

**A Normal Response to Abnormal Events:  
A Model for a Tier 5 Substance Abuse Program for Youth**

by

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## ABSTRACT

There is a growing call for a commitment to evidence based practice with corresponding measures of success built into all services provided along the continuum of care for mental health and addictions services. It has been well established that the treatment of youth substance use cannot be developed based on the experiences of the adult population, and specific consideration must be given to youths' cognitive and developmental levels, experiences, family dynamics, peers, and type of substance use. Very often, youth entering inpatient, residential treatment programs for problematic substance use have experienced trauma in their formative years that may be core to their illness and paramount to their healing.

Based on current literature pertaining to best and promising practices for substance affected youth and trauma-informed care, this project provides recommendations for daily programming within a tier 5 setting for youth. It is a call for provincial standards and guidelines for treatment and rehabilitation of youth to be trauma-informed at their core.

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## **Chapter 1: Introduction**

### **Change is in the Air**

Canada's health care system has dedicated itself to providing people opportunities to experience life in a way that is meaningful, fosters creativity, and offers a multitude of avenues to be productive members of society. Mental health is essential for this to happen, and is integral in physical health, personal well-being, and positive family and interpersonal relationships. Worldwide, the impact of mental health and substance use problems is a significant issue, effecting people from all ages and walks of life. It is estimated that the Canadian economy spends upwards of \$51 billion annually in indirect costs of mental illness and/or substance use, and British Columbia's (BC) proportional share of this in loss productivity is \$6.6 billion, with \$1.1 billion related to alcohol use alone (Healthy Minds, Healthy People, 2010). Needless to say, the development and sustainability of mental health and addictions services across the continuum is a major focus in Canada, both nationally and provincially.

Certain people within the general population are more vulnerable to substance use and/or mental health problems at different stages in their lives. In November 2010, the BC Government released a document entitled, "Healthy Minds, Healthy People", outlining a ten year plan to address mental health and substance use. This document recognises the emerging research evidence that intervening with certain groups of people, often at key developmental stages or transition points in their lives, can reduce the risk of future problems. More specifically, this knowledge has shaped the strategic focus in building a continuum of relevant services for vulnerable groups of children and youth.

At especially high risk are those youth who are sexually exploited, substance dependant, and living on the street. In 2007, the Canadian Centre on Substance Abuse (CCSA) published a

second edition of a document entitled, “Substance Abuse in Canada”, which focussed on what addictions experts identified as the population of greatest concern – youth. Over the past decade, intense focus has been directed to the treatment and rehabilitation for youth with substance use problems, recognizing that young people are most likely to use substances, engage in risky forms of use, and experience related harms as a result (Canadian Centre on Substance Abuse [CCSA], 2007). It has been well established that the treatment of youth substance use cannot be developed based on the experiences of the adult population, and specific consideration must be given to youths’ cognitive and developmental levels, experiences, family dynamics, peers, and type of substance use (Alberta Alcohol and Drug Abuse Commission [AADAC], 2006).

For children and youth, severity has been measured in terms of functional impact, such as inability to attend school, difficulties living at home, and involvement in the criminal justice system (Healthy Minds, Healthy People, 2010). While a small number of children and youth require specialised residential services, these services are imperative in the continuum of services offered. Perhaps more importantly, it is essential that these programs are guided by best and promising practices informed by the unique needs of the population they serve. At this point, there is a commitment in BC’s 10 year plan to (a) strengthen community residential treatment options for individuals with severe mental health and substance use disorders and (b) provide evidence based treatment options in residential substance use programs (youth and adult) with the end goal of establishing provincial standards and guidelines for publicly funded residential substance dependent treatment facilities. Although we have become more sophisticated at evaluating prevention and treatment outcomes, many programs continue to use ineffective approaches (CCSA, 2007). There is a growing call for a commitment to evidence based practice with corresponding measures of success built into programming. This would mean coming to a

consensus on what constitutes success in prevention and intervention, and the existence of such an agreement is absent or too general to have substantial meaning at this time.

From this perspective, it is imperative that the Northern Health Region in B.C. have a structured residential service that can provide intensive, multidisciplinary, specialized treatment for youth with severe and complex substance use problems. It is perhaps even more imperative that this service is informed by the context of interpersonal violence and abuse that a majority of individuals who access these levels of services will have. These individuals are often the highest users of the systems costly inpatient and residential services, and often carry with them psychiatric diagnoses including PTSD, borderline personality disorder, schizophrenia, depression and other affective disorders, anxiety disorder, eating disorder, psychotic, dissociative disorder, addictive, somatoform, and sexual impairments – all of which have been related to past trauma (Jennings, 2004). Although the trauma experienced in formative years may be core to their illness and paramount to their healing, it is seldom asked about or viewed as a central issue in many current services. There needs to be an increased awareness and commitment to a trauma paradigm on the part of policy makers.

It is the aforementioned goal of establishing provincial standards and guidelines for treatment and rehabilitation services for youth with substance use problems which is at the core of this project. Based on current literature pertaining to best and promising practices for substance affected youth and trauma-informed care, recommendations are made to adjust current programming in an existing inpatient addictions facility in Northern BC, called the Nechako Youth Treatment Program (NYTP). This in turn will offer an inpatient addiction and mental health service to BC's Northern Health Region that is reflective of the youth being referred, respecting historical contexts and presenting issues.

## Significance of Project

The Ministry of Health works with BC's health authorities to provide quality, appropriate and timely health services to British Columbians. To do this, the ministry sets province-wide goals, standards, and performance agreements for health service delivery by the health authorities. For mental health and substance use, this has been outlined in the aforementioned, "Healthy Minds, Healthy People" document. Each Health Authority has the legislative authority to develop policies, prepare budgets and allocate resources for the delivery of health services under a regional health plan. This includes the health services provided, the type, size, and location of facilities in the region, the programs for the delivery of health services provided in the region and the human resource requirements under the regional health plan (Northern Health Authority [NHA], 2010). In other words, each health authority has the responsibility to build systems that meet province-wide goals in ways that are fiscally responsible, reflect current standards, and are population informed.

As highlighted previously, the goal of this project is to propose a model for a youth residential addictions treatment program for the NHA that is in line with relevant best and promising standards and guidelines, and that is population informed. In so doing, a population health approach can be used to guide and direct policy and program development so that initiatives reflect population health key elements. Programming should be sensitive to the risk factors and health determinants of the individuals accessing the service. This would directly imply that addictions based services offer programming that are trauma informed, providing services that foster interventions that are culturally relevant, and that help youth heal from



trauma, learn healthy ways of coping with stress (chronic and acute), and help them connect and stay connected to protective resources in their lives (CCSA, 2007).

### **Population Informed: BC's Northern Health Region**

Northern Health provides health care services to the largest geographical region in BC, covering two thirds of the province, comprised largely of rural and remote communities. There is an estimated 285,328 residents living in an area spread over 592,116 square kilometres. Approximately 17.5% of the population is Aboriginal, primarily First Nations, but with a significant number of Métis and Inuit persons as well. Although the health status of Aboriginal people has improved, this population continues to experience poorer health compared to other BC residents (NHA, 2010).

Northern BC also has proportionately more children and youth than the rest of BC, with youth between the ages of 0 – 17 years comprising around 24% of the population, at least 22% of which are Aboriginal. This is estimated to be three times that of BC overall (NHA, 2010). In September 2010, Northern Health made available a service plan up to and including 2013, highlighting that in addition to having a high proportion of children and youth, many are considered to be at risk. This document also states that many children are living in poverty and deprivation, with the Northwest and Northern Interior Health Service Delivery Areas having the highest percentage of children living in families receiving Income Assistance, and highest percentage of youth receiving Employment Insurance. Throughout the north, academic achievement and graduation rates are far below other areas of BC, and, perhaps of greatest concern, these areas have the highest child-abuse rates in the province.

We have learned a lot in the past several decades about what determines health, and where our efforts should be concentrated. Much of the research suggests looking at the big picture of health, and examining factors inside and outside the health care system that affect our health. Health is determined by complex interactions between social and economic factors, the physical environment and individual behaviour, and it is the combined influence of the determinants of health that determines health status. One of the challenges is to take what is known about the determinants of health and increase basic understanding of how they influence collective and personal well-being, and adopt strategies to improve health for Canadians (“Public Health Agency of Canada,” n.d.).

From a population health approach, this means focussing on the root cause of a problem, using evidence to support the strategy to address the issue, and improving the health status of the whole society, while considering the special needs and vulnerabilities of sub-populations. Thus, we know that the Northern Health region of BC has a proportionately high number of children and youth, and that there are several determinants of health that interact to make many of these youth at risk.

## Background

In 2001, Health Canada published a document titled, “Best Practices: Treatment and Rehabilitation for Youth with Substance Use Problems”, outlining best practices that appeared to result in the most successful treatment outcomes for youth. Based on this document, provinces and jurisdictions have continually worked to build programs and services that are reflective of the most up to date best and promising practices. In May of 2006, the Standing Senate Committee on Social Affairs, Science and Technology offered a final report on mental health, mental illness, and addiction, titled “Out of the Shadows at Last”. This report highlighted how substance abuse can mask the symptoms of a mental illness but, for those who are known to be mentally ill, it makes psychiatric symptoms worse. As a result, people with concurrent disorders generally have more complex problems and are more difficult to help because they often exhibit more disruptive behaviours, are less accepting of treatment and are more prone to relapse than those whose mental illness is not compounded by addiction or vice versa. Nationally, both the mental health and addiction “systems” have been slow to acknowledge even the existence of concurrent disorders. Literature on best practices recommends that mental health and addiction programs screen clients for mental health and addiction issues, and, when problems are discovered, those affected should be fully assessed to ensure proper treatment. It also calls for integrated treatment – both problems are treated simultaneously by the same team, using compatible techniques and philosophies. Established in 2000, the Nechako Youth Treatment Program (NYTP), located in Prince George, British Columbia, provides an inpatient addictions based treatment program for eight adolescents, 13-18 years of age, who live in BC’s Northern Health catchment region. The program utilizes a multi-disciplinary approach, with services provided by

Youth Counsellors, Nurses, Licensed Practical Nurses (LPNs), Physicians, Psychiatry, Psychology, a school program, and a Waitlist Clinician. Every youth entering the program receives a biopsychosocial assessment and addictions and mental health issues are treated by the team simultaneously. The NYTP belongs to a larger family of services called Northern Health Mental Health and Addiction Youth Services. Other programs within these services include an Adolescent Psychiatric Assessment Unit, an Eating Disorders Clinic, an Early Psychosis and Identification Treatment Program, as well as youth community outpatient services guided by an assertive case management model. All of the aforementioned programs work from a prevention perspective. As a result, depending on the needs of youth who enter the program, there is opportunity to access the specialised services of any of the aforementioned teams.

As a result of this integration of mental health and addiction services and the multidisciplinary team of professionals involved, the NYTP is able to offer treatment options to youth with complex, chronic, and persistent addictions and mental health issues. While this integration has been vital, programming has not necessarily kept apace with up to date research and treatment recommendations. Thus, while there is a willingness to be creative in treatment strategies and overall programming, there is a risk that this is not always guided by clinically relevant intent, and reflective of best and promising practices.

The program itself has not been static since its inception, and has changed based on service recommendations that have been both externally and internally driven. External influences have included best practice documents, accreditation processes, and regional feedback from clients, families, and service providers. Internally, the team has participated in a SWOT (strengths, weaknesses, opportunities, threats) analyses of the program with the overall intent of ensuring services offered reflect the needs of the unique northern region in that it is a resource

for. Overall, service changes have been based on the above recommendations. However, there are fundamental program shifts that need to occur in order to offer a tier 5 service that is sensitive to the stories and lived experiences of youth who attend. More specifically, programming needs to take into account that individuals with histories of violence, abuse, and neglect, beginning in childhood, make up the majority of clients served in mental health and substance abuse service systems. Many of the youth who enter the program also have stories with major themes of trauma which are often generational and complex.

Knowledge regarding counselling theory and practice is growing within the Nechako Youth Treatment Team. However, not all counsellors have been afforded the opportunity to receive formal education or training in specific counselling techniques. This at times, despite the most courageous efforts by staff, has led to a disorganised form of eclecticism in supportive practice. There is however, a commitment to embark on a journey where integration would mean taking an open and flexible stance that is meta-theoretical, and abandoning an eclectic approach that lacks theoretical rationale and intent. With increased knowledge and skill the team can take a large step away from haphazardly picking techniques to a practice space full of intent.

## **Personal Location**

Working with people in public mental health and addiction services requires a dedication and passion that is unique in its rewards and its vicissitudes. A career in this field requires passion embedded in the human condition, a humbleness that subsumes every action, and the willingness to see multiple truths from multiple realities. It offers the greatest experiences, and the worst, most de-humanizing stories that clients have lived. For me, the journey into a career in a helping profession is rooted in personal experiences, thrust forward by a belief that we are all one, and maintained by the connection and responsibility I believe we have for one another. Helping our fellow man is not something that should be heralded as heroic and unique, but rather should be our status quo. Thus, life has given me the opportunity to offer my ideas in building a service for high risk youth in Northern British Columbia who are struggling with chronic and persistent mental health and substance use issues, and my goal is to embrace this.

## **Chapter 2: Where Have We Come From and Where Should We Go?**

### **Where Have We Come From?**

As previously mentioned, in 2001 Health Canada published a document titled, “Best Practices: Treatment and Rehabilitation Services for Youth with Substance Use Problems”, identifying best practices based on a literature review and consensus of expert opinion that appeared to result in the most successful treatment outcomes for youth. However, best practice statements and recommendations in this document, as in other best practice documents, are overly general and universal, such as using a harm reduction model, and having programming that is flexible (Ontario Youth Strategy Project, 2008). Translating these directions into clinical practice is based on interpretation and subjective opinion, and there is an inherent risk that program planning and overall service implementation between and even within jurisdictions will not be consistent.

Several documents have been produced outlining best and promising practices in adolescent substance use treatment since 2001. For the purposes of this discussion, only a select few will be highlighted to identify the progression leading to the National Treatment Strategy (2008). In June 2006, the Alberta Alcohol and Drug Abuse Commission (AADAC) published a document titled, “Youth Detoxification and Residential Treatment Literature Review: Best and Promising Practices in Adolescent Substance Use Treatment”. For this review, a treatment was considered to be a best practice when evidence of effectiveness was presented in the findings of individual research or evaluation reports. Of significance was the observation that studies reviewed were complex in nature, and interventions and treatment approaches were multi-faceted

within or across settings, thus making it unclear which factors, namely setting, treatment approach or specific interventions, led to results obtained. Regardless, there were several overall findings:

- a) Youth substance use programs cannot use the same treatment approaches that are used for adults
  - b) Treatment needs to encompass elements related to family, school, peers, and community
  - c) Program environment should be non-threatening
  - d) Programming should be client-centered
  - e) Treatment modalities often overlap and are rarely carried out in isolation
  - f) Treatment services should respond to the cultural needs of individual youth
- (AADAC, 2006, p. 11).

Specifically in regards to residential treatment for youth, overall findings suggested that the goals of treatment were to prevent youths' return to active substance use, provide healthy alternatives, explore underlying factors supporting substance use, teach youth how to deal with cravings, resist pressures to use substances, and make healthier decisions. In terms of best evidence findings, residential programming was shown to decrease substance use for some period of time post-treatment.

In September of 2006, Vancouver Island Health Authority (VIHA) in British Columbia, offered their own review of best and promising practices in a document titled, "Current Promising Practices: Youth Withdrawal Management, Supported Residential Stabilization and Day Treatment Services on Vancouver Island". As in the review done by AADAC, this study also gathered and analyzed information regarding youth addiction treatment from those who



were presently offering services, with the purpose of informing service providers and managers as they sought to enhance and expand services. A review of the literature in this document suggests what seems to be consistent across the board, namely that youth addiction treatment services is an emerging area of research, and therefore there is limited available empirical evidence or literature on the subject (VIHA, 2006). Recommendations were not different from those outlined in the best practices document from Health Canada (2001) mentioned at the beginning of this discussion, again calling for general constructs such as the importance of flexible, accessible, integrated services, a continuum of programs, and the need for system wide collaboration and standardization. This document, consistent with other documents, does not suggest ways for service providers and managers to apply research outcomes to specific cases or programs.

