic - 'Parenting issues' should be introduced briefly. Then – if possible – the video is watched (duration 20 minutes), followed by a discussion involving participants feedback on the video, on the topic (parents with trauma histories) and their experiences in working with parents who experienced traumatization.

INTRODUCTION

- Greeting
- Provide an overview of today's agenda:
  1) Parenting Issues
  2) Feedback & Wrap up (Leave enough time!)

Parenting Issues, including Transgenerational trauma.

Discussion about how trauma is passed down from one generation to another; parenting issues; ameliorating the effects of transgenerational trauma.

Show video: 20 minutes – video available on website until September 2099. http://ww3.tvo.org/video/192655/marla-sokolowski-biology-childhood-hardship

Discussion Background - Impact of trauma on children

"Infants and toddlers who witness either violence in their homes or a violent incident in their community show increased irritability, immature behavior, sleep disturbances, emotional distress and crying, fears of being alone, physical complaints, and loss of skills, such as regression in toileting and language. "

What is less well understood is the impact of trauma on a woman's capacity to mother. For many of these women, mothering means struggling to parent your child while at the same time struggling to recover. A history of past trauma can affect how a woman experiences parenting and how effective she is as a parent. There are several major parenting issues for trauma survivors that are often discussed. Introduce them – e.g. with the slide provided – and facilitate discussion around these statements including participants's experiences:

- Feelings of shame, guilt, and inadequacy can interfere with parenting.
- Interaction with a child can trigger a mother's traumatic past.
- The mothers are at risk of becoming overprotective of their children.
- At the other extreme, they may be seen as neglectful in order to avoid being "triggered" (reminded of their own childhood trauma)by interacting with their children.
- Mothers with substance use issues may have been inadequately nurtured themselves.

Addiction programs for women who have children should include education in parenting and child development and interventions that address relationships with and re unification with their children.

Facilitate discussion after watching the video, encouraging workshop participants to share examples they have came across when working with their clients/patients. Summarize discussion and announce that workshop contents are finalized. More on to...

Feedback round, which should include time for informal and formal feedback, opportunity to debrief. Encourage participants to provide constructive feedback and ideas how to improve this workshops.

Thank you.

"What is less understood is the impact of trauma on a woman's capacity to mother. For many of these women, mothering means struggling to parent your child while at the same time struggling to recover.

D. References

1. Buxton J, Mehrabadi A, Preston E, Tu A. Vancouver Drug use Epidemiology. Vancouver site report for the Canadian Community Epidemiology Network on Drug Use (CCENDU) [Internet]. Vancouver, BC: Canadian Community Epidemiology Network on Drug Use (CCENDU); 2007. Available from: http://www.ccsa.ca/2007%20CCSA%20Documents/CCENDU-Vancouver-highlights-2007-e.pdf

2. City of Vancouver. 2005/2006 Downtown Eastside community monitoring report, 10th edition [Internet]. Vancouver, BC: City of Vancouver; 2006. Available from: vancouver.ca/commsvcs/planning/dtes/pdf/2006mr.pdf

3. Spittal PM, Hogg RS, Li K, Craib KJ, Recsky M, Johnston C, et al. Drastic elevations in mortality among female injection drug users in a Canadian setting. AIDS Care. 2006 Feb;18(2):101–8.

4. Duff P, Shoveller J, Zhang R, Alexson D, Montaner JS, Shannon K. High Lifetime Pregnancy and Low Contraceptive Usage Among Sex Workers Who Use Drugs- An Unmet Reproductive Health Need. BMC Preg Child Birth. 2011 Aug 18;11(1):61.

5. Weber AE, Tyndall MW, Spittal PM, Li K, Coulter S, O'Shaughnessy MV, et al. High pregnancy rates and reproductive health indicators among female injection-drug users in Vancouver, Canada. Eur J Contracept Reprod Health Care. 2003 Mar;8(1):52–8.

6. Shannon K, Kerr T, Strathdee SA, Shoveller J, Montaner JS, Tyndall MW. Prevalence and structural correlates of gender based violence among a prospective cohort of female sex workers. BMJ. 2009;339:b2939.

7. Torchalla I, Strehlau V, Li K, Linden IA, Noel F, Krausz M. Posttraumatic stress disorder and substance use disorder comorbidity in homeless adults: prevalence, correlates, and sex differences. Psychol Addict Behav. 2013 epub ahead of print;

8. Brown PJ, Stout RL, Mueller T. Substance Use Disorder and Posttraumatic Stress Disorder Comorbidity: Addiction and Psychiatric Treatment Rates. Psychol Addict Behav. 1999 Jun;13(2):115–22.

9. Reynolds M, Mezey G, Chapman M, Wheeler M, Drummond C, Baldacchino A. Co-morbid post-traumatic stress disorder in a substance misusing clinical population. Drug Alcohol Depend. 2005 Mar 7;77(3):251–8.

10. Najavits LM, Gastfriend DR, Barber JP, Reif S, Muenz LR, Blaine J, et al. Cocaine dependence with and without PTSD among subjects in the National Institute on Drug Abuse Collaborative Cocaine Treatment Study. Am J Psychiatry. 1998 Feb;155(2):214–9.

11. Braitstein P, Li K, Tyndall M, Spittal P, O'Shaughnessy M, Schilder A, et al. Sexual violence among a cohort of injection drug users. Soc Sci Med. 2003 Aug;57(3):561–9.

12. Driessen M, Schulte S, Luedecke C, Schaefer I, Sutmann F, Ohlmeier M, et al. Trauma and PTSD in patients with alcohol, drug, or dual dependence: a multi-center study. Alcohol Clin Exp Res. 2008 Mar;32(3):481–8.

13. Brady KT, Killeen T, Saladin ME, Dansky B, Becker S. Comorbid Substance Abuse and Posttraumatic Stress Disorder. Am J Addict. 1994 Apr;3(2):160–4.

14. Linden IA, Mar MY, Werker GR, Jang K, Krausz M. Research on a vulnerable neighborhood - the Vancouver Downtown Eastside from 2001 to 2011. J Urban Health. 2013 Jun;90(3):559–73.

15. MacPherson D, Mulla Z, Richardson L. The evolution of drug policy in Vancouver, Canada: Strategies for preventing harm from psychoactive substance use. Int J Drug Policy. 2006 Mar;17(2):127–32.

16. Dansky BS, Brady KT, Saladin ME, Killeen T, Becker S, Roitzsch J. Victimization and PTSD in individuals with substance use disorders: gender and racial differences. Am J Drug Alcohol Abuse. 1996 Feb;22(1):75–93.

17. Ouimette PC, Kimerling R, Shaw J, Moos R. Physical and Sexual Abuse Among Women and Men with Substance Use Disorders. Alcoholism Treatment Quart. 2000 Nov;18(3):7–17.

18. Tolin DF, Foa EB. Sex differences in trauma and posttraumatic stress disorder: A quantitative review of 25 years of research. Psychol Bull. 2006;132(6):959–92.

19. Marcenko MO, Kemp SP, Larson NC. Childhood experiences of abuse, later substance use, and parenting outcomes among low-income mothers. Am J Orthopsychiatry. 2000;70(3):316–26.

20. DiLillo D, Damashek A. Parenting characteristics of women reporting a history of childhood sexual abuse. Child Maltreat. 2003 Nov;8(4):319–33.

21. Banyard VL, Williams LM, Siegel JA. The impact of complex trauma and depression on parenting: an exploration of mediating risk and protective factors. Child Maltreat. 2003 Nov;8(4):334–49.

22. DiLillo D, Tremblay GC, Peterson L. Linking childhood sexual abuse and abusive parenting: the mediating role of maternal anger. Child Abuse Negl. 2000 Jun;24(6):767–79.