In 2008, the Ontario Youth Strategy Project developed a workbook to help youth-serving organisations begin the process of reflecting on their practices by taking the general statements in the document Health Canada offered in 2001, (Best Practices: Treatment and Rehabilitation for Youth With Substance Use Problems) reframed them to make them more practical, and broke them down into more specific practice guidelines. Overall, this was an attempt to help organizations assess whether their policies, procedures, and overall program directives were reflective of best practice. Recommendations were divided into three broad categories, including orientation to client, approach to practice, and appreciating the context. For the purposes of this discussion, briefly outlining recommendations that fall under these three broader categories is pertinent as jurisdictions nationally have reviewed and established programs based on these guidelines.

Recommendations from the Ontario Youth Strategy Project (2008) that fell under the category of orientation to client included:

- (1) Be individualised, client-centred and client directed
- (2) Trust and respect the youth's inherent motivation for treatment
- (3) Involve the family, as defined by the youth
- (4) Consider youth within their system of relationships, including peers, family, community, and others

Recommendations that fell under the category of approach to practice included:

- (1) Have an explicit framework that directs practice and leads to demonstrated outcomes
- (2) Use a holistic, biopsychosocial approach
- (3) Use a harm reduction approach
- (4) Be strength-based and experiential, and focus on skill building.

Recommendations that fell under the category of appreciating context included:

- (1) Provide safe, respectful service
- (2) Involve youth in meaningful ways in developing, delivering, and evaluating services
- (3) Recognise that youth are not a homogenous group
- (4) Manage tension among clients' needs, clients' choices and program resources

Organisations using this workbook (Ontario Youth Strategy Project, 2008) to assess and improve practice were encouraged to become aware of best and promising practices for youth with substance problems, think about what their organisation was doing to meet each guideline, set out plans to improve practice, and score current practice. The impetus to developing this workbook rested on the fact that the youth sector had grown and developed in a largely

uncoordinated, fragmented manner, leading to individual jurisdictions creating programs and services based on best and promising practices in ways that lacked consistency.

## **Where Are We Now?**

A review of the most recent best and promising practices literature informed a national working group in Canada to develop the previously cited, “A Systemic Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy (2008)”. Nine core operating principles are outlined that reflect the values and assumptions that guide the development and implementation of an effective system of services and supports in response to problematic substance use, including;

- Any door is the right door.
- Accessibility and availability
- Matching
- Stepped care
- Flexibility
- Choice and eligibility
- Responsiveness
- Collaboration
- Co-ordination (p. 15)

Historically there has been little integration or effective communication within and between systems and jurisdictions that provide services to people with substance use problems (National Treatment Strategy Working Group, 2008). The result has been gaps in services,

barriers to accessing the help needed, and a complex maze of supports and services that need to be navigated at a time of heightened personal strain and stress. The National Treatment Strategy report discusses enhancing a continuum of care using an upstream-downstream orientation within various settings, stepping away from traditional prevention programs and addressing the impact of powerful determinants of health. Moving downstream to a settings approach, flexibility in how the supports and services are delivered is emphasized, suggesting that overemphasis on individual service system components or on the delivery of a specific continuum of services often inhibits access and may limit the type of supports provided (Alberta Alcohol and Drug Abuse Commission [AADAC], 2008).

Instead, the adoption of a tiered model for understanding, organizing, and better linking services and supports along a continuum of care is recommended, thereby addressing the risks and harms associated with substance use on all levels. This would provide various levels of services and supports corresponding to the acuity, chronicity, and complexity of risks and harms associated with substance use. Services and supports in lower tiers would be open to everyone with the intention of meeting the needs of a large number of people, while services and supports in the upper tiers would be designed to meet the needs of a smaller number of people requiring more specialised services. In effect, this model aims to match the level of support needed to the specific nature of a person's substance use problem, and needs to be flexible enough to enable people to access services and supports on any tier at any given time (see Appendix A for outline of tiered system).

Using the recommendations put forth from this strategy as a guide for making decisions about the continuum of services and supports within a given jurisdiction, of specific consideration for youth are supports and services found within tier 5. These services are

intended for people with severe and complex substance use problems, tend to be located in urban centres and are available to those living within a broad catchment area, such as a region or province. This would include structured, residential treatment settings with the capacity to provide specialised, intensive multi-disciplinary treatment services to individuals with severe and complex substance use problems.

There appears to be several key risk factors of substance use and abuse by youth, ranging from individual characteristics such as age, gender, attitudes and beliefs, interpersonal factors including abuse and family conflict, peer substance use, school related factors such as academic failure, and even cultural and social environments, such as availability and media portrayals of substance use creating and fulfilling a social norm (CCSA, 2007). Although risk and severity increase as risk factors multiply, risk factors for use are different from those for abuse. While the initiation of substance use is influenced more by social and environmental factors, heavy use and abuse are generally associated with biological factors such as genetics and difficult temperament, and psychological determinants such as childhood abuse, trauma, and psychological disorders (CCSA, 2007). Thus, not all youth are at equal risk, and specific groups of youth are at much higher risk than their peers for heavy use, leading to both abuse and dependence. Questions such as who are the groups of youth at higher risk and what do they have in common become paramount in suggesting effective methods for prevention, and in the case of this document, inpatient treatment.

Statistics suggest that these groups include runaway and street involved youth, youth in custody, adolescents with co-occurring disorders, sexually abused and exploited youth, gay, lesbian, bisexual, and questioning teens, and Aboriginal youth. The experiences and risk factors of these sub-populations of youth vary, however there are compelling experiences that overlap

all of these groups; they have higher rates of trauma and loss, exposure to sexual and physical abuse and other types of violence, intense experiences of stigma and racism, as well as risk for psychological disorders that may increase chances for victimization, making coping with subsequent trauma more challenging. Thus, whether the evidence is neurobiological or at a population level, there is a high likelihood that substance abuse and dependence disorders in these groups of youth are attempts to manage intense stressors, toxic environments, physiological effects of chronic stress, and psychological outcomes of untreated trauma, both historical and present (CCSA, 2007).

It is therefore vital that interventions in an inpatient, tier 5 service for youth experiencing complex and persistent substance use issues are culturally relevant (population informed) and aimed at helping youth heal from trauma, learn healthy ways of coping with chronic stress and distress, and stay connected with protective resources in their lives. BC's ten year plan to address mental health and substance use maintains that by 2011, there should be provincial standards and guidelines for publicly funded residential substance dependence treatment facilities that are based on evidence based treatment options. Specifically for youth, programming offered in every service should be based on the nine guiding principles previously mentioned as outlined in The National Treatment Strategy (2008). However, to embark on a truthful, honest, evidence-informed effort to explore underlying factors supporting substance use, the root cause needs to be addressed, and all too often, the root is trauma. Arguably, without recognising this, teaching youth to deal with cravings, resist pressures to use substances, and make healthier decisions may offer patchwork success in the short term, but it will ignore perhaps the main reason for their use. Thus we enter the conversation - Where should we go from here?



## Where Should We Go?

First of all, it is difficult to compare the effectiveness of substance abuse treatment programs as there are few studies on the topic. However, treatment appears better than no therapeutic intervention at all. Literature suggests several factors linked to treatment success, including low levels of substance abuse problems, the support of one's peers and family for treatment objectives, and staying to complete a program. However, considering the previous discussion on the sub-populations for youth that appear to be the most vulnerable to heavy substance abuse and/or dependence, very often these factors are obsolete in the lives of those who access inpatient substance abuse programs. Other factors that appear to show promise include providing services that meet the needs of young people including schooling, vocational guidance, recreational activities, and integrating motivational and family therapy modules, as well as offering post treatment services (CCSA, 2007). However, once again, this highlights a major gap in the literature that we do not know which interventions work, and why they work.

There is much to learn about the potential negative impacts on ineffective interventions. For example, specifically in inpatient settings, retention is often a problem, and youth regularly leave programs prior to completion. While the contributing factors for this are diverse, the answer to this may in part be because programs at the core are not fully recognising the issues youth are presenting with. A change to a trauma-informed organizational or service system environment would be a profound cultural shift in which consumers and their conditions and behaviours would be viewed differently, staff would respond differently, and the day to day delivery of services would be conducted differently. Arguably, without such a shift in the

culture of an organisation or service system, including the NYTP in Northern BC, even the most evidence based treatment approaches have potential to be compromised.

### **The Light is Beginning to Shine: The Emergence of Trauma-informed Services**

Awareness of the prevalence and impact of trauma is increasing, and individuals for whom trauma-informed and trauma specific services are relevant are increasingly being viewed not as a subgroup or special population of clients, but as encompassing nearly all persons served by public substance abuse and mental health service systems. Both the United States (US) and Canada are beginning to shift service systems to acknowledge emerging research. In 2004, 31 states in the US reported supporting the development of trauma related activities in programs and integrating knowledge about trauma into existing services or the development of new services (Jennings, 2004). It has become increasingly evident that a majority of persons served in state mental health and child welfare systems have experienced repeated trauma since childhood, and have been severely impacted by this trauma. Furthermore, it was recognised that ignoring or refusing to address trauma had massive implications for the use of services and costs incurred. Evidence exists for the effectiveness of trauma-based integrated treatment approaches for individuals with complex, severe, and persistent mental health and addictions problems, and trauma-informed models are both applicable and replicable within public service sector settings (Jennings, 2004).



## **A Link Between Trauma, Mental Illness, and Substance Abuse**

Many statistics are available regarding sources and prevalence of trauma and the link to mental health and addictions issues. The direct cost associated with childhood abuse is astronomical, estimated at 24.4 billion dollars, with indirect costs including special education and adult criminality estimated at 69.7 billion dollars (van der Kolk, 2005). Statistics in the United States suggest that 90% of public mental health clients have been exposed to or experienced multiple types of trauma. Of those accessing substance abuse treatment programs, 75% report abuse and trauma histories. In regards to statistics from the homeless population in the US, it is estimated that 97% of homeless women with mental illness experienced severe physical and/or sexual abuse, 87% of which experienced this abuse both as children and adults. Furthermore, 55% of consumers with a dual diagnosis of mental illness and substance abuse reported histories of physical and/or sexual abuse.

Perhaps even more pertinent to the context of this discussion, teenagers with alcohol and drug problems were six to twelve times more likely to have a history of being physically abused and eighteen to twenty-one times more likely to have been sexually abused than those without alcohol and drug problems. Nearly eight out of ten adolescent female offenders with a mental illness reported having been sexually or physically abused (Jennings, 2004). van der Kolk (2005) suggests that childhood trauma, abuse and neglect is probably the nation's single most important public health challenge, citing statistics that in 2001, there were almost 1 million substantiated cases of child maltreatment, and the estimated true incidence to be almost 3 million.

In Canada, as in other jurisdictions, incidences of violence and abuse are generally underreported, especially sexual assault and sexual abuse. This is likely due in part to the stigma and shame related to trauma. Regardless, incidences of trauma abuse as reported by the Canadian Incidence Study of Reported Child Abuse and Neglect (2003) are staggering. Focussing on children and adolescents, several statistics are relevant to highlight in support for a call for action for services to be trauma informed. Rates of sexual abuse and sexual assault are five times higher in children than adults, and perpetrators of this trauma are often part of the immediate environment for children and youth, with parents being the most common perpetrators. In terms of the breakdown of substantiated cases of child abuse, neglect and exposure to domestic violence accounted for over half of all reports, while physical, emotional, and sexual abuse accounted for most of the remaining cases. Further research suggests that one in six boys is sexually abused (Klinic Community Health Centre, 2008).

Shifting focus to trauma and substance abuse, the statistics are even more revealing. In a study done by Najavits, Weiss, and Shaw (1997), it was estimated that 33% - 59% of woman and 12%-34% of men who entered substance abuse treatment programs had current post-traumatic stress disorder (PTSD). It is further estimated that four million people in the United States have co-occurring disorders, but today this number could be as high as ten million. Also, in mental health programs, it is estimated that 25-50% have a substance use disorder, and in drug treatment facilities it is estimated that 50-75% have a mental disorder (Klinic Community Centre, 2008). Once again, statistics for children and youth are not as available as for adults, but reflecting on the amount of trauma that is reported for youth, the same assumptions can be made.

It is clear that there is a strong link between trauma, mental illness, and substance use. Considering that co-occurring disorders are so common in individuals with trauma backgrounds,

such conditions should be considered expected rather than an exception. The days of programs based on getting clean and sober first, than looking at co-occurring issues such as trauma need to become faded and distant memories. Unfortunately, this is not always the case at the present time. It is also clear that youth who access intensive, inpatient substance abuse treatment programs come from sub-populations where traumatic experiences and exposure are highly prevalent. Many mental illnesses are born out of unresolved trauma effects from childhood, and disorders such as depression, personality disorders, and anxiety disorders can be directly related to a history of unresolved trauma (Herman, 1992). It is imperative that treatment not only address current symptoms, but the root cause of these systems. These are the fundamentals of a population health approach. The fact is if individuals were not dealing with the effects of trauma, many wouldn't need substances to cope. Inpatient substance abuse treatment programs should offer programming that at the core is trauma informed.

Chapter three and four will discuss in detail what it means for service organisations to be trauma informed, and propose recommendations for day to day programming for a Tier 5 service in Northern BC. However, it seems pertinent to first discuss the reality of the clinical presentations of children and adolescents exposed to interpersonal trauma as a guide to develop and utilise effective interventions. There is a growing body of evidence that children and adolescents who have developed in the context of on-going danger, maltreatment, and inadequate care-giving systems are ill served by the current diagnostic system, as it often leads to no diagnosis, multiple unrelated diagnosis, emphasis on behavioural control without recognition of interpersonal trauma, and little to no attention to the developmental disruptions that underlie symptoms (van der Kolk et al., 2009). The forthcoming discussion includes a historical perspective of trauma, beginning with the introduction of PTSD in the psychiatric classification

system in 1980, leading up to the latest research in the field of Developmental Psychopathology, recognising the effects of trauma on the development of affect regulation, attention, cognition, perception, and interpersonal relationships. Also important to discuss in terms of making recommendations for daily programming in youth focussed substance abuse residential treatment programs is the effects of adverse early life experiences on brain development.

### **If We Only Knew Then What We Know Now**

Judith Herman is a pioneer in the study of psychological trauma, and in her book *Trauma and Recovery* (1992), she writes that in the study of “psychological trauma, we come face to face with human vulnerability in the natural world and the capacity for evil in human nature. To study psychological trauma means bearing witness to horrible events” (p. 7). Trauma is the result of people’s adaptability to their experience of events. Some develop resiliency, enabling them to keep on living, and others find that their social, psychological, and biological equilibrium is damaged (Faust & Katchen, 2004). Regardless, throughout history, those who have been traumatized have had to contend with the tendency for society to discredit the victim, or render them invisible (Herman, 1992).

The past two decades has witnessed the field of Developmental Psychopathology emerge as one of the cutting edges of psychiatry. Extraordinary human and economic costs have ensured this. However, the prevailing accepted viewpoints surrounding diagnosis and treatment for symptoms stemming from incidences of complex trauma are rooted in a history that has seen public awareness both embrace and deny the realities of trauma. Herman (1992) eloquently

sheds light on three times over the past century that a particular form of psychological trauma has surfaced into public awareness.

The nomenclature of symptoms that today make up trauma diagnoses were first referred to as hysteria, which 150 years ago was considered to be a strange disease with incomprehensible symptoms, “a disease proper to women and originating in the uterus” (Herman, 1992, p. 10). Amidst the republican, anticlerical movement of mid 19<sup>th</sup> century France, the study of hysteria became a major focus of inquiry and the patriarch of the study of hysteria was French neurologist Jean-Martin Charcot (Herman, 1992). His progressive thinking captured the interest and imaginations of pioneers in the field including Pierre Janet, one of the first systematic investigators of the relationship between traumatic experiences and the effect on a person’s psychopathology, inspiring both William James and Sigmund Freud. The study of hysteria began to bring into public awareness the idea that a person’s intense, otherwise inexplicable emotions in response to a traumatic event were caused by the state of the person and cognitive interpretation of the situation. In the late 19<sup>th</sup> century, Sigmund Freud pursued the investigation of hysteria the furthest and grasped its implications the most completely. He published a report in 1896 wherein he claimed to have found the aetiology of hysteria, and suggested that at the bottom of every case of hysteria were one or more occurrences of premature sexual experience, belonging to the earliest years of childhood experience (Herman, 1992). He further claimed that these experiences could be reproduced through work of psychoanalysis, and called it a discovery in neurological pathology. Regardless, he renounced his publication, as the social implications for his discovery were overwhelming. If his suggestions and patients stories were true, and his theory correct that traumatic acts against children were endemic among the proletariat of Paris and Bourgeois families of Vienna, then incest and sexual abuse of children ran rampant in an

otherwise enlightened, modern society. This proved to be unacceptable and this idea was silenced for many years on the public forum.