23. Linden IA, Torchalla I, Krausz M. Addiction in maternity: prevalence of mental illness, substance use, and trauma in a vulnerable urban population. J Aggression Maltreat Trauma. 2013;22(10):1070–84.

24. Torchalla I, Linden IA, Strehlau V, Neilson E, Krausz M. "Like a lots happened with my whole childhood": Trauma and addiction in pregnant and postpartum women from Vancouver's Downtown Eastside. Journal of Health Care for the Poor and Underserved. under review;

25. Sledjeski EM, Speisman B, Dierker LC. Does number of lifetime traumas explain the relationship between PTSD and chronic medical conditions? Answers from the National Comorbidity Survey-Replication (NCS-R). J Behav Med. 2008 Aug;31(4):341–9.

26. Van Ameringen M, Mancini C, Patterson B, Boyle MH. Post-traumatic stress disorder in Canada. CNS Neurosci Ther. 2008;14(3):171–81.

27. Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005 Jun;62(6):617–27.

28. Back SE, Dansky BS, Coffey SF, Saladin ME, Sonne S, Brady KT. Cocaine dependence with and without post-traumatic stress disorder: a comparison of substance use, trauma history and psychiatric comorbidity. Am J Addict. 2000;9(1):51–62.

29. Clark HW, Masson CL, Delucchi KL, Hall SM, Sees KL. Violent traumatic events and drug abuse severity. J Subst Abuse Treat. 2001 Mar;20(2):121–7.

30. Stewart SH, Conrod PJ. Psychosocial models of functional associations between posttraumatic stress disorder and substance use disorder. In: Ouimette P, Brown PJ, editors. Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders. Washington, DC, US: American Psychological Association; 2003. p. 29–55.

31. Tate SR, Norman SB, McQuaid JR, Brown SA. Health problems of substance-dependent veterans with and those without trauma history. J Subst Abuse Treat. 2007 Jul;33(1):25–32.

32. Ouimette PC, Brown PJ, Najavits LM. Course and treatment of patients with both substance use and posttraumatic stress disorders. Addict Behav. 1998;23(6):785–95.

33. Mills KL, Teesson M, Ross J, Darke S, Shanahan M. The costs and outcomes of treatment for opioid dependence associated with posttraumatic stress disorder. Psychiatr Serv. 2005 Aug;56(8):940–5.

34. Norman SB, Tate SR, Anderson KG, Brown SA. Do trauma history and PTSD symptoms influence addiction relapse context? Drug Alcohol Depend. 2007 Sep 6;90(1):89–96.

35. Ouimette PC, Finney JW, Moos RH. Two-year posttreatment functioning and coping of substance abuse patients with posttraumatic stress disorder. Psychology of Addictive Behaviors. 1999;13(2):105–14.

36. Read JP, Brown PJ, Kahler CW. Substance use and posttraumatic stress disorders: symptom interplay and effects on outcome. Addict Behav. 2004 Nov;29(8):1665–72.

37. Ouimette PC, Moos RH, Finney JW. Two-year mental health service use and course of remission in patients with substance use and posttraumatic stress disorders. J Stud Alcohol. 2000 Mar;61(2):247–53.

38. Ouimette PC, Moos RH, Finney JW. PTSD treatment and 5-year remission among patients with substance use and posttraumatic stress disorders. J Consult Clin Psychol. 2003 Apr;71(2):410–4.

39. Zilberman M, Tavares H, el-Guebaly N. Gender similarities and differences: the prevalence and course of alcohol- and other substance-related disorders. J Addict Dis. 2003;22(4):61–74.

40. Wilsnack RW, Vogeltanz ND, Wilsnack SC, Robert T. Gender differences in alcohol consumption and adverse drinking consequences: Cross-cultural patterns. Addiction. 2000;95(2):251–65.