Fast forward to the catastrophe of World War I and the reality of trauma was once again forced into the public eye. Soldiers began coming home from the atrocities of war and behaving like hysteric women, screaming and weeping uncontrollably, mute and unresponsive, forgetting memories and behaving in ways that suggested a lost capacity to feel (Herman, 1992). Once again, the social and political implications of a broken soldier seemed unacceptable, and military authorities attempted to attribute the high amount of mental breakdown in soldiers to shell shock, defined as concussive symptoms resulting from being close to an explosion. However, soldiers who hadn't been exposed to physical trauma were also experiencing symptoms, and authorities were forced to accept the fact that symptoms of shell shock were due to psychological trauma, and the emotional distress of prolonged exposure to violent, horrific death resulted in a neurotic syndrome resembling hysteria (Herman, 1992).

A debate emerged that would eventually see the formation of countless veterans' organizations over five decades later, focussing on the moral character of soldiers, with many vigorously maintaining that soldiers should glory in war, and not succumb to terror. However, progressive medical authorities argued that combat neurosis was a real psychiatric condition occurring in all soldiers with high moral character (Herman, 1992). War neurosis represented a form of hysteria, but history would seem to repeat itself, and once again this became a pejorative term, with hidden assumptions of weakness, both of moral integrity and of will.

When World War II began, it was beginning to be widely recognised that any man could break down under fire, and psychiatric casualties could be predicted based on severity of combat exposure (Herman, 1992). In other words, there was no such thing as getting used to combat.

With this recognition came theories regarding treatment, and early techniques adopted the talking cures first suggested in the 19<sup>th</sup> century. Unfortunately, warnings about unburdening traumatic memories not being enough in and of itself for long lasting cures were largely ignored. It was not until the Vietnam War that the first large scale investigations of long term psychological effects of combat were undertaken. This movement was spearheaded through the efforts of soldiers disaffected by war, in an anti-war movement that defined psychological trauma as a lasting and inevitable legacy of war (Herman, 1992).

Finally in 1980, informed by observations of war trauma from both World Wars, and as a response to needing a diagnostic nomenclature to describe adverse reactions by combat troops returning from the Vietnam War, the characteristic syndrome of psychological trauma, PTSD, was included in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM – III). Diagnostic criteria consisted of a triad of symptomology including re-experiencing, numbing/avoidance, and hyper-arousal (American Psychiatric Association [APA], 1980). However, Herman (1992) points out that it has since become evident that symptoms seen in survivors of rape, domestic battery, and incest are not the same as those seen in survivors of war. Both are altogether horrifying, and Herman calls hysteria the “combat neurosis of the sex war”, and “raped victims, battered woman, and sexually abused children as its casualties” (p. 32).

In the years surrounding 1980, researchers were beginning to investigate other types of trauma, including rape, domestic battering, and child abuse and neglect, and the newly available diagnosis of PTSD started to be applied for symptoms being observed within these subgroups of trauma victims. The third edition of the DSM also contained diagnostic criteria for dissociative disorders (DD), and it was becoming apparent that children and adults who met the criteria for DDs had one commonality - histories of severe childhood abuse and neglect. It was clear there

was a cross over between both populations of individuals who met diagnostic criteria for DD and PTSD (Courtois, 2008).

Thus, the argument was born that PTSD was not a fit for reactions experienced by victims of domestic violence, child abuse, and other populations where trauma occurred repeatedly and extensively and was interpersonal in nature (Herman, 1992). Reactions of those involved in combat were significantly different from those of individuals whose exposure to traumatic stress was ongoing and related to family life, namely that the effects of trauma, though PTSD in nature, included symptoms such as depression, anxiety, self hatred, dissociation, substance abuse, self destructive and risk taking behaviours, re-victimization, problems with interpersonal and intimate relationships, medical and somatic concerns, and despair (Courtois, 2008). Ask anyone working in the field of mental health and addictions, and they will no doubt have the opinion that these complex conditions are difficult to treat. Courtois (2008) suggests severity is impacted by the age and stage of development when the trauma occurred, relationship to the perpetrator, the complexity of the trauma itself, duration and objective seriousness of the trauma, and support received at the time of the event, the point of disclosure and discovery, and later on.

Just as a movement was needed to include symptoms that define PTSD in the DSM-III, another movement grew for an alternative conceptualization for those who experience interpersonal trauma. Herman (1992) referred to this as Complex Post Traumatic Stress Disorder (CPTSD), and in the literature, this is often interchanged with Disorders of Extreme Stress Not Otherwise Specified (DESNOS) (Courtois, 2008). After extensive field trials, CPTSD/DESNOS became an associated feature of PTSD in the DSM-IV, and symptoms associated with interpersonal trauma included: alterations in regulation of affective impulses, attention and consciousness, and self perception; perception of the perpetrator; relationships to



others; somatisation and/or medical problems; and alterations in systems of meaning (American Psychological Association [APA], 1994). As stated previously, survivors of childhood abuse present with complex symptom sets, including emotional lability, relational instability, impulsivity, and unstable self structure, all of which are associated with Borderline Personality Disorder (APA, 1994). This diagnosis however has come to be understood as post traumatic adaptation to severe childhood abuse and neglect, and carries enormous stigma and is often applied in a pejorative way (Courtois, 2008).

In 2005, Bessel A. van der Kolk, Medical Director at the Trauma Center in Boston, MA, and renowned pioneer in the field of trauma, suggested that an alternative diagnosis was necessary to capture the spectrum of symptoms of children exposed to interpersonal violence and disruptions in care giving. Based on over twenty years of literature on developmental psychopathology and effects of ongoing childhood adverse experiences and trauma, the National Child Traumatic Stress Network has proposed criteria for a new diagnosis in the DSM-V called Developmental Trauma Disorder (DTD) (van der Kolk et al, 2009). The proposed criteria for DTD include exposure to adverse events, affective and physiological dysregulation, attentional and behavioural dysregulation, self and relational dysregulation, posttraumatic spectrum symptoms, duration of disturbance, and functional impairment (see Appendix B for more detailed criteria).

The impetus for field trials of DESNOS for the DSM- IV clearly demonstrated the impact of interpersonal trauma on adults who as children were exposed to chronic interpersonal trauma compared to patients who as mature adults had been exposed to assaults, disasters, or accidents. Many researchers are vehemently arguing that the current diagnostic classification system is inadequate for traumatised children receiving psychiatric care for trauma related difficulties, and DTD captures the reality of clinical presentations of children and adolescents exposed to chronic

interpersonal trauma. This in effect will have greater potential to guide clinicians and programs to use effective interventions (van der Kolk et al., 2009).

van der Kolk et al. (2009) cite several studies strongly suggesting that a profoundly high percentage of children that have significant trauma related symptoms do not qualify for the diagnosis of PTSD in the DSM- IV, so are not diagnosed. Alternatively, they often fall into other diagnoses including Bipolar Disorder and Attention Deficit Hyperactivity Disorder (ADHD), both of which will have respective psychopharmacological interventions. Even when children do meet full criteria for PTSD, this fails to capture the most clinically salient symptoms. The results are worrisome to say the least, leading to no interventions at all, or inappropriate, ineffective, incomplete interventions that do not give any credence to histories of trauma that are likely most impacting the symptom set.

Presently, field trials are occurring to more precisely delineate who meets criteria for DTD, and readers are referred to van der Kolk et al. (2009) for an in depth discussion on differential diagnoses of DTD when symptoms may be shared with other disorders, as well as a vast body of research for evidence of DTD. DTD represents a consensus amongst leaders in the field that an alternative diagnosis is essential to capture the reality of clinical presentations from children and adolescents exposed to prolonged, complex trauma. It appears to be important for clinicians and program developers to honour the clinical utility that lies within this new conceptualization. There is an opportunity to advance science and clinical interventions in a way that will no longer ignore the impact interpersonal trauma plays on members of our society. Thus, in proposing programming for a tier 5 addictions service for youth in Northern BC, this is an essential component in the fundamental framework on which interventions are built.

## **The Neurobiology of Childhood Trauma**

Research and clinical observation of complex trauma exposure in early childhood have demonstrated impairment in regulatory capacities of children in affective, cognitive, behavioural, physiological, relational, and self-attributional domains (Gabowitz, Zucker, & Cook, 2008). It has also been strongly suggested that children exposed to complex trauma have life-long effects, which according to Gabowitz et al. (2008) include risk for additional trauma exposure, other psychiatric disorders including PTSD, anxiety and mood disorders, substance abuse, eating, conduct, personality, dissociative, and learning disorders, and chronic medical illness. Functional impairments are also observed across a variety of domains including legal, educational, vocational, and social. It is not surprising then that there is a large and growing body of empirical research suggesting that complex trauma exposure is associated with structural and functional alterations in brain development, which in turn result in numerous cognitive and neuropsychological deficits that impact development and functioning across the lifespan (Jackowski, Araujo, Lacerda, Mari, & Kaufman, 2009). The following discussion summarizes literature pertaining to neurostructural and neurofunctional abnormalities in children exposed to complex trauma. This knowledge is vital in diagnosing, conceptualizing, and designing effective treatment and interventions for traumatised youth, and it is critical that professionals working with traumatised youth become aware of this literature to avoid both misdiagnosis and the implementation of ineffective treatment strategies.

## Neurostructural and Functional Abnormalities

It seems irrelevant to discuss the effects of trauma in children without first addressing the quality of the parental attachment bond (van der Kolk, 2003). There is a vast body of literature that suggests that by providing soothing at appropriate moments, caregivers protect children from the adverse effects of stressful situations and play a critical role in a child's ability to regulate affective states. Attachment theory suggests that attachment relationships create inner maps of the world which in part determines how a child views themselves, their caregivers, and the way the external world works. There is an interplay between cognitive and affective knowledge and elicited emotions that help interpret the meaning of incoming stimuli by linking present experience with past emotional responses (van der Kolk, 2003). Liotti (2004) refers to this interplay as a person's internal working model (IWM) which guides both attachment behaviour and the appraisal of attachment emotions in self and others. If the attachment figure has been accessible in real life situations, a child's IWM conveys a secure attachment, where there is a sense of inner legitimacy of attachment emotions so even when the attachment figure is not present in distressing experiences, there is comfort that help is accessible. Conversely, in insecure attachments, there is an expectation that the attachment figure is not available or will respond negatively. Liotti (2004) suggests that traumatic experiences, attachment dynamics, and dissociative reactions are "inextricably intertwined, like three threads woven into a single strand" (p. 478). When caregivers are extraordinarily inconsistent, frustrating, violent, intrusive, or neglectful, children will likely become intolerably distressed, and without a sense that the external environment will provide relief. If this happens when the nervous system is undergoing tremendous maturational and organization change, literature points to a number of changes in the

structure and physiology of the brain that have long-term effects in functioning and behaviour (van der Kolk, 2003).

From the moment we are born, we are constantly taking in information, creating and activating neural connections, and strengthening existing ones. The brain is a relatively plastic organ, influenced by a complex interplay of genetic and environmental factors, and in our formative years, it is continually in the process of pruning, myelination, differentiation, migration, and sprouting (Lipschitz, Morgan, & Southwick, 2002). Neurobiologists have identified points in infant development that appear to be critical for the establishment of particular physical, cognitive, behavioural, and emotional functioning and maturity. This developmental window is proposed to predominantly occur between six months to three years (Lipschitz et al., 2002), and appears to represent a time of increased stress related vulnerability for children. Exposure to early life stressors in these critical phases of development appear to lead to neurobiological changes that increase the risk of psychopathology in children and adults (Nemeroff, 2004).

Nemeroff (2004), van der Kolk (2004), and Lipschitz et al. (2002) summarize findings from rodent and primate models indicating that there is an important interaction between development and stress, and the type, timing, and predictability of stress can influence the development of neuro-endocrine systems and brain structures long after the stressor is removed. Maternally deprived rats had decreased cortisol in the hippocampus, hypothalamus, and frontal cortex, and areas of the brain particularly vulnerable to early stress have a high density of glucocorticoid receptors and some postnatal neurogenesis. Furthermore, chronic stress appears to have an impact on the neuroendocrine (NES) system that regulates the stress response, and in infant rats this system is very similar to that in infant humans (Gilles, 1999 as cited in Guenette,

2005). However, much of the preclinical research has examined the long term impact of early stress on adult animals, and application of these research findings in the understanding of the neurobiology of trauma in children is somewhat limited.

In the past decade, advanced neuroimaging techniques have been used to investigate neurofunctional and neurostructural abnormalities in children. Jackowski et al. (2009) reviewed thirteen structural brain imaging studies that were performed in abused and traumatized children. The literature revealed several important findings in regards to morphometry of the hippocampus, corpus callosum, cerebellum, pituitary and superior temporal gyrus, and cerebral lobes and cerebrospinal fluid. Overall, brain volume reduction and ventricular enlargement observed in pediatric patients with PTSD suggested generalised atrophy or impaired brain development. Although adverse brain development as a consequence of trauma is not entirely understood, studies that Jackowski et al. (2009) reviewed did strongly suggest that severe and persistent stress was associated with hypothalamic-pituitary-adrenal (HPA) axis dysregulation and increased activity of the catecholaminergic system in children and adolescents. This in turn may lead to disturbed brain development including accelerated loss of neurons, abnormalities in pruning, delays in myelination, and impairment in neurogenesis. A study from Teicher, Anderson, & Polcari (as cited in van der Kolk, 2003) suggests that like the hippocampus, the cerebellum develops gradually over the course of human development, continues to create new neurons after birth, and has a high density of cortisol receptors, making it vulnerable to stress.

## **A Closer Look at the Limbic System, Hippocampus, and Prefrontal Cortex**

The frontal lobes of the cerebral cortex deal with the most integrated brain functions including thinking, conceptualizing and planning, and conscious awareness of emotion. The main reason that children have far more emotional outbursts than adults is because signals sent from the frontal cortex, or “higher brain”, are weak and not developed (Davies, 2002). In infants, axons that carry signals down from the cortex to the limbic system have yet to grow, and cells in the prefrontal lobe where rational processing of emotions take place do not fully mature until adulthood. The amygdala, however, located in the limbic system in the lower middle area of the brain, is more or less mature at birth and capable of full activity. A young brain then is essentially unbalanced, with an immature cortex that is not yet able to control impulses from a powerful amygdala (Davies, 2002). The consequences are storms of emotion observed in young children. The amygdala is the brain’s alarm system, and the central generator of states of mind that evolved to aid survival under threat, including fight, flight, or appeasement, allowing swift transition from one to the other (Davies, 2002). This appraisal system circuit bypasses cortical evaluation, allowing for fast and sometimes irrational emergency responses (van der Kolk, 2003).

van der Kolk (2003) describes how the amygdala makes the initial interpretation of whether an incoming stimulus is a threat, initiating emotional responses by transforming stimuli into emotional and hormonal signals. Arousal is mediated in part by elevated norepinephrine (Jackowski et al., 2009). This is associated with impaired function of the prefrontal cortex, planning and organizing, using working memory, and inhibiting executive functions (Lipschitz et al., 2002). Mezzacappa and Kindlon’s study (as cited in van der Kolk, 2003) showed an



interaction between the capacity to modulate autonomic arousal and frontal lobe function, suggesting executive control is associated with vagal modulation of respiratory driven, high frequency heart rate variability. Conversely, motivational control is associated with sympathetic modulation of posturally driven, low frequency heart rate variability. This suggests that proficiency in executive control is associated with greater vagal modulation. Lipshitz et al. (2002) summarise findings that also suggest that in traumatized youngsters there appears to be a dysregulation of psychophysiological responsiveness, such as heart rate regulation and electrodermal responses.

When a child feels threatened and their noradrenergic alarm system is activated, the fast tracts of the limbic system are activated before the slower prefrontal cortex has a chance to evaluate the stimulus (van der Kolk, 2003). When the amygdala-thalamus pathway is dominant, reactions may appear impulsive, inappropriate, and lacking insight that the prefrontal cortex would normally offer (Guenette, 2005). Lester, Wong & Hendren (as cited in Guenette, 2005) suggest that repeated activation of this pathway can lead to kindling, where exposure to stress at a critical time in development becomes encoded in the brain, and van der Kolk (2003) posits that minor irritations are reacted to in stereotyped, totalistic ways that prevent learning from experience.

In an adult, information reaches the frontal cortex where it is placed in context and a rational plan of action is conceived to cope with it (Davies, 2002). The maturity of the cortex can be accelerated by use, and children who are encouraged to exhibit self control are more likely to become more emotionally continent. In environments of extreme and persistent stress, this process can be thwarted. van der Kolk (2003) states that when adults with PTSD are reminded of trauma, there is an increased activation in the right amygdala and decreased



activation of the speech centre of the brain, Broca's area, which is responsible for language processing and higher functioning. Thus, when amygdala activation in response to sensory stimuli misinterprets information as a threat, an inappropriate fight, flight, or freeze response is elicited (van der Kolk, 2003).

The hippocampus, a grey matter structure of the limbic system involved in explicit memory, working memory, and memory for episodic events, is heavily involved in the human stress response (van der Kolk, 2003). Studies are confirming that overall hippocampal volume is positively correlated with age of trauma and psychopathology severity, and severity of PTSD symptoms and cortisol levels predicted a reduction in hippocampal volume. Furthermore, clinical studies examining subjects with a history of trauma suggest dysfunction in the HPA axis and in the noradrenergic system (Jackowski et al., 2009). The HPA axis has been one of the most studied components of the neuroendocrine system, and acts as the primary biological stress response system in humans. When the HPA axis is activated a series of events occur preparing the organism to fight or flight, and a complex set of feedback events are initiated that will turn off when response to a threat is over (van der Kolk, 2003). Nemeroff (2004) writes that the relationship between early life stress and the development of psychiatric disorders is mediated by constant changes in corticotrophin-releasing factor (CRF), which is the major coordinator of the behavioural, autonomic, immune, and endocrine components of the HPA axis. Although increased glucocorticoid secretion is critical to the adaptation of an organism to stress, prolonged or excessive exposure may damage the central nervous system and physical organs (van der Kolk, 2003). The two scenarios highlighted in the literature are hypercortisolism, which results in an inability to terminate a stress response, and hypocortisolism, which is the deficiency of cortisol or an enhancing of the negative feedback of the inhibition of the HPA axis. Both of

these patterns play a key role in the development and maintenance of physical and psychological illness (Bevan, Cerbone, & Overstreet, 2005).

There is also a substantial body of research looking at altered hemispheric lateralization. For an overall review of these studies readers are directed to Jackowski et al (2009). For purposes of this discussion, the most significant structural MRI findings show left-sided electroencephalographic abnormalities in most patients with a history of childhood trauma, and diminished right-left hemisphere integration. Jackowski et al. (2009) and van der Kolk (2003) both cite recent studies that show decreased mid body and posterior portions of the corpus callosum, the primary pathway connecting the two hemispheres, in abused children and adolescents. This is an important finding because the left hemisphere is specialized for perceiving and expressing language, where as the right hemisphere is for processing spatial information and processing and expressing negative emotions (van der Kolk 2003).

Thus, based on everything we know about the neurobiology of trauma, the implications for treatment are profound. Trauma memories are laid down as affective states instead of narratives, and they come back as emotional or sensory states with very little verbal representation. As Guenette (2005) points out, the imprint of the trauma memory is somewhere, but it is not episodic or verbal. As a result, van der Kolk (2003) states that “traumatized children tend to communicate what has happened to them not in words but by responding to the world as a dangerous place and by activating neurobiologic systems geared to survival, even when they are objectively safe” (p. 309). Providing environments and opportunities to have controllable stress reactions is essential for the central nervous system to develop the capacity for neural inhibitory mechanisms and executive functioning that would promote regulation in emotions and behaviour in the face of physiological arousal (Williams, 2006). Actual experience with safety

and predictability are essential for children to gain physiological control over their arousal, and learn from new experiences to eventually respond flexibly to new challenges (van der Kolk, 2005). As long as children are overcome by habitual responses to fight, flight, or freeze, they are unable to talk about their traumatic experiences, and will have no story, and cease to understand the connections between their experience and their emotions and reactions. Thus, the task of therapy is to develop mastery of physical experience, so that an individual develops "...awareness of who they are and what has happened to them to learn to observe what is happening in present time and physically respond to current demands instead of recreating the traumatic past behaviourally, emotionally, and biologically" (van der Kolk, 2003, p. 311). Traditional therapies that rely solely on words and meaning making will not modulate the effected neurobiologic systems. It is time we do something different.

### **Chapter 3: A Trauma-informed Model for a Tier 5 Youth Substance Use Program**

The use of cognitive behavioural approaches and family systems therapy have received the most substantiated research findings for the treatment of classic forms of PTSD (Courtois, 2008; Jennings, 2004; Faust & Katchen, 2004). The use of these approaches for individuals with CPTSD is in preliminary stages, and research is showing some effectiveness. Courtois (2008) reviewed models that have been tested, and suggests the most recommended treatment approach presently is that of a meta-model, encouraging careful sequencing of therapeutic activities and tasks with specific attention to establishing safety and the ability to regulate emotion. Without ascribing to mandated interventions, general guidelines for therapists emphasize safety, security, and affect regulation.

This meta-model approach involves stages of treatment to address specific issues and skills. In 1992, Judith Herman published the most influential book on CPTSD, "Trauma and Recovery", and recommended a model consisting of three stages; creating safety, remembrance and mourning, and reconnection. For an in depth discussion of these phases, readers are referred to Herman (1992) and Courtois (2008). The following is a brief description of this tri-phasic model.

## Safety and Stabilization

The central task of recovery in this phase is safety, recognising that “victims of trauma are betrayed both by their experiences as well as their own bodies” (Baranowsky, Gentry, & Schultz, 2005, p. 13). Clients may feel lack of control over difficult emotions in everyday life that stem from trauma, and a service provider works with the client to help contain these emotions through alternative means of self-regulation and self-management. As Herman (2002) writes:

Establishing safety begins by focusing on control of the body and gradually moves outward toward control of the environment. Issues of bodily integrity include attention to basic health needs, regulation of bodily functions such as sleep, eating, and exercise, management of post-traumatic symptoms, and control of self-destructive behaviours. Environmental issues include the establishment of a safe living situation, financial security, mobility, and a plan for self-protection that encompasses the full range of the patient’s daily life. Because no one can establish a safe environment alone, the task of developing an adequate safety plan always includes a component of social support (p. 160).

Client education is an integral component of stage one, and is the foundation for teaching skills including identification and regulation of emotional states, personal mindfulness, self-care, life skills, coping skills, problem solving skills, social skills, and decision making (Courtois, 2008). This is likely to be the longest stage in treatment and most important to its success. Herman (1992) cautioned that one of the most common errors in treatment is premature

engagement in exploratory work without sufficient attention to the tasks of establishing safety and securing a therapeutic alliance.

## **Remembrance and Mourning**

The second phase of recovery involves the client reconstructing the trauma story in minute detail (Baranowsky et al., 2005). The objective is to create a space in which a clinician can bear witness to the client's experiences, helping them find the resilience to heal. This stage relies heavily on the self-regulatory skills acquired in stage 1, without resorting to old patterns of defences. Courtois (2008) cites several specialized approaches or techniques that have been proposed, including eye movement desensitization and reprocessing (EMDR), guided imagery, imaginal rescripting, narrative telling/writing, or sensorimotor approaches, all of which are considered to be trauma specific interventions. Judith Herman (1992) writes:

Avoiding the traumatic memories lead to a fruitless and damaging reliving of the trauma. Decisions regarding pacing and timing need meticulous attention and frequent review by patient and therapist in concert. There is room for honest disagreement between patient and therapist on these matters, and difference of opinion should be aired freely and resolved before the work of reconstruction proceeds (p. 176).

This stage requires the client and therapist to monitor affective states and intrusive symptoms closely, and dramatic worsening is taken as a signal to slow down.

## **Reconnection**

This stage of recovery involves redefining oneself in the context of meaningful relationships (Bodowsky et al., 2005). The trauma survivor, having come to terms with the traumatic past, is faced with the task of creating a future (Herman, 1992). Clients may realise the dysfunction of the past, and attempt to move beyond its influence (Courtois, 2008). This stage also involves fine tuning the self-regulatory skills developed in stage 1, and clients begin to develop trustworthy relationships. It is a time when helplessness and isolation begin to be replaced by empowerment and reconnection (Herman, 1992). As Bodowsky et al. (2005) state, “Successful resolution of the effects of trauma is a powerful testament to the indomitability of the human spirit” (p. 13).

## **We Are Trauma-informed!**

It has been well established that violence and trauma play a major role in the lives of people seeking addictions and mental health services and treatment. The term “trauma-informed” is used to describe services and systems that have reconsidered and evaluated all components of programming in light of a basic understanding of the role that trauma plays. This understanding is paramount in designing services that accommodate the vulnerabilities of trauma survivors, and allows services to be delivered in ways that avoid inadvertent re-traumatization and facilitates consumer participation.

Trauma-informed services are not designed specifically to treat symptoms related to sexual abuse, physical abuse or other trauma, but rather they are informed about and sensitive to

trauma related issues. “Trauma-specific” services on the other hand, are designed to treat the symptoms of the actual trauma. In Herman’s (1992) tri-phasic model of treatment, this would include more specialised interventions in stage 2.

### **NYTP: Different Treatment as Opposed to More Treatment**

The admission sequence for the NYTP is based on a continuous intake system, where both male and female clients are endlessly flowing through the program, all at unique and different points in their recovery. The length of stay in the program is variable, as consumer feedback indicated “cookie cutter” models, such as 28-day model which the program previously operated on, did not provide the flexibility needed to offer an approach that was client centered. Thus, length of stay is negotiated in pre-screening, initial assessment, and in on-going care plans. Admission criteria assume that youth entering the program lead lives that have been adversely affected by substances. It is assumed that on some level, clients wish to participate in treatment, though it is recognized that social control tactics are often an integral part of the process of seeking treatment for alcohol and other drug problems (Wild, Cunningham, & Ryan, 2006). However, as Najavits (2007) cautions, given the powerlessness inherent in trauma and addiction, facilitating choice for clients is paramount.

Interventions utilised are both individual and group based, though clients are not screened on the basis of being “group ready.” In this way, the program follows Herman’s (1992) recommendations that treatment be as inclusive as possible, and progress be continually monitored in collaboration with the client over time to evaluate if it is helping. Furthermore, clients should not be discontinued from treatment unless they are direct threat to other clients or



staff, and an open door policy should be utilised that welcomes back clients at any time. This is a position advocated for by Herman (1992) and is one of the core operating principles outlined in the National Treatment Strategy (2008).

### **Programming Rooted in Establishing Safety: Do No Harm**

Recognizing that trauma is all too often part of the lived experience for youth entering inpatient addictions based treatment programs, establishing safe ways to cope both internally and externally is the priority of interventions suggested in this project. They are characterised by an emphasis on skill building and acquisition (through rehearsal and practice) rather than symptom management, an understanding of symptoms as attempts to cope, a view of trauma as a defining and organizing experience influencing the core of a person's identity, and a focus on what has happened to the person rather than what is wrong with the person. Najavits (2004) defined safety as the discontinuing of substance use, reduction of suicidal and self harm behaviour, ending of dangerous relationships, and gaining control over symptoms. In Herman's (1992) tri-phasic model, the intensity and duration of the entire process varies substantially, but skills acquired in stage 1, with initial focus on safety, affect regulation, and skills development, offers all who enter treatment tools to function in the world (Courtois, 2008).

## **To Dig or Not To Dig: NOT**

The first stage of recovery is an enormous therapeutic task for many clients, where the focus is learning how to cope in the present, providing opportunities for clients to learn how to decrease aversive symptoms when they “flare up”, and gain control over current life problems (Najavits, 2007). Treatment that is focussed on safety, coping, and stabilization is less likely to destabilise a client. For someone who is in active substance use, there are significant questions about when, how, or whether to do trauma processing work. van der Kolk (2005) cautions that there is a misconception that treatment for trauma means “digging up” trauma memories, telling the story of what happened, and processing meaning. Based on what is known about the neurobiology of complex trauma, this may be futile. In addition, in the context of addiction, trauma processing work is often too emotionally upsetting, and clients often don’t have adequate coping skills to control impulses that may come up in such processing. Najavits (2004) refers to this as the opening up of pandora’s box, leading to clients being destabilised when they are in most need of stabilization. In an outpatient setting, there are concerns repeated in the literature that this may lead clients to use substances more, relapse, or increase dangerous behaviours such as self harm or suicidality (Courtois, 2008). This is consistent with anecdotal evidence from the NYTP, where certain situation or interactions have resulted in destabilization, causing clients to feel overwhelmed, which may lead them to leave treatment prematurely.

## Qualities and Characteristics of Service Providers

The betrayal and relational damage occurring when a child is repetitively abused and neglected sets up lifetime patterns of fear and mistrust which have enormous impacts on the ability to relate to others and to lead the kind of life a person wants (Jennings, 2004). Recovery cannot occur in isolation, and can only take place within the context of relationships characterized by belief in persuasion rather than coercion, ideas rather than force, and mutuality rather than authoritarian control—precisely the beliefs that were shattered by the original traumatic experiences (Herman, 1992). Thus, trauma-informed service models should be delivered within the context of a relational approach that is based upon the empowerment of the survivor and the creation of new connections.

Service providers should emphasize compassion for clients' experiences, and encourage control whenever possible to counteract the loss of control inherent in trauma and addiction. Overall, therapists working in a trauma informed model should be

- Self aware
- Flexible
- Comfortable with the unknown
- Willing to learn from and connect emotionally with client's experience
- Willing to step into the world of the survivor (high degree of empathy)
- Ability to regulate their own emotions
- Ability to treat clients as an equal
- Good listener
- Willing to debrief (Herman, 1992; Najavits, 2007; Courtois, 2008; Stone, 2002).

## **Strength-based Approach**

In addition to the above characteristics, service providers in a trauma informed model should understand what it means to be “strength-based”. Focussing on strengths instead of weaknesses has become a basic tenant of working with people, but is especially important when working with trauma survivors, who may see themselves as inherently weak due to their experiences (Courtois, 2008). This is the basis for forming trusting relationships, wherein conversations should be non-judgemental and occur within the context of compassion and empathy. The focus is on building rapport and client capacity for survival and healing, while taking a step away from viewing a client as a label or illness (Klinic Community Health Centre, 2008). The client is seen as the expert of their own lives, and treatment needs to consider the mind, body, spirit and soul.

## **The Need to Know Ourselves**

A brief look at the proposed criteria for DTD by van der Kolk et al. (2009) and anyone would assume that clients who meet criteria in any of the seven clusters would be challenging to work with. They would be right. In settings ranging from youth detention centres to residential group homes, these clients are considered difficult, and Najavits (2003) states that dual diagnosis clients have been explained by service providers to be severe, or extreme. In effect, providing effective therapy in a tier 5 service for youth is clinically and behaviourally challenging, and by the time they arrive at an intensive inpatient treatment setting, many youth have already been through a number of treatment attempts to resolve their issues.

Stone (2001) discusses the unique transference and counter-transference dynamics that can occur in adolescent residential facilities, again influenced by the fact that clients are usually children who have been greatly traumatized, with family of origin issues including neglect, abandonment, violence, and abuse. Affect dysregulation often manifests itself in intense feelings of anger, aggression, shame, lack of trust, hopelessness, and helplessness. This in turn can and will provoke intense reactions within some staff.

Shortly after admission, peers and staff will inevitably become part of the youth's internalized world of object relations, and there is a risk that even the most experienced clinicians are vulnerable to counter-transferential (CT) responses (Stone, 2001). There can be a feeling that everything a clinician stands for and everything they are offering is being rejected. If clinicians unwittingly react with intense emotion, strength based characteristics risk shifting into confrontation, difficulty holding clients accountable due to misguided sympathy, and power struggles.