41. Brady KT, Randall CL. Gender differences in substance use disorders. Psychiatr Clin North Am. 1999 Jun;22(2):241–52.

42. Stevens SJ, Murphy BS, Mcknight K. Traumatic Stress and Gender Differences in Relationship to Substance Abuse, Mental Health, Physical Health, and HIV Risk Behavior in a Sample of Adolescents Enrolled in Drug Treatment. Child Maltreat. 2003 Feb;8(1):46–57.

43. Cottler LB, Nishith P, Compton WM. Gender differences in risk factors for trauma exposure and post-traumatic stress disorder among inner-city drug abusers in and out of treatment. Compr Psychiatry. 2001 Mar;42(2):111–7.

44. Sonne SC, Back SE, Diaz Zuniga C, Randall CL, Brady KT. Gender differences in individuals with comorbid alcohol dependence and post-traumatic stress disorder. Am J Addict. 2003;12(5):412–23.

45. Legerski J-P, Bunnell SL. The Risks, Benefits, and Ethics of Trauma-Focused Research Participation. Ethics Behav. 2010;20(6):429–42.

46. Becker-Blease KA, Freyd JJ. Research participants telling the truth about their lives: The ethics of asking and not asking about abuse. Am Psychol. 2006;61(3):218–26.

47. Shalev AY, Freedman S, Peri T, Brandes D, Sahar T, Orr SP, et al. Prospective study of posttraumatic stress disorder and depression following trauma. Am J Psychiatry. 1998 May;155(5):630–7.

48. Torchalla I, Nosen L, Rostam H, Allen P. Integrated treatment programs for individuals with concurrent substance use disorders and trauma experiences: A systematic review and meta-analysis. J Subst Abuse Treat. 2012;42(1):65–77.

49. Amaro H, Dai J, Arévalo S, Acevedo A, Matsumoto A, Nieves R, et al. Effects of integrated trauma treatment on outcomes in a racially/ethnically diverse sample of women in urban community-based substance abuse treatment. J Urban Health. 2007 Jul;84(4):508–22.

50. Cocozza JJ, Jackson EW, Hennigan K, Morrissey JP, Reed BG, Fallot R, et al. Outcomes for women with co-occurring disorders and trauma: Program-level effects. J Subst Abuse Treat. 2005 Mar;28(2):109–19.

51. Hien DA, Cohen LR, Miele GM, Litt LC, Capstick C. Promising treatments for women with comorbid PTSD and substance use disorders. Am J Psychiatry. 2004 Aug;161(8):1426–32.

52. Back SE, Waldrop AE, Brady KT, Hien D. Evidenced-Based Time-Limited Treatment of Co-occurring Substance-Use Disorders and Civilian-Related Posttraumatic Stress Disorder. Brief Treat Crisis Interven. 2006;6(4):283–94.

53. Finkelstein N, VandeMark N, Fallot R, Brown V, Cadiz S, Heckman J. Enhancing Substance Abuse Recovery Through Integrated Trauma Treatment. Sarasota, FL: National Trauma Consortium, Center for Substance Abuse Treatment; 2004.

54. Health Canada. Best Practices: Concurrent Mental Health and Substance Abuse Disorders [Internet]. Ottawa, ON: Health Canada; prepared by the Centre for Addiction and Mental Health; 2002 Feb. Report No.: ISBN: 0-662-31388-7; Cat. No.: H39-599/2001-2E. Available from: http://www.hc-sc.gc.ca/hc-ps/pubs/adp-apd/bp_disorder-mp_concomitants/index-eng.php

Appendix: Trauma informed care training exercises

Short Breathing Exercise

- Make sure that you sit comfortably in your chair.
- Breathe in evenly through your nose - one – two – three – four (4 seconds).
- Hold the breath.
- And exhale slowly through your mouth - one – two – three – four (4 seconds).
- And pause slightly before breathing in again.
- Continue to breathe in evenly through your nose (one – two – three – four), hold the breath, and breathe out slowly through your mouth (one – two – three – four).
- Exhale all of your tension and anxiety. Relax your entire body as you exhale.
- Whatever feelings, sensations, images, thoughts, or memories arise, pleasant or unpleasant, gently acknowledge them, and let them go. (...) Allow them to come and go, and keep your attention on your breath. (...).
- So inhale evenly - one – two – three – four (4 seconds).
- ... hold ...
- And exhale slowly - one – two – three – four (4 seconds).
- And pause slightly before breathing in again.