While CT responses in adolescent residential facilities are inevitable, simply recognizing and understanding that CT does occur is a tremendous safe-guard. Debriefing times for clinicians built into daily structure, as well as protected time in team meetings to discuss how CT is manifesting itself in overt or subtle ways, will help a team to recognise it operationally. There needs to be a commitment for all members of a multi-disciplinary team to practice self awareness, regulate their own emotions, and perhaps most importantly, be willing to debrief.

## Group Work

Herman (1992) suggests waiting a period of weeks or months from the time of trauma to the time of entry into a group. However, as is the case for NYTP, if intake is open and continuous, this variable often cannot be controlled. Thus, the primary focus of group work must also be on the task of establishing safety and stabilization. Herman (1992) cautions that hearing details of others experiences may trigger a client's own intrusive thoughts so they are not able to listen empathically or accept emotional support. If this happens, safety is lost, and group members can frighten each other with the horrors of the past or dangers in present life. For this reason, Herman (1992) suggests that groups be highly cognitive and educational rather than exploratory.

Corey (2008) discusses the importance of screening for groups, and suggests that as a general rule, prospective group participants should be screened to the extent possible so that inclusion does not impede the group process or jeopardize the well-being of any group members. This becomes difficult in agency settings such as the NYTP where inclusion criteria are predicated by problem substance use more than "group readiness". When screening for specific group work is impractical, Corey (2008) recommends pre-screening interviews. For tier 5 youth addiction settings, this would include explaining the program in general, discussions pertaining to duration and expectations, as well as answering any questions prospective clients may have so an informed decision can be made about the appropriateness of their participation.

Furthermore, especially with youth, a degree of reluctance to enter programming is often the case, but this should not be sufficient grounds alone to rule them out for participation. Instead, Corey (2008) suggests asking the question, "Will this group be productive or

counterproductive for a particular client?" In tier 5 settings, where trauma is very often a part of a clients lived experience, resulting in dysregulated affect, physiology, attention, and behavior, participation in a group may only serve to trigger impulsive, volatile emotional states. Thus, the above question bears even more weight and should not only be asked at pre-screening for entry into services, but in daily programming. If participating in a group is likely to be counterproductive, then forced inclusion would only result in a negative experience.

This is where services have opportunities to truly step towards a client centered model as opposed to a program centered model, where participation in all aspects of programming is guided by on-going assessment through a trauma informed lens. In cases where group work seems to be destabilizing, individual care plans should focus on helping a client discover and practice coping and self soothing techniques outside of the group, with the overall goal of establishing safety so that participation in all programming is meaningful and helpful instead of overwhelming and unmanageable. Najavits (2007) advocates for built in flexibility to honour client's needs, clinicians preferences, and a variety of treatment contexts, and interactions should be primarily supportive in nature rather than confrontational.

Overall, groups should follow a structured format, both to make the best use of time available and guard against deviating into exploratory conversations. The multiple needs, impulsivity, and intense affect of this population of clients can lead to derailed sessions if therapists do not impose clear structure. Again, anecdotal evidence from the NYTP would support this. Najavits (2007) suggests that the goal of groups should be to counteract the impulsivity and chaotic nature of trauma and substance use by offering a process that emphasizes planning, pacing, and predictability.

## Not Treatment as Usual

Clinicians are strongly encouraged to be guided by the motto, “show it rather than say it” when implementing topics and activities in this framework, or other interventions that will no doubt be added as the program naturally shifts and grows, keeping in mind doing everything from a trauma-informed lens. This means finding a way to have clients rehearse a new skill rather than abstractly talking about it. There are a variety of ways to help clients work on new skills. The following suggestions are adapted from Najavits (2002), “Seeking Safety: A Treatment Manual for PTSD and Substance Use”.

- Rehearse out loud. Ask clients to identify a specific situation where the skill might be helpful. This is especially helpful from a cognitive lens when the goal is to shift internal dialogue.
- Question and answer. Asking questions to see what people do and do not know is one of the best ways to introduce a topic.
- Conduct an in-session exercise. Some topics will offer opportunity to actually guide clients through an experience rather than talking about it. For example, guiding clients through grounding exercises is recommended so the group can talk about whether or not it was helpful.
- Role Play. This is one of the most popular methods, especially for interpersonal topics. One suggestion is for the clinician to play the role of “the other person” so exercises are adapted and relevant to each client.
- Do a walk-through. Present real life situations and ask how they might be handled. These topics can be brainstormed by the group, and then discussed.



- **Replay the scene.** This is helpful for reflecting on experiences or choices that “went wrong”, such as conflict with family, or relapses. You may want to ask clients to go through the situation in slow motion, noticing every detail of what they were thinking, feeling, and doing.
- **Review key points.** Ask clients to summarize the main points of the activity/intervention, and use this as a departure to work on the skill. For example, “What do you think the sheet describing anxiety is trying to convey?”

### **Respecting all Levels of Cognitive/Academic Capacity**

Information processing, language development, and overall executive functioning are very often compromised for youth with substance use issues and histories of trauma. As a result, programming offered needs to be sensitive to the learning needs of all clients. As outlined in Domain 4 (Appendix C), there can be difficulties in following direction and verbal response and expression, particularly in response to open-ended questions. Furthermore, clinicians may observe socially inappropriate behaviors and difficulty completing tasks which are at the youth’s level of cognitive/academic ability as well as challenges with working memory, attention, planning and organizing, processing speed, and complex problem solving. Finally, a client’s academic achievement/deficits may be the result of learning disorders, which are discrepant from measured cognitive ability. The NYTC has access to psychological testing if there are individual concerns and the need for further assessment. However, all written programming should match the reading level of client’s participating, and programming be adjusted for client’s as needed. Written content should be continually evaluated by the team, and feedback from

clients should be the driving force behind changing language that is confusing, unclear, or not “youth friendly.” It is the author’s recommendation that written material be no higher than a grade 6 reading level.

It is also imperative to always remember that traditional therapies that rely solely on words and meaning making will not modulate the effected neurobiologic systems. Thus, therapeutic interventions and environments need to have assumed flexibility built in to provide the greatest opportunities for successful learning. For example, if the topic is “anger”, and questions pertain to recognizing how we know if anger is “lurking around the corner” or about to “jump on us”, client’s should be given the creativity and flexibility to explore this in ways that are relevant and meaningful for their learning style. Examples of this built in creativity include; drawing, writing a song or poem, sculpting, verbalizing, role playing etc. Flexibility should also be viewed in the context of structure. It does not mean fostering an environment where “anything goes”, but rather offering creativity within a defined set of parameters. This will no doubt be difficult to do at times, and clinical debriefing will be integral for clinicians to gain a comfort level in respect to this.

## The Impact of Grief and Loss

The experience of loss often involves intense emotions, pain and confusion. Reeves (2001) defined loss and grief as:

**Loss** - occurs any time you feel diminishment or restriction. At any given point in your personal history, a small or large loss is probably part of the living tapestry of your life. Events we perceive as loss include chronic or life threatening illnesses; bereavement; inability to fulfill a dream; separation or divorce; estrangement from a friend, family member, or God; accident; unemployment; and caring for a loved one with special needs.

**Grief** – involves your total reactions and responses to any loss, not just bereavement. Grieving occurs for some aspects of every major life change. Even extremely positive changes mean some letting go, some goodbyes. By allowing yourself to acknowledge and feel all leanings of a positive change, you can integrate the newness in your life more thoroughly (p. 17).

Feelings surrounding grief and loss are often a large part of the lives of clients who are survivors of trauma. There can be a feeling of “unfinished business” which involves grieving many losses associated with abuse including never having a proper childhood or parent, and being unable to trust or to enjoy human intimacy (Reeves, 2001). If a parent/caregiver or other family member is strongly influenced by past or ongoing physical or mental illness, or substance abuse, the entire family is often in a chronic state of loss and grief. Attempts to cope with overwhelming feelings brought on by loss can be unhealthy, such as using substances.

The same principles of establishing safety and stabilization that form the framework of forthcoming program recommendations can be used when dealing with overwhelming feelings

related to loss. Reeves (2001) describes healing as a shift of energy so that people are able to think about the loss without becoming overwhelmed (safety and stabilization), being able to live, not just exist, and having the ability to integrate the loss into the rest of life (stage 3). Thus, working with grief and loss should not be confined to one topic or intervention, but rather be interwoven into all programming by teaching client's how to cope with intense, overwhelming feelings in ways that rely on empathy and compassion.

## **Chapter 4: Program Possibilities for a Tier 5 Youth Substance Use Program**

### **Framework and Rational**

For children and youth, the severity of trauma effects has been measured in terms of functional impact. The following framework for program topics is based on establishing function to the whole person. In every activity and interaction, emphasis is always on honesty, safety, and compassion. Client education is an integral component to this framework, and is the foundation for teaching skills including identification and regulation of emotional states, personal mindfulness, self-care, life skills, coping skills, problem solving skills, social skills, and decision making. These skills also encompass the overall goal of establishing safety and stabilisation, focussing on issues important to Herman's (1992) stage 1 of recovery which has been outlined previously. Briefly, these issues are related to bodily integrity (attention to basic health needs, regulation of bodily functions such as sleep, eating, and exercise, management of symptoms, and control of self-destructive behaviours) and environmental issues (establishing safe living situation, financial, security, mobility, a plan for self protection, reliable and trustworthy social support). Topics are structured to honour the importance of all of these issues.

This framework is also informed by a holistic health, or biopsychosocial model, which stresses assessing and treating the whole individual, including their personal well being (biopscho) as well as their social-economic well being (social). This is important as the initial assessment is guided by the foundations of this model. The personal well being part of holistic health suggests assessing and treating for (a) physical health (nutrition, sleep, exercise, medical issues) (b) social health (relationships with partner, friends, parents or guardians, etc.) (c)

emotional health (personal time or “down time”, hobbies, sense of humour) (d) spirituality (that which gives meaning to one’s life) (e) intellectual health (our brains need regular and diverse stimulation) and (f) occupational health (finding meaningful work). The social part of holistic health suggests assessing and treating for (a) basic needs (food security, clothing, shelter, access to health care) (b) care giving and education (child care, education, income) (c) community life (safe recreational areas to access, a valued role in family, school/work, community) and (d) equal opportunity (addressing issues relating to discrimination on all levels). A closer look at the domains and core issues in Appendix C that provide the framework for interventions will reveal that this model, as well as Herman’s (1992) stage 1 of recovery are taken into full account.

Treatment topics/activities fall into any of four domains as described by Tishelman, Haney, O’Brian, & Blaustain (2010). Each domain is explained in detail in Appendix C, and includes Self-Regulation (Domain 1), Physical Functioning (Domain 2), Relationships (Domain 3), and Cognitive Functioning (Domain 4). Because NYTC follows an open intake admission format, with length of stay often being unpredictable, skills for safety and stabilisation in each domain need to be part of daily programming. The result of this form of implementation will mean that irrespective of length of stay, clients are less likely to “miss out” on important treatment topics because the importance of functioning on all levels is the daily status quo. An implementation plan is not outlined in this document, as there is an assumption that each team will harness their own creativity and flexibility in building daily program structure based on this framework. Each activity will include which domain it falls under in this framework (e.g., 1A., 2C., etc.), and because domains overlap and deficits/strengths in one domain can also be an aspect of dysfunction in others, for many activities more than one domain is referenced.

## **Assessment**

Use of domains to guide assessment and intervention is consistent with a bio-psychosocial approach. For a trauma informed assessment, emphasis should be on functioning and not solely diagnostic profiles. Each clinician will develop their own “style” of assessment within the framework often provided by agencies, as is the case for NYTP. The following is an example of (a) a framework for a bio-psychosocial assessment (b) domains and associated core issues related to trauma (see Appendix C for detailed version) and (c) a set of sample questions that could be embedded into initial assessment.

### **First Impressions Count!**

Clients with substance use are notorious for high “dropout” rates from treatment, and clients with trauma have a difficult time trusting people. People coming to treatment may feel vulnerable, anxious, or scared. Talking about these feelings will create an atmosphere of emotional validation from the beginning. There will be times when clients become emotionally upset and overwhelmed right away. If this happens, empathize with their emotional pain, and try to re-direct the conversation to a neutral, present topic. Ensure to provide a rationale when doing this so the client does not feel invalidated. For example, “I would like to hear about your experiences, but I’m concerned at this point that we may not be able to do that safely. You will have ample opportunity to talk with staff, but right now let’s focus on getting unpacked and settled.” Even if the client appears to be stable emotionally, this is a time to talk about the overwhelming feelings and emotions that often do arise in treatment, and assure them that they will not be pushed to talk about anything they do not want to. The goals of treatment fall largely

within stage 1 of Herman's (1992) tri-phasic model, so safety and stabilization are the foundations for all therapeutic work.

Intake is an opportune time to explain that the overall goals of the program are to help (a) people work towards moving substance use out of their in ways that have meaning for them (using harm reduction philosophies), (b) stay alive, (c) not hurt themselves or others, (d) build healthy relationships, (e) learn to cope with day to day problems, (f) gain control over overwhelming feelings, (g) learn healthy self care, (h) remove oneself from dangerous situations, and (i) attain stability.

This is also a time to discuss how as a team, we work with the past. This can be accomplished by acknowledging that many people want to talk a lot about their past, but we find often they are unable to manage overwhelming feelings and memories that arise. The initial goal is always to establish safety in learning strategies to cope with intense feelings. Also, because the NYTP is largely a group treatment program, details about traumatic events, just as war stories about substances, can be upsetting and triggering to other clients. For this reason, it is our job to monitor and guide these conversations as they arise to maintain the safety for all in the program.



**Sample Bio-psychosocial Assessment Tool**

Date:

Client Name:

Age:

Gender:

Allergies:

Admission status:

Diagnostic Impression:

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

Comments:

Reason for admission:

Client's perception:

Perception of others:

Precipitating factors:

Predisposing (risk) factors (family history):

Treatment history:

Present medications (including supplements, vitamins, herbal preparations):

Substance use history:

Living situation:

Ethnicity/culture:

Cultural and spiritual beliefs and practices:

Health beliefs and practices:

Present life circumstances (ex. educational and work history, living situation, legal issues):

Mental status:

General appearance (dress, behavior, posture, eye contact):

Motor behavior:

Speech:

Mood and affect:

Thought process (how the client thinks, including cognition):

Thought content (what the client thinks about, including delusions):

Sensorium and intellectual processes (orientation, memory, concentration, attention, intellectual functioning, hallucinations):

Suicidal or homicidal ideation:

Judgment and insight:

Self-concept:

Roles and relationships:

Physiologic and self-care concerns (medical problems, physical impairments or disabilities, self-care deficits, review of systems):

Client strengths/resiliency:

Coping skills (effective and ineffective):

Interests and hobbies:

How the client spends a typical day:

Teaching needs:

Barriers to learning:

Client's expectations for care:

Discharge planning:

## Domains and Associated Core Issues

### DOMAINS

### CORE ISSUES

Self Regulation

Deficits in emotion identification  
Hyper-vigilance to threat  
Impaired ability to modulate arousal  
Extreme mood states  
Dissociation

Physical Functioning

Disconnection from body  
Physical holding of stress  
Physical integrity/boundaries  
Trauma-related injuries

Relationships

Sense of self  
Trust and safety  
Social skills and competence

Cognitive Functioning

Information processing  
Language development  
Executive functioning  
World view and personal agency  
Learning disorder

(Adapted from Tischelman, Haney, O'Brain, & Blaustein, 2010)

## Possibilities for Trauma Questions to Embed in Assessment

1. At any time in your life, have you been involved in a natural disaster or severe accident where you or someone else was seriously injured or killed (plane or auto crash, fire, flood, explosion, etc.)?

2. At any time in your life, have you experienced the sudden and unexpected death of a close friend or loved one due to an accident, illness, suicide or murder?

3. At any time in your life, have you been seriously injured or witnessed someone else seriously injured or killed, due to an unnatural event such as a shooting, stabbing or hit-and-run accident?

4. At any time in your life, have you been physically abused (e.g., punched, slapped, kicked, strangled, restrained, burned, threatened with object or weapon, etc.)?