Practice the breathing exercise every day, and use it whenever you feel distressed, or at night before you go to sleep.

Breathing Exercise

- Find a comfortable position in your chair with as much support as you need. And close your eyes if you like.
- Breathe in evenly through your nose. Gently rest your hands on your stomach, and notice how the stomach rises as you inhale. Hold the breath for 2 seconds.
- Exhale slowly through your mouth, until your lungs are empty. Notice how the stomach drops as you exhale. And pause slightly before breathing in again.
- Continue to breathe in evenly through your nose, hold the breath for 2 seconds, and breathe out slowly through your mouth.
- And you may find it helpful to associate your breathing with a word that has a calming effect on you.
- So inhale evenly ... hold ...
- And exhale slowly and say to yourself silently "... calm and relaxed."
- Exhale all of your tension and anxiety. Relax your entire body as you exhale.
- And pause slightly before breathing in again.
- Inhale evenly ... hold ...
- And exhale slowly "... calm and relaxed."
- Imagine the muscles of your body becoming more and more relaxed with each breath you take.
- Whatever feelings, sensations, images, thoughts, or memories arise, pleasant or unpleasant, gently acknowledge them, and let them go. (...) Allow them to come and go, and keep your attention on your breath. (...).
- Inhale evenly ... hold
- Exhale slowly "... calm and relaxed."
- Exhale all of your tension and anxiety. Relax your entire body as you exhale. And pause slightly before breathing in again (...)
- And every time your attention gets caught up in your thoughts, gently acknowledge it, and return your attention to your breath. (...)
- Inhale evenly ... hold
- Exhale slowly "... calm and relaxed."

Practice the breathing exercise every day, and use it whenever you feel distressed, or at night before you go to sleep.

Progressive Muscle Relaxation

When people are highly distressed or anxious, their body often becomes very tense because they are in constant fight-or-flight mode. It is important that we learn to relax, in order to relieve feelings of stress and anxiety. I will now introduce you to a technique named progressive muscle relaxation that will help you to achieve a state of relaxation. The idea is that people can calm their minds by relaxing their bodies. To attain this goal, progressive muscle relaxation involves a series of exercises where you first tense and then release various muscle groups in your body.

During the exercise, I will ask you to tense each muscle group tightly and hold the tension for about 5 seconds. Note that the tension should be tight but not painful. I will then ask you to release the tension and focus your awareness on the relaxation for about 10 seconds, before progressing to the next muscle group. We will begin with the hands and works our way down to the feet.

- Find a comfortable position in your chair with as much support as you need. And close your eyes if you like.
- Take some time to focus on your breathing, noticing your abdomen rise and fall with each breath (...). Breathe in evenly through your nose, notice how your abdomen rises as you inhale, and hold the breath for 2 seconds.
- Exhale slowly through your mouth, until your lungs are empty. Notice how your abdomen drops as you exhale. And pause slightly before breathing in again.
- Imagine how, with each exhalation, the tension is flowing off your body.
- As your breathing becomes more restful, turn your attention to your right hand. Clench your right hand into a tight fist; feel the tension in the muscles of your hand and lower right arm. Hold it (5 seconds). And then release the tension (5 seconds). Let your hand and fingers relax, and experience the transition from tension to relaxation in these muscles (5 seconds).
- Make a fist with your right hand again, raise it towards your shoulders, and tighten your biceps as if you are lifting weights. Feel how the muscles contract, and experience the tension. Hold it (5 seconds). Then release the tension (5 seconds), and notice the difference between the tension and relaxation (5 seconds).
- Now clench your left hand into a tight fist; feel the tension in the muscles of your hand and lower left arm. Hold it (5 seconds). And then release the tension (5 seconds). Let your hand and fingers relax and experience the transition from tension to relaxation (5 seconds).

- Make a fist with your left hand again, raise it towards your shoulders, and tighten your biceps. Feel how the muscles contract and experience the tension. Hold it (5 seconds). Then release the tension (5 seconds), and notice the difference between the tension and relaxation, as you continue to breathe evenly and calmly (5 seconds).
- Now turn your attention to your face. Raise your eyebrows as high as you can; feel the tension in your forehead and hold it (5 seconds). Then release it (5 seconds). Notice the transition from tension to relaxation, and how your forehead muscles become smooth and soft as you relax (5 seconds).
- Close your eyes tightly, and at the same time bring every part of your face toward your nose and hold it there (5 seconds). Feel the tension in your face. Then release it, and experience the relaxation (5 seconds). There is no tension around your eyes, your eyelids are gently closed, and your face is still, as you continue to breathe (5 seconds).
- Now clench your jaw and bite your teeth together. Hold it (5 seconds), and release (5 seconds). Feel how your jaw is completely loose, your lips are slightly parted, your cheeks are deeply relaxed, your eyelids become heavy, your forehead and scalp are smooth and soft (...), and enjoy the peace and calmness that arise from relaxing the muscles in your body (5 seconds).
- Continue to breathe in and out freely and evenly, letting go of all the tension (5 seconds).
- Now direct your attention to your neck. Bring your head forward, pressing your chin against your chest and at the same time working against it. Focus on the tension in your neck muscles. Hold it (5 seconds) and release (5 seconds). Relax, and let your head return to a balanced and comfortable position (5 seconds).
- Now tighten your shoulders by rising then up as far as you can. Feel the tension in your shoulders. Hold it (5 seconds). Then release (5 seconds), and notice the difference between the tension and relaxation. Feel the relaxation spreading through your shoulders and neck. Let it spread into your arms and hands and down to your fingertips, and feel how your body and mind becomes more and more relaxed (5 seconds).
- Now turn your attention to your chest. Take a deep breath in, hold the breath for 5 seconds, and feel the tension in your chest (5 seconds). Exhale slowly, until your lungs are empty (5 seconds). Notice how your chest relaxes as you exhale (5 seconds). Repeat the deep inhalation and feel the tension in your chest as you hold your breath (5 seconds), and enjoy the relaxation as you slowly exhale (5 seconds). Now, just observe your breath and the air streaming in and out, and how, with each inhalation, you breathe in calmness, and with each exhalation, the tension is flowing off your body (5 seconds).
- Now direct your attention to your abdomen. Tighten all your abdominal muscles, and focus on the tension in these muscles. Hold it (5 seconds). And then release the tension (5 seconds), and notice the difference between the tension and relaxation, while you continue to breathe evenly and calmly (5 seconds).

- Tighten your lower back by arching it up. Hold it, and study the sensation of tension (5 seconds). Release (5 seconds), and notice the difference between the tension and relaxation (5 seconds).
- Tighten your buttocks and thighs, hold it, and focus on the sensation of tension (5 seconds). Release (5 seconds), and notice the difference between the tension and relaxation (5 seconds).
- Press your heels firmly into the ground, curl your toes toward your face and tense the muscles of your calves. Feel the tension in your feet and lower legs and hold it (5 seconds). Release (5 seconds), and enjoy the difference between tension and relaxation (5 seconds).
- Take some time again to focus on your breathing, just noticing how your abdomen evenly rises and falls with each breath (...). Notice your abdomen rise and fall, and enjoy the pleasant sense of relaxation. Feel all of your muscles be loose and heavy, relaxing further and further as you feel the relaxation spreading through your body. Let the relaxation proceed on its own.
- I will now count backwards from 5 to 1. And when I get to one, you may come back into this room, relaxed and refreshed. 5 – 4 – 3 – 2 – 1.
- And now open your eyes, move your hands, arms, legs, and feet, rotate your head, and stretch a bit.