5. At any time in your life, have you been sexually abused (e.g., unwanted kissing, hugging, touching, nudity, attempted or completed intercourse)?

If yes, ☐ Childhood ☐ Adolescence ☐ At Present

By whom: ☐ Stranger ☐ Acquaintance ☐ Partner ☐ Parents

Other Family Member ☐ Ritual Abuse

6. At any time in your life, have you been afraid that a specific person (whether it was someone you knew well or not) would hurt you physically or emotionally?

7. At any time in your life, have you witnessed a physical or sexual assault against a family member, friend, or other significant person?

8. At any time in your life, have you been raped?

9. At any time in your life, were you ever exposed to warfare or combat?

10. At any time in your life, have ever witnessed abuse/torture to animals?
11. If yes to any of the above, are you experiencing flashbacks, nightmares, insomnia, numbness, confusion, memory loss, self injury, extreme fearfulness or terror, or any other symptoms you think may be related to the trauma?

***It is important to remember that trauma history is also asked for in the Northern Health Youth Services inpatient referral packages. As is the general rule, use clinical judgment in assessing for trauma. If you already know there is a trauma history, asking this may not be as necessary as asking about symptoms associated with trauma. Remember:***

- 1. The intent of asking about trauma is so that clinicians/multi-disciplinary teams are sensitive to the full context of a client's substance use and presenting symptoms. Uncovering and exploring the story of the trauma is not and should not be the intent.***
- 2. Always ensure client's feel comfortable in invasive procedures, including assessments, and make adjustments to these procedures where/when clients request to.***
- 3. Inform before performing – continually inform clients of what is happening during all health care encounters and assessments. Assessments and interventions are not something that should be "done to", but rather "done with".***

**Daily Check-in****Domain(s):** 1A, 1B, 3A, 3C**Overall goal is to promote self regulation by:**

1. Promoting identification/naming of physical and emotional states.
2. Promoting identification and reflection on ways to cope with uncomfortable or overwhelming feelings (both presently and in past 24 hours).
3. Establish and maintain trust and safety within the group.
4. Review structure and activities of upcoming day.

**Materials:**

1. Poster of emotions in group room.

**Process:***Review:*

1. This group is a check-in, so keep it simple. It can be difficult at times to keep check-in for its purpose, but once it becomes routine, it is easier to do. Keep reflections and interpretation to a minimum. Maintain balance in the group. A general guideline for check-in is no more than 5 minutes per client.
2. Remind client's to not to speak during someone else's check-in.
3. Find opportunities to give brief positive feedback. Enthusiastically praise positive gains, and display genuine concern if clients are reporting unsafe behavior. Recognizing good coping skills is one of the most powerful methods for growth, and counteracts the tendency to define patients by their pathology and highlights how resourceful they can be.

*Working Time:*

1. Remind clients that check-in is a time to practice becoming familiar with how we truly are, physically, emotionally, and mentally. This is something that the chaos of substance affected lives often prevents. The reason why there is check-in everyday is to provide time to practice "tuning in" to ourselves. There will be days where we feel good and confident, and days where we feel negative, overwhelmed, and maybe even triggered. By identifying which emotions "push us around", we can begin to take steps to (a) name them (b) make them more predictable (get to know them) and (c) discover new ways to cope.
2. When reviewing the day, remind clients that we try to build in structure and predictability in daily programming in recognition that the lives of people who often come to the program are chaotic and unpredictable. One of our goals is to be able to "quiet the noise", enabling us to start to become aware of ourselves. While this may not be comfortable, we are here to help people learn how to cope without depending on substances or other unhealthy strategies people would like to change.

3. If there are new clients to the group, go over group norms. If there is a member of the group who would read these out, ask them to. This provides opportunity to empower the group to hold themselves and each other accountable.

## **Important Disclaimer**

As stated previously, the motto is “show it rather than say it.” Thus, documents are not intended to be used as worksheets, where literature is given to a client to read and write down answers to be discussed upon completion. For this reason, the heading “Facilitator Review” on the top of the page implies that the facilitator would spend time (usually 10 – 15 minutes) introducing the topic. Activities are designed to be interactive. There is no one way to facilitate these activities, and success relies on a clinician’s creativity and flexibility to deliver material in a way that is sensitive to the clients in the group.

The heading “Activity” means that based on the information reviewed, everyone would participate in an activity to process the topic further. Activities can be done as “break out” activities or “group activities”. In break out activities, following the facilitator review, participants would be offered a structured time and space to individually explore the topic, and then come back as a group for discussion. If this is chosen by the facilitator, ensure options are given to respect learning styles and information processing abilities of all clients (e.g. writing, drawing, sculpting etc.). Group activities would be an activity explored as a group without breaking away.



## Goal: Identification of Emotional States - Anger

### Facilitator Review

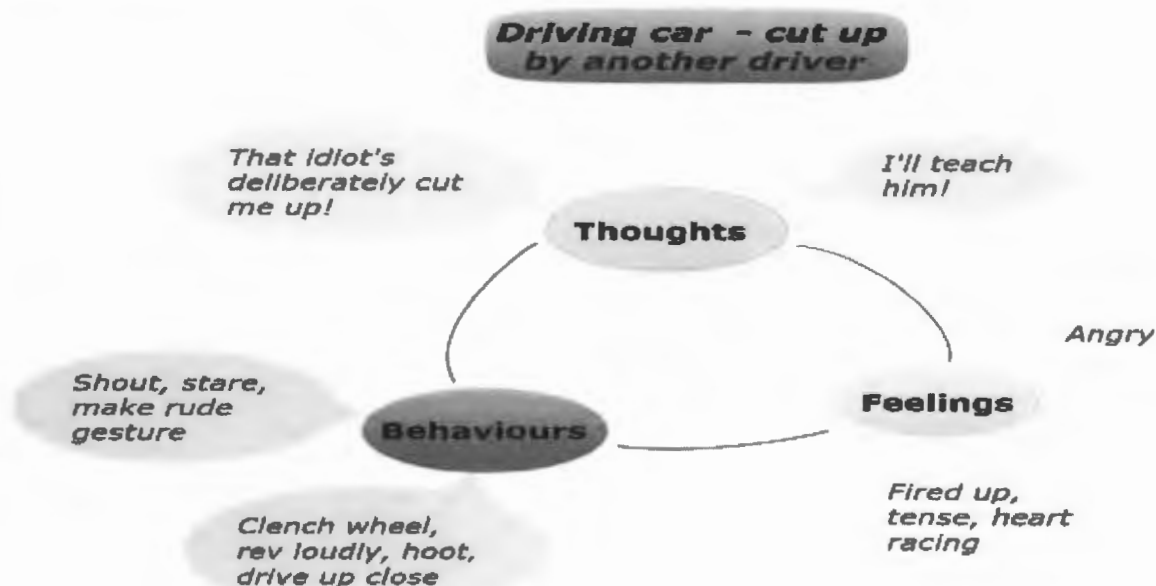
## ANGER



Anger is a very energising and motivating emotion. It's a natural and normal response to feeling threatened, or thinking something is unjust or unfair. Sometimes we're right to think and respond in that way. It can be a very appropriate and healthy response. For instance, we see a crime being committed or someone being attacked, we might instinctively react and rush to help the person being attacked, and stop the attacker.

However, there are times when, perhaps due to our past experiences, something around us, a noise, the way someone looks at us, the way someone says something, a gesture – anything – triggers this response. We can mis-interpret situations and believe others are having a go at us, that we're being criticised or attacked in some way, which then starts the angry cycle. We can get into the habit of responding this way, and it can be a hard habit to shake. This vicious cycle though, is a cycle – and we can break cycles, particularly at the points where we think and act: we can learn to think and act differently.

Here is an example of the Angry Cycle:



### **How do we “break” the cycle?**

Sometimes anger, like other emotions, can “sneak up on us”, and before we know it, we are in a full blown state of anger!! We all feel angry sometimes, but anger has its consequences, and they often involve hurting other people - more usually their feelings, but sometimes physically. Anger can cause problems in our personal lives, and affect work and study. After an angry outburst, we can think very critically of ourselves and our actions, leading us to feel guilty, ashamed and lower our mood, which might result in our withdrawing from others, not wanting to do anything.

In order to act differently when anger “comes around” we need to get to know it better, make it more predictable. This includes paying attention to the thoughts that make us angry, as well as our body’s reaction. We can turn down our “super-scanner” from high sensitivity, to a level where we are less reactive. This is an on-going process, but is something we can start at any time – so let’s start!

**Activity: The Anger Iceberg****Domain(s): 1C, 3A****Goal(s):**

1. For participants to be aware of (a) how they express their anger and (b) what is below the surface of their anger.

**Process:*****Facilitator Review***

Anger is what we all see. When someone is angry, it is obvious by the look in the person's eyes, the clinched fists, sweat on the brow, and loud voice...

Upon closer inspection, anger is like an iceberg. The tip represents the anger, which everyone sees. However, there is 90% more of that iceberg hidden below the surface of the water. This tip of the iceberg is actually the symptom. The more complex feelings responsible for this symptomatic anger vary widely from person to person. Generally, anger icebergs often include fears, insecurities, frustrations, hurt pride, feelings of disrespect, and various other emotions.

Given that it is usually quite easy to see a person's anger, but difficult to see the underlying issues, the task of starting to reduce our anger often takes a bit of detective work. The best way to control anger is to ask, "What is making me feel this way?" When we examine our feelings that cause the anger, then the problem might be easier to address.

The anger iceberg is great to use to control your own anger. However, it is also helpful to control your reactions to others. For instance, let's assume that you see someone's angry actions and you then become angry. By using the anger iceberg, it will quickly become apparent the other person has feelings causing him or her to behave this way. It is much more difficult to become angry with someone when you recognize they are showing anger out of fear, insecurity, jealousy, or hurt. When one recognizes this, it is much easier to use empathy to understand their situation. This will then enable you to help that person deal with their anger, or at least help you to stay calm in this situation.

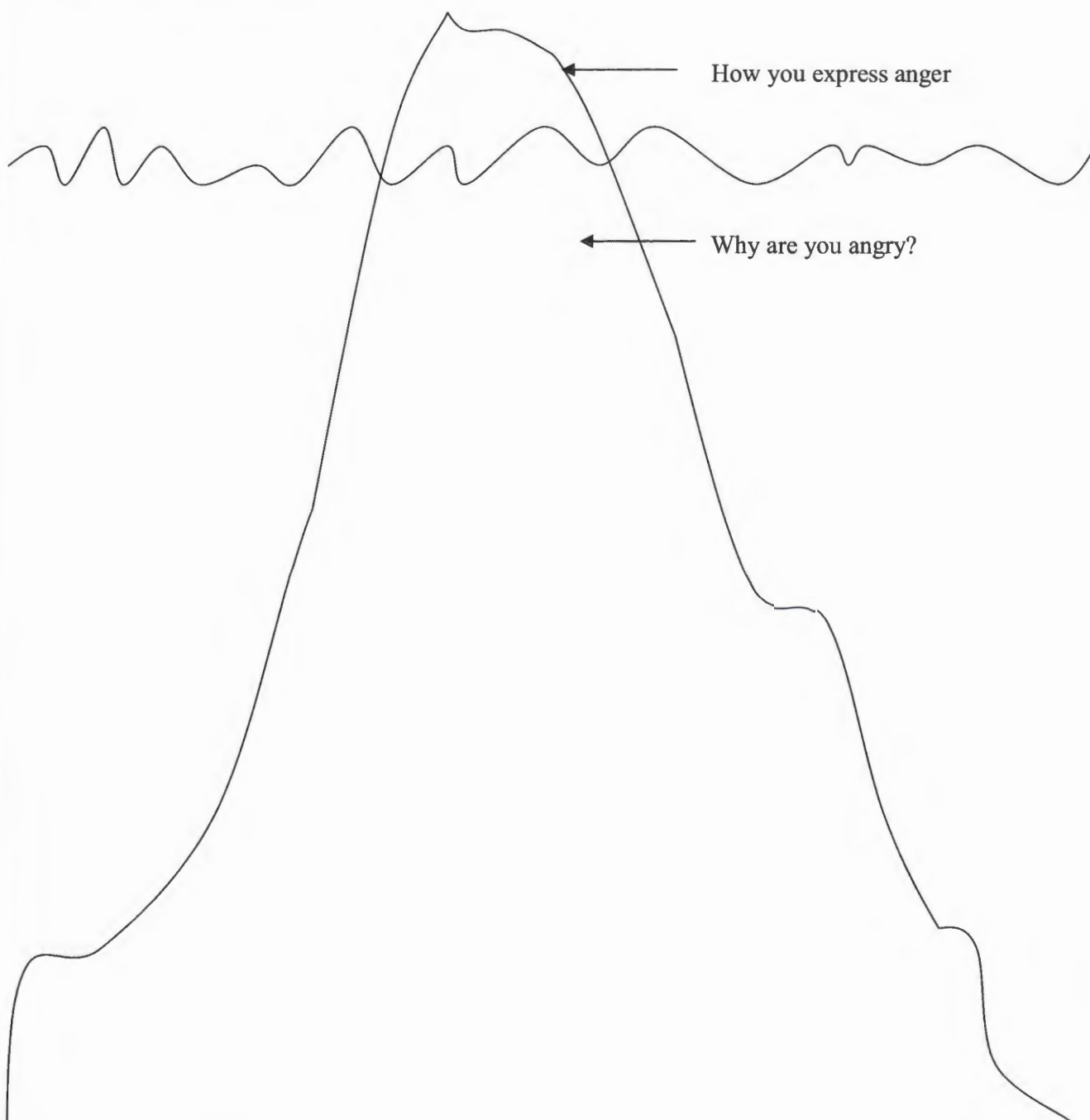
**For Male Clients:** Many people, especially males, subscribe to the notion that it is okay to show anger by being violent. However, it is not okay to show other emotions, such as sadness, guilt, fear, shame, and inferiority. It is no mistake that many of these feelings fit the part of the anger iceberg that is hidden below in the water's depths and do not surface because of societal expectations. Everyone is challenged to discuss their true feelings, instead of taking the "macho" route and only express the symptomatic anger. Ask yourself, "What am I feeling other than

anger?" This will certainly increase the chances of reducing one's anger, while helping to change how our society treats emotions.

***Working Time: Anger Iceberg***

**ANGER ICEBERG**

What drives your anger? Think of anger, and your expression of anger as the tip of an iceberg. What lies underneath the tip of your anger iceberg, or under the surface of what you allow people to see (i.e. you getting angry)?



**Activity: Identifying Our Triggers****Domain(s):** 1A, 1B, 1C, 1D, 3A**Goal(s):**

1. Learn to identify thoughts, feelings, and behaviours associated with anger

**Process:****Facilitator Review:****Thoughts** that often occur:

- I'm being treated unfairly
- I'm being disrespected
- They're breaking a rule or standard
- I won't stand for it

**Physical Sensations** - The Adrenaline Response

When there is real, or we believe there is a real, threat or danger, or that we have to defend or stand up for what we believe is right, our bodies' automatic survival mechanism kicks in very quickly. This helps energise us to fight or run away ('fight or flight response'). We will notice lots of physical sensations, which might include:

- heart racing or pounding - enabling good blood supply around our bodies
- breathing quickly - allowing more oxygen around the body
- tense muscles - a state of readiness to fight or flee
- shaking
- hot, sweating
- light-headed
- stomach churning or butterflies
- fist or teeth clenching

**Behaviours** might include:

- |                                       |                                     |
|---------------------------------------|-------------------------------------|
| ● staring & angry facial expression   | ● aggressive body posture           |
| ● go towards what makes us angry      | ● attacking or arguing              |
| ● hitting out (or urge to hit out)    | ● shouting, snapping at others      |
| ● running or storming away            | ● staying silent, inwardly seething |
| ● door slamming, making lots of noise | ● sulking                           |

(Adapted from Vivyan, 2011)

***Working Time: Identifying Our Triggers***

**How does your body tell you that you're getting angry? Make a list:**

- 
- 
- 
- 
- 
- 
- 
- 
- 
- 
- 
- 
- 

**What do you do when you're angry?**

- |   |   |
|---|---|
| - | - |
| - | - |
| - | - |
| - | - |
| - | - |
| - | - |
| - | - |

**If people around you see you getting angry, is there anything they can do to help?**

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**Activity: The ABC's of Anger/STOPP****Domain(s):** 1A, 1B, 1C, 1D, 3A, 3C**Goal(s):**

1. For participants to practice identifying triggers, beliefs, and consequences of anger.
2. Begin to learn perspective taking, and practice what works in situations when they are angry.