This is a technique that, with regular practice, will enable you to relax your entire body within a few minutes. And with each cycle, you will notice it becomes easier and easier to relax. So find a quiet place to practice this technique every day, and use it whenever you feel distressed, or at night before you go to sleep.

Grounding Exercise

Grounding is a distress coping strategy to focus the attention on the present moment.

Examples for physical grounding

- Press your feet on the floor. Notice how they connect you firmly to the ground.
- Push your legs up. Notice how your muscles tense ... and let them relax again.
- Tighten your fists and flex your arms. Feel the tension.
- Hold on to your chair. Feel everywhere your body touches it. Feel what material it's made of, how hard or soft it feels. How smooth or rough the surface feels.
- Pick up an object around you and touch is with both of your hands – feel it. How heavy or light, how cold or warm, how big or tiny it feels in your hands.
- Pick up an ice cube. Feel how cold it is, how it melts.
- Run water over your hands, feel the water pressure, notice the temperature.

Examples for mental grounding

- Use a safety statement, e.g.;
  'My name is _____. I am safe right now. Today is _____ and it is _____ o'clock. I am at/in_____). I am in the present moment, neither in the future or the past.'
- Notice and describe the things around you. Notice and describe how many there are, what colors or shapes do you see, what are they made of, etc.) You can do this with objects, images, the weather outside. Try to describe every detail as if you're seeing this object for the first time in your life.
- Play a category game. Try to think of types of animals, sports, cars or plants. Try to make a list in your head of all the words that start with the letter 'H'
- Count numbers or the alphabet v..e..r..y.. s..l..o..w..l..y..
- Spell words backwards

Safe Place #1

To go to your safe place, lie down and make yourself totally comfortable. Close your eyes….or leave them open, whatever your prefer. In your mind, walk slowly to a quiet place…Your place can be inside or outside….It needs to be peaceful and safe…. Picture yourself unloading your anxieties, your worries…Notice the view in the distance…. What do you smell?…. What do you hear? Notice what is before you…. Reach out and touch it…. How does it feel? Smell it…. Hear it…. Make the temperature comfortable…. Be safe here…. Look around for a special spot, a private spot…. Find the path to this place…. Feel the ground with your feet…. Look above you…. What do you see?…. Hear?….Smell?…. Walk down this path until you can enter your own quiet, comfortable, safe place. You have arrived at your special place…. What is under your feet?…. How does it feel?…. Take several steps…. What do you see above you? What do you hear? Do you hear something else? Reach and touch something…. What is its texture? Are there pens, paper, paints nearby, or is there sand to draw in, clay to work? Go to them, handle them, smell them. These are your special tools, or tools for your inner guide to reveal ideas or feelings to you…. Look as far as you can see…. What do you see? What do you hear? What aromas do you notice? Sit or lie in your special place…. Notice the smells, sounds, sights…. This is your place and nothing can harm you here…. If danger is here, expel it…. Spend three to five minutes realizing you are relaxed, safe and comfortable.

Memorize this place's smells, tastes, sights, sounds…. You can come back and relax here whenever you want…. Leave by the same path or entrance…. Notice the ground, touch things near you…. Look far away and appreciate the view…. Remind yourself this special place you created can be entered whenever you wish. Say an affirmation such as "I can relax here" or "This is my special place. I can come here whenever I wish."

Safe Place #2

Sit comfortably, with your back and neck completely supported. Allow the floor, or chair, or whatever you are sitting on to hold you. Let tension melt away as you bring your attention to your breath. With each breath in . . . feel your diaphragm moving down toward your feet. . . and your lower abdomen beginning to expand. . . With each breath out. . .as your abdomen relaxes. . . feel the muscles in your neck and shoulders drifting down with gravity. . . and relaxing even more deeply. . .

Take a mental journey now, through your body, beginning at the bottom of your feet. Tighten the muscles of your feet, your toes, then let them relax and release the day's tension. . . Next tighten your calves and thighs, then loosen them. Move your attention slowly to the top of your head in this way, letting go of any tightness or restriction you find. (Pause about one minute.)

Your mind has just moved through your body, connecting with it, giving it attention, soothing the tense, tired places. Now let your mind move to a still point, a place of pure peace and calm. In your imagination, think of a place that is safe and comfortable . . . a place where you can retreat and care for yourself . . . a place where you can go to replenish your body and spirit . . . a place that is absolutely your own, secure and private. The place that you choose will be uniquely yours . . . It can be a place you have been to before, or somewhere you would like to find . . . It may be a beautiful outdoor scene . . . a beach, a meadow, an ancient forest. . . or it may be a special room. . . a childhood bedroom, a music room, a chapel. . . it may be a bubble in the clouds. You may decorate this place any way you wish. Imagine it with all your senses, smelling the fragrance of flowers, incense, or the ocean breeze . . . Feel the texture of the surface under your feet and against the skin of your hands, your arms . . . Hear all the sounds of this place . . . birds singing, wind blowing, waves on the beach or beautiful classical music or jazz. See the colors and shapes as you turn full circle to get a complete view. Let this place be a safe and nurturing hideaway, full of color, music. All the things that you need to feel sheltered and cared for.

Find a place to sit, on an old hollowed-out log or a rock that feels as if it were contoured just for you, in a billowy cloud-chair, or whatever fits in your special place. Make yourself very comfortable. For in this place of safety, only you are allowed. In this place of safety, no one can come without your invitation. In this place of safety, you are always at peace…. Allow the images to come…. Notice the color of the sky at your favourite time of day. And in this place, at this most perfect time of day, at the season and the temperature that you like on your skin, allow your senses to become more and more alive. Look around at the surroundings and allow yourself to see; if not with your eyes, then sense with your heart…. Each time you come to your safe place, you may develop it and allow it to become more and

more beautiful. Allow yourself to see, feel and hear what is here today.... Let yourself bask in the safety and the peace....

Allow yourself to walk around, to be in this place, to notice more and more, to create more and more in this place.... Perhaps you would like to build a shelter of some kind, a cottage, a cave, a tent, a tree house. And if it's already there, you may add to it.... Plant flowers, adding a splash of color. Add special places or rooms to your safe place.... Create special places for special kinds of feelings that need to be healed, special places to wash away fear and pain.... Create a waterfall or a pool of healing water. Stand under the waterfall to wash away the fear.... Let the healing waters wash away what you'd like to be finished with. Each time you come to the waterfall or the healing pool of water, you can wash away more and more of the past.... Each time you come, you are cleansed and rejuvenated, shame is washed away. Wash away the pain. Wash all of it away, as you are ready. [Long pause.] When you are finished, step out of the water and you will find a robe or a towel to dry and warm yourself.

Now allow yourself to continue walking around your safe place.... You find a place for a healing garden, a place that is just for your healing. You can plant anything you would like.... You can plant wishes and dreams for the future. You can plant seeds of your healing. And you can weed out what you want to be finished with. Take some time to work with your garden now. [Long pause.]

And now, find your favorite place in all of safety. Walk around until you find just the right place. [Long pause.] Sit down, and get comfortable.... Breathe in the safety and the peace. Breathe out the fear.... Breathe in the safety and peace. Breathe out the fear.... Breathe in the safety and peace. Breathe out the fear.... And just be in this place as you breathe and heal.... Stay in this place as long as you would like.... And when you are ready, simply count yourself out by counting from one to five. When you reach the number five, your eyes will open. And you will be awake and alert, and feeling safe and at peace. One ... two... three... take a deep breath ... four.... and five.