**Process:****Facilitator Review:**

There are two worksheets attached; The ABC's of Anger, and STOPP. There are questions outlined on each sheet to go through with participants. This can be done as a group (if these examples are something that a team of clinicians find useful, having them enlarged and laminated to keep in a group room would enable facilitators to use dry erase markers to walk through scenarios) or as a break out activity.






<b>A</b>	<b>B</b>	<b>C</b>
<b>Activating / Triggering Event Situation</b> (Trigger may also be a feeling)	<b>Beliefs</b>	<b>Consequences</b>
<ul style="list-style-type: none"> <li>• What was happening just before I started to feel this way?</li> <li>• What was I doing? Who was I with? Where was I? When was it?</li> </ul>	<ul style="list-style-type: none"> <li>• Thoughts and/or Images <i>What was going through my mind at that time?</i></li>   <li>• Meanings &amp; interpretations <i>What did this say or mean about me?</i> <i>What was the worst thing that could happen?</i></li> </ul>	<ul style="list-style-type: none"> <li>• Emotions Describe as in one word/s &amp; rate intensity 0-100%</li>   <li>• Physical sensations <i>What did I feel in my body?</i></li>   <li>• Behaviours: actions &amp; urges <i>What did I do?</i> <i>What did I feel like doing?</i></li> </ul>

www.getselfhelp.co.uk

www.get.gg

(Vivyan, 2010)

## STOPP

<b>STOP</b> 	<b>Take a BREATH</b> 	<b>OBSERVE</b> 	<b>PULL BACK</b> <b>PUT IN SOME PERSPECTIVE</b> 	<b>PRACTISE WHAT WORKS</b> 
<p><i>Stop and step back from the situation, in your mind</i></p>	<p><i>Breathe slowly once or twice</i></p>	<p><i>What's happening? What am I reacting to? What am I thinking and feeling? What are the words that my mind is saying? What physical sensations do I notice in my body? Where is my focus of attention?</i></p>	<p><i>Is this fact or opinion? See the situation as an outside observer. Is there another way of looking at it? What would someone else see and make of it? What advice would I give to someone else? What's 'the helicopter view'? What meaning am I giving this event for me to react in this way? How important is it right now, and will it be in 6 months? Is my reaction in proportion to the actual event? What will be the consequences of my action?</i></p>	<p><i>What can I do that will be most helpful? Will it be effective and appropriate? Is it in keeping with my values and principles? What is best thing to do, for me, for others, for the situation?</i></p>



## Goal: Identification of Emotional States - Anxiety

### Facilitator Review

#### ANXIETY



Anxiety is the body's way of responding to being in danger. Adrenaline is rushed into our bloodstream to enable us to run away or fight. This happens whether the danger is real, or whether we believe the danger is there when actually there is none. It is the body's alarm and survival mechanism. Primitive man wouldn't have survived for long without this life-saving response. It works so well, that it often kicks in when it's not needed - when the danger is in our heads rather than in reality. We think we're in danger, so that's enough to trigger the system to go, go, go! People who get anxious tend to get into scanning mode - where they're constantly on the lookout for danger, hyper-alert to any of the signals, and make it more likely that the alarm system will be activated.

#### "Cycle of Anxiety"

**Trigger - real or  
imagined danger**

*I can't cope*

*I feel bad so  
it must be  
bad*

*Something  
terrible is  
going to  
happen*

**Thoughts**

*Anxious,  
fearful*

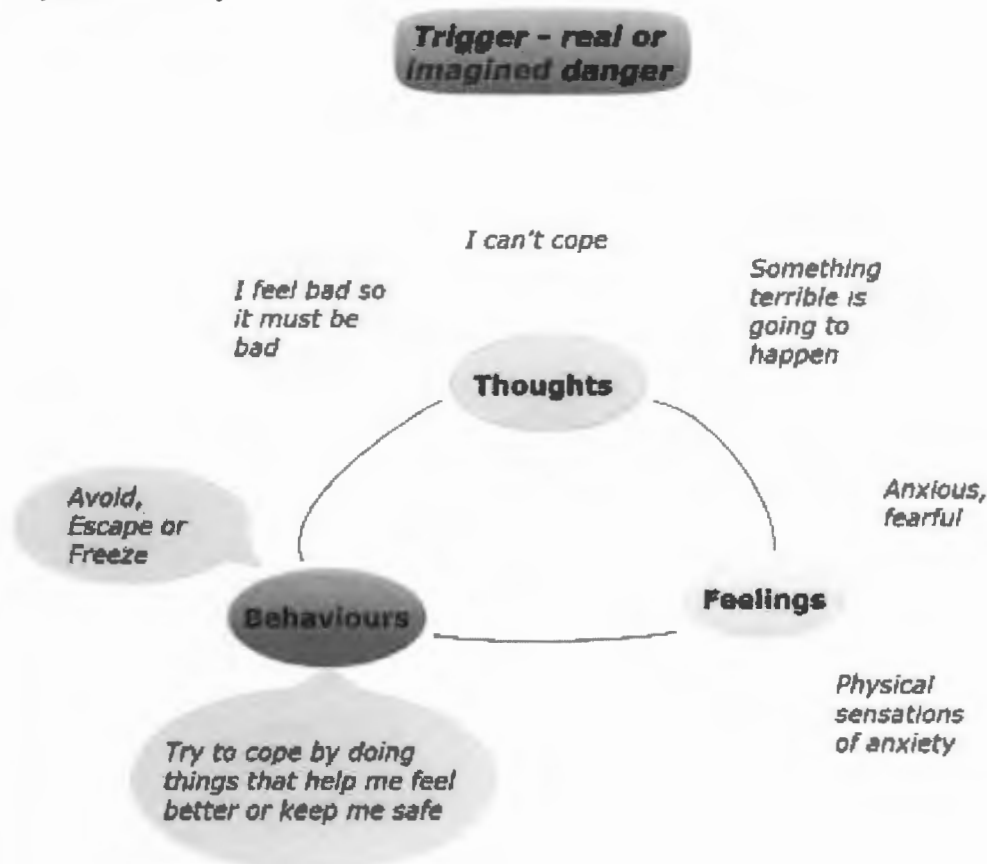
*Avoid,  
Escape or  
Freeze*

**Behaviours**

**Feelings**

*Physical  
sensations  
of anxiety*

*Try to cope by doing  
things that help me feel  
better or keep me safe*



We all feel anxious some times. A certain amount of anxiety helps us to be more alert and focused. For example just prior to an exam, a few exam nerves have a positive effect - motivating us, helping us focus our thoughts on the job in hand, or making us more alert. Too much anxiety, or constantly being anxious, is unhealthy and detrimental to our lives and relationships.

### **Thoughts**

- Something bad is going to happen
- I won't be able to cope

### **Body reaction**

Adrenaline response – Body's alarm system - Energised for fight or flight.

Blood is diverted to the big muscles to help us escape or fight the threat, and blood is therefore taken away from other body systems.

You might notice in your body:

- Heart rate increases
- Breathing speeds up, breathless, choking feeling
- Muscles tense, aching, shaking
- Hot, Sweating
- Lightheaded, Blurred vision
- Butterflies in tummy, urge to go to toilet
- More alert – scanning for danger

**Behaviours** might include:

- Avoiding people or places
- Not going out
- Going to certain places at certain times, e.g. shopping at smaller shops, at less busy times
- Only going with someone else
- Escape, leave early
- Go to the feared situation, but use coping behaviours to get you through: examples include: self talk, holding a drink, smoking more, fiddling with clothes or handbag, avoiding eye contact with others, having an escape plan, medication. These are called 'safety behaviours'.

### **Thinking differently**

- Is this threat a real one or is it really bound to happen?
- Am I exaggerating the threat? Am I misreading things?
- I feel bad, but that doesn't mean things really are so bad.
- What would someone else say about this?
- What would I say to a friend in this situation?
- What would be a more helpful way of looking at things?
- Where's my focus of attention?
- I can cope with these feelings, I've got through it before. This will pass.

**Doing differently**

- Take a breath
- How will doing this affect me in the long term?
- Don't avoid situations – go anyway.
- Problem solve or make plans if necessary.
- Take things slowly or gradually.
- Focus attention outside of me – external rather than internal focus.
- What's the best thing to do?
- What would help most?

(Adapted from Vivyan, 2011)

## Goal: Identification of Emotional States - Depression

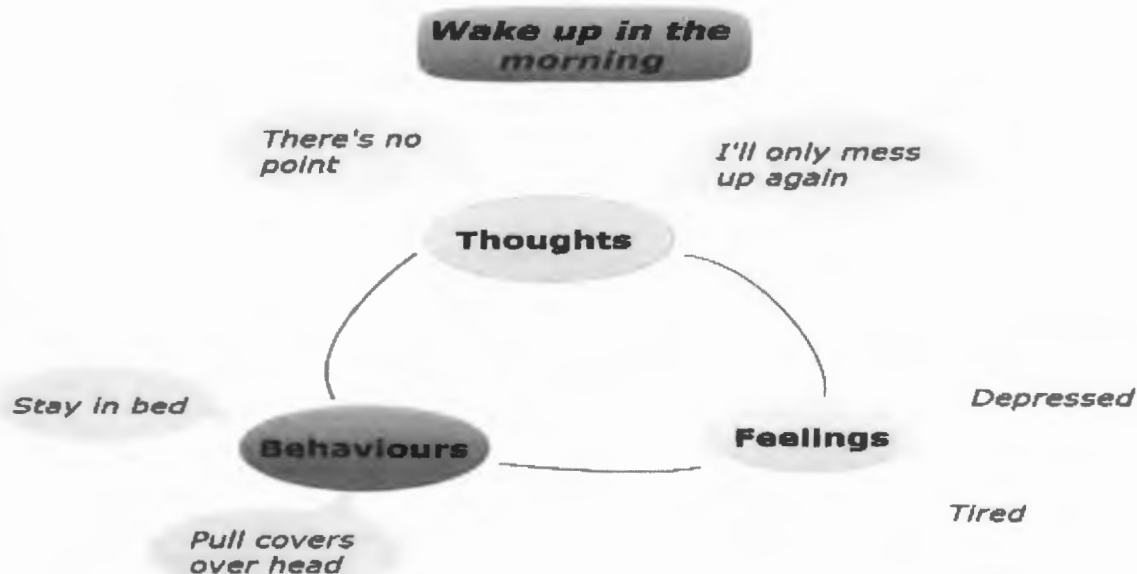
### Facilitator Review

## DEPRESSION



Depression can happen to anyone - and does happen to one in four of us over our lifetimes. Different factors that make it more likely to happen include biological make-up, upbringing, or reaction to life events. What keeps it going though is how we deal with those things. The way we think and what we do affects the way we feel. Depression is often accompanied by other feelings such as guilt, shame, anger and anxiety.

### "Cycle of Depression"



## Thoughts

People who are depressed tend to think very negatively about themselves, the future and the world around them. It can be like seeing life through “gloomy specs”.

- Everything is hopeless - nothing can change
- I'm useless, worthless
- It's all my fault
- The world is a terrible place - everything goes wrong

We can dwell on these thoughts repeatedly, mulling over things, asking ourselves why, thinking regretful things about the past, what we should or shouldn't have done.

## Physical Sensations

- Tiredness, fatigue, lethargy
- Difficulty concentrating or remembering
- Sleep changes (sleep more or less)
- Eating changes (eat more or less)
- Lose interest in hobbies, activities, sex

## Behaviours

Because of the tiredness, difficulty sleeping and eating, and negative style of thinking, we tend to do less and less. We stop doing the things we used to do and enjoy. It could get so bad that we can't even go to work, or do things at home. We want to stay in bed, or stay at home doing very little. We might isolate ourselves from friends and family.

## Breaking the cycle:

### Activity & Physical Exercise



When we're feeling depressed, we tend to do less and less because of the tiredness, difficulty sleeping and eating, and negative style of thinking. We stop doing the things we used to do and enjoy. It could get so bad that we can't even go to work, or do things at home. We want to stay in bed, or stay at home doing very little, and we might isolate ourselves from friends and family. Just increasing our activity and exercise levels can make an enormous impact on our mood by:



- Making us feel better about ourselves
- Making us feel less tired
- Motivating us to do more
- Improving our ability to think more clearly
- Helping us think about something other than focussing on our unhelpful thoughts

- Using up the adrenaline resources created by anxiety and anger
- Increasing motivation
- Giving us a sense of achievement
- Enjoyment
- Being with other people
- Stimulating the body to produce natural anti-depressants
- Making us generally healthier
- Stimulating our appetite

(Adapted from Vivyan, 2011)

## Goal: Identification of Emotional States – Stress

### Facilitator Review:

## STRESS



Stress is the *general* feeling you get as a result of a lot of different kinds of problems and challenges. Imagine that every worry, relationship problem, tough homework assignment, and issue with a parent is a separate rubber band around your head. As your life gets more complicated, more rubber bands are layered on until your head is completely covered. Stress is the pressure you feel on the inside.



Human beings have limits to the amount of internal pressure they can stand. When you're close to your limit, life can feel depressing, overwhelming, frightening, or even dangerous.

It's hard to do something about your stress when there are so many rubber bands that you can't tell which *one* is making you feel bad. Instead, you have an overall sense that something is wrong. You may feel anxious, but you can't name the problem that is causing or contributing to your anxiety. It's almost impossible to know where to start fixing things when you're dealing with a general feeling. Some people say it's like "**fighting an invisible tiger**" because when your life is stressful, it can feel like you're in a thick jungle with lots of dangerous tigers – ferocious, hungry, invisible tigers. You can't see them, but you can sense them stalking you. Imagine...

*You're alone in a steamy, spooky jungle. You've been hacking through it for days while huge mosquitoes chomp at your flesh. Weird noises and strange smells fill the air, and the heat is enough to fry your brain. And every now and then you hear a deep, menacing growl...*

Now imagine if you had to live with this fear every day – always watchful, on edge, and ready to react. Being on guard every minute takes an enormous amount of energy. A person with many *tigers* and no way to manage them can get pushed to the limit in a hurry.

What if you had to live in that jungle for years and years? When high levels of stress continue over long periods of time, this can lead to illness, depression, and other problems. Chronic stress is serious business.

### **The Bad News**

- You can't cure stress by thinking about it or worrying about it.
- Being smart, creative, motivated, or energetic does not necessarily help relieve stress and can even add to the stress in your life.
- There are no easy answers or quick fixes for managing stress.

So....what can you do to keep from being swallowed by stress?

### **The Good News**

- You can learn about stress and understand why you sometimes feel depressed, overwhelmed, or exhausted.
- You can learn to better understand the complex emotions and physical responses that all people experience when they are under pressure.
- You can develop an "early warning system" to help you know when to do something about the increasing stress in your life.
- You can learn positive ways to take care of yourself during hard times.
- You can learn new skills to gain control over your life and manage your "tigers".
- You can learn to create a life in which tigers can't eat away at the fun and generally positive attitude you should be experiencing every day.
- **YOU CAN START HERE AND NOW**

(Adapted from Hipp, 1995; Vivyan, 2011)



**Activity: Getting To Know Your Stress****Domain(s): 1A****Goal:**

1. For participants to be aware their own sources of stress.

**Materials: (will vary depending on how group is facilitated)**

1. Whiteboard
2. Poster paper
3. Markers

**Process*****Facilitator Review:***

Stress is not just a modern phenomenon. Think of the tiger example. On a nice day in the jungle, a huge saber tooth tiger with lunch on its mind could leap out in front of unsuspecting people. Because most hungry tiger are in no mood for conversation, smart people learned to react right away and either bash the cat or dash for safety. This required a fine tuned nervous system that could instantly mobilize the body into what we now call the “fight or flight” response. Pre-historic folks that weren’t good at it became tasty snacks, and those who could run or fight lived to tell the story around the fire. Over millions of years, the people with the best fight or flight skills survived. And the other...they didn’t come home after lunch.

This means we have inherited an incredible nervous system that gets our bodies ready to do battle or run like the wind at the first hint of danger. It is so sensitive that even thinking about “tigers” and other frightening things can be enough to get us fired up.

Most of us obviously have never had to face real tigers, but the world you live in can be every bit as threatening. For example, it can be anxiety-producing to:

- watch your parents fight
- take a test in class
- move away from friends
- worry about getting into a fight

***Working Time: Sources of Stress***

Discuss with participants:

What are the sources of stress in your life? This can be brainstormed as a group or done as a breakout activity.

(Adapted from Hipp, 1995)

**Activity: Early Warning System****Domain(s): 1A, 1B, 1C, 3A****Goal(s):**

1. For participants to learn about the bodies normal fight-or-flight response, and learn their own early warning system.

**Process:*****Facilitator Review:***

The problem is that whenever we're up against something that makes us feel threatened, our body still responds to it as if we are meeting a "hungry tiger". At the first hint of danger, off goes the alarm, and instantly you're ready to physically and emotionally fight or flee.

During high times of stress, many different physical events occur inside our bodies at the same time. If we don't understand what's happening, it can feel as if our bodies are having problems instead of gearing up to deal with the challenges we're facing. As we learn about stress and the changes it creates in our bodies, we start to recognize the changes as an early-warning system, a set of signals indicating the need to do something about our lives in that particular moment.

Here's a description of some of the physical changes that take place in *healthy* bodies during the fight-or-flight response, along with reasons why they happen. While each person's body will react slightly differently, we all experience some version of these events, instantly and automatically, whenever we perceive we are in danger.

- Your heart pounds – the body needs all of the oxygen-rich blood it can get, and it needs it in a hurry, so the heart beats harder and faster.
- Your hands and feet feel cooler than usual – the capillaries in your hands and feet constrict to make more blood available at the centre of the body and in large muscles needed for running and fighting.
- You may feel warm in the face, your cheeks and ears may get pink, and/or you may suddenly develop a "pressure" headache – the carotid arteries in the neck open up to allow more blood to the brain
- Your mouth may get dry and/or you may have an upset stomach – the digestive tract shuts down to let its blood be used elsewhere
- You may get "butterflies" in your stomach and/or feel "restless" – glands and organs produce chemicals that help the body to prepare for running or fighting. The most common of these is adrenaline.
- You sweat. Your hands may get clammy – anticipating the extra heat that running and fighting generate, the body turns on its climate-control system by producing excess moisture on the surface of the skin. Evaporation of this moisture creates a cooling effect.

It's important to know that it's **completely normal** to feel weird physical sensations during times of major stress. Our bodies aren't malfunctioning – they're working exactly how they should.

The question to ask yourself isn't "what's wrong with me?" but "what's happening that is making me feel this way?"

***Working Time – Early Warning System***

Question: What is your bodies "fight-or-flight" response. Again, this can be brainstormed as a group or done as a break out activity.

One way to do this is provide each participant with a poster board and ask them to title it "My early warning system", and they can make a list as creatively as they would like and keep it in their rooms so they can add things to it as they hone their own early warning systems. This exercise can easily be adapted to other emotions/mood states as well (e.g. – Early-warning system for anger.)

**Activity: I'm at My Limit!!****Domain(s): 1A, 3A****Goal(s):**

1. For participants to begin to understand the difference between short term and long term stress.
2. To gain awareness of their own "stress limits" in order to know when they need to "slow the world down."

***Facilitator Review:*****Short-term stress and long term stress:**

**Short term stress:** The fight or flight response takes a lot out of us. Battling real or invisible threat ("tigers") is a total body experience. Fortunately, these moments don't last very long. After the danger passes, there is a period which our bodies can calm down, rest, and return to normal.

**Long term stress:** So what happens when we live with stress constantly? When our lives are full of triggers that never go away? We gradually adapt to higher and higher stress levels, and may never find the time to calm down, rest, and recuperate. Soon, we're living with and *unhealthy* amount of stress and calling it normal. Long-term stress can be dangerous because we may not be aware of the physical and emotional toll it is taking on us.

We all do our best to live in a world full of "tigers". We try to be responsible and handle everything that comes in our way. But when stress in our lives increases we often forget to take time to rest and recuperate. Without realizing it, we gradually lose our energy, positive attitude, and performance edge. Eventually, you reach the limit of what you can handle.

***Working Time: I'm at my Limit!!***

How do you or people around you know when you are stressed out? Again, this can be brainstormed as a group or done as a breakout activity.

Examples: more trouble with teachers, needing a lot of sleep or not sleeping well, wanting to eat all the time or never eating, headaches, stomach aches, colds, infections, escapist behaviour (over doing one thing like TV, music, sleeping, substances), withdrawing, crying for no reason, restless, anxious all the time, depression, sadness, crabbiness etc.)

(Adapted from Hipp, 1995)

**Activity: This is How I Cope****Domain(s):** 1A, 1C, 1D, 2B, 3A**Goal(s):**

1. To learn the difference between positive and negative coping skills.
2. To begin to reflect on and build their own positive coping strategies.

**Facilitator Review:**

We have complicated lives, challenges, things to worry about, pressures to perform and conform, and a head full of misconceptions that make things worse. So, how do we survive?

**We cope.** We use coping strategies (positive and negative) to get through the hard times.

Coping is not stress management – it is what we do to survive!

Coping is a short-term way to do something about the feeling of being stressed. None of the actions will fix the problem that caused the stress in the first place, and some create new problems. For the moment though, they give us a way to decompress or get away from the uncomfortable feeling of stress.

There's nothing wrong with coping activities, as long as they don't go on forever.

Unfortunately, it's easy to string them together for hours, days, months, or a lifetime to avoid dealing with the real problems that are driving the stress. It's like using your finger to plug a leak in a dam. It works for a while, and then the growing pressure behind the dam breaks through in another place and another...until you run out of fingers!

There are 3 basic levels of coping – *distraction, avoidance, and escape*.

**Distraction:** Watching TV, phoning a friend, eating, listening to music, going for a walk.

Distractions are the least harmless and often shortest lived coping activities.

**Avoidance:** Avoidance activities are like distractions carried to an extreme, but they take up more time and energy and enable you to sidestep your troubles for longer periods. Avoidance can come in the form of *procrastination, illness, sleep, and withdrawal*.

**It's important to remember that coping is different than acquiring and practicing life skills of stress management. Coping is a short term way to deal with uncomfortable feelings. All coping is just getting by.**

**Working Time: This is How I Cope**

What are the ways that you cope with stress now?

Would you like to change some of the ways you cope with stress?

Again, these questions can be processed as a group, or as a breakout activity. One idea based on the ways they would like to change the way they cope is to start practicing them in the program.

If these new ways of coping don't work, conversations can be had as to why? What could happen differently?

(Adapted from Hipp, 1995)

**Activity: The Art of Distraction****Domain(s): 1B, 1C, 1D, 3A, 3C****Goal(s):**

1. For participants to learn to practice healthy ways of coping to work through triggers to use substances if/when they arise.

***Facilitator Review***

Sometimes, a little bit of distraction is enough to get past moments where we are feeling “triggered”, overwhelmed, and when we really want to use substances to step away from feelings that are uncomfortable. This is an exercise to gain perspective on what might work for you to get you through those difficult moments. A trigger or craving does not last forever, but we have to stop them before they gain too much power or momentum.

***Working Time: The Art of Distraction***

Give all participants a chocolate bar. Explain to them that their job is to put this chocolate bar in a place in their rooms where they will always see it. The goal is for them to go for a specified amount of time (2 – 3 days) and not succumb to their urges to eat the chocolate bar (if they don't like chocolate bars, buy something they like). Over the specified time frame, have them record the things they did to “distract” themselves from wanting to eat the chocolate bar. This is a fun, interactive activity to begin to learn positive ways of distraction.

**Activity: My Safety Plan for When I Can't Cope****Domain(s):** 1C, 1D, 2C, 3A, 3B, 3C, 4B, 4C**Goal(s):**

1. Discuss times when participants should ask for help.
2. Develop individual "safety plan" for times that are too overwhelming

***Facilitator Review:***

It's frightening to reach the limit of what we can cope with. It can feel as if you're crazy...or the whole world is crazy. It can seem as though no one understands you, like you're all alone. Your hopelessness can lead you to believe that almost any behaviour is justified. It's not! This type of thinking is a sign that you need **HELP, SUPPORT, AND PEOPLE YOU TRUST!**

The first step is to admit you're in trouble. This is never easy, and to protect our self-esteem most of us have a tendency to lie to ourselves about how we are doing. Not admitting our problems is called **denial** – and denial is not just a river in Egypt (Chamberlist, 2010).

**Denial** is a self delusion and the biggest barrier standing between you, the help you need, and feeling better about yourself and your life. It can be a twisted view of reality that strengthens as you decline. If you are here, on some level you have asked for help (or accepted help someone has offered).

***Working Time: Safety Plan***

1. Give each participant a sheet with several "safety plans" (see attached). These are designed to be wallet sized so that they have them all of the time. **It is a good idea to let their family and support network around them know what they're safety plans are, especially if they are involved in the plans as people they would call or safe places to go.** These safety plans can be adapted for any feeling or emotion that is overwhelming, and makes people feel like they can't cope. One example is suicidal thoughts.



**SAFETY PLAN**

I will cope, calm &amp; soothe myself by:

I will tell myself:

I will call: ☎

I will go to: →

**SAFETY PLAN**

I will cope, calm &amp; soothe myself by:

I will tell myself:

I will call: ☎

I will go to: →

**SAFETY PLAN**

I will cope, calm &amp; soothe myself by:

I will tell myself:

I will call: ☎

I will go to: →

**SAFETY PLAN**

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I will call: ☎

I will go to: →

**SAFETY PLAN**

I will cope, calm &amp; soothe myself by:

I will tell myself:

I will call: ☎

I will go to: →

**SAFETY PLAN**

I will cope, calm &amp; soothe myself by:

I will tell myself:

I will call: ☎

I will go to: →

**SAFETY PLAN**

I will cope, calm &amp; soothe myself by:

I will tell myself:

I will call: ☎

I will go to: →

**SAFETY PLAN**

I will cope, calm &amp; soothe myself by:

I will tell myself:

I will call: ☎

I will go to: →

(Adapted from Vivyan, 2011)

**Activity: Nourishing and Depleting Activities****Domain(s): 3A, 3B, 3C****Goal(s):**

1. Explore what a “healthy balance” in life means.
2. Gain awareness of how each participant can invite more of a healthy balance into their lives.

**Facilitator Review:**

When we start to feel depressed or stressed, we tend to neglect the nourishing activities which usually help us feel better, and try to keep doing those which we really have to do – which further deplete and exhaust us. We then feel even worse, so do even less.

Even if we can’t reduce the depleting activities, we can aim to find a healthier balance by:

- Increasing the amount of nourishing activities
- Learning to see our depleting activities in a new way

**Working Time:**

On a piece of poster paper, make two lists.

List 1 – normal daily activities in a typical week day.

List 2 – normal daily activities on a typical weekend.

Be sure to write down everything you can think of including getting up, getting dressed, eating, showering etc. Then look back at the list and decide which activities are nourishing, and which are depleting. Indicate this with an N or D next to each item.

**Nourishing Activities:**

- Lift mood
- Increase energy
- Help you feel calm and centred

**Depleting activities:**

- Lower mood
- Drain energy
- Increase stress and tension

People will likely find that some activities are not so clearly ‘either-or’, but sometimes nourishing and sometimes depleting – depending on the meaning that we give them at that time.

**Questions to process as a group:**

1. How you can find a healthier balance by increasing your nourishing activities, and/or considering what depleting activities you can change.
2. What will you do differently? When? How? Who with?

(Adapted from Hipp, 1995)

**Activity: Learning to Self Sooth – Grounding****Domain(s): 1C, 1D****Goal(s):**

1. To learn healthy ways of “detaching” or coping when feeling overwhelmed from emotional pain.

**Process:*****Facilitator Review***

**What is Grounding:** Grounding is a set of simple strategies to detach from emotional pain (eg. drug cravings, self-harm impulses, anger, sadness). Distraction works by focusing outward on the external world rather than inward toward yourself. For this reason, you can also think of grounding as healthy ways of distraction, centering, finding a safe place, or looking outward.

**Why do Grounding:** Grounding can be used when we need to do something to feel better **right now**. Sometimes when we are overwhelmed from emotional pain, we need a way to detach to gain control over our feelings, and stay safe. As long as we are grounded, we can’t use substances or hurt ourselves. Grounding “anchors” us to the present.

Many people who use substances often feel too much (overwhelming emotions and memories) or too little (numbing, dissociation). In grounding, we attain a balance between the two: conscious reality and ability to tolerate it. Remember, pain is a feeling, it is not who you are! When we get caught up in it, it feels that pain is all that exists, but it is only one part of our experience. There are others that are hidden and can be found through grounding.

The amazing thing about grounding is that it can be done **anytime, anyplace, anywhere**, and no one has to know.

**Guidelines:**

- Use grounding when faced with a trigger, enraged, having a craving, or whenever your emotional pain is too intense (above a 6 on a 0-10 scale)
- Keep your eyes open, scan the room, turn on the light – anything to stay in touch with reality.
- Self rate your mood before and after the grounding to test if it worked.
- No talking about negative feelings or journal writing! The purpose is to distract away from negative feelings, not get in touch with them.
- Focus on the present, not the past or future.
- Grounding is not the same as relaxation training. It is much more active, focuses on distraction, and is intended to help extreme feelings.

There are three major ways of grounding – mental, physical, and soothing. “Mental” means focusing your mind; “physical” means focusing on your senses; and soothing means talking to yourself in a very kind way. You might find that one type works better for you than others. The following “working time” examples are ideas for each one.

## ***Working Time:***

### **Mental Grounding**

Discuss/brainstorm as a group ideas for mental grounding. Some ideas include:

1. Describe your environment in detail, using all five of your senses. Describe objects, sounds, textures, colors.\
2. Play a “categories” game with yourself. Try to think of music groups, movies, cars, types of dogs etc.
3. Count to ten, or say the alphabet s-l-o-w-l-y.

### **Physical Grounding**

Discuss/brainstorm as a group ideas for physical grounding. A break out activity could involve participants creatively make their own list and keep it in their rooms as a reminder. This is especially important because these are techniques that need to be practiced! Some examples include:

1. Run cool or warm water over your hands.
2. Grab tightly onto your chair as hard as you can.
3. Touch various objects around you.
4. Dig your heels into the floor.
5. Carry an object in your pocket.
6. Collect items into an emergency bag or box that you can turn to.
7. Keep a picture of something soothing in your wallet or purse that you know will be calming.

We have five senses, and depending on the person, each one may work better or worse in trying to “ground” ourselves. On a white board or individually, make a list for each sense:

Vision – (focus attention on something around you)

Hearing – (listen to favorite music)

Smell – (really notice smells – maybe there is a smell that is soothing to then they can carry with them)

Taste – (eat mindfully, savoring each moment)

Touch – (stroke a pet, carry something that you know if you grab will be a reminder to come back to the present)

A useful reminder, using the 5 senses:

5 – things I can see

4 – things I can hear

3 – things I can touch

2 – things I can smell or taste

1 – breath. Then continue to just notice your breathing, and the sensations of breathing in your body – in your nose, throat, abdomen.

(Adapted from Vivyan, 2010; Najavits, 2002)

**Activity: Positive Affirmations****Domain(s): 3A, 3B, 4C****Goal(s):**

1. To begin to learn and practice saying positive statements about ourselves and situations, recognizing that over the years, we tend to fall into “unhelpful thinking habits.”
2. To develop a new attitude to ourselves and situations.

**Process:*****Facilitator Review:***

Over the years, we tend to get into unhelpful thinking habits, and think negatively about ourselves and situations. Using positive self-statements can help us develop a new attitude to ourselves and our situations. For the positive affirmations to work, you must use it whenever you notice you have that negative thought – immediately turn it around by using your affirmation. We need to show ourselves **compassion**.

***Working Time:***

Give each participant a poster board/large piece of paper to make a list of all of the positive affirmations that have meaning to them. There is a list of examples below. Ask participants to use a statement that begins with “I” and use the present tense, and make it realistic, even if it is hard to believe right now.

This is a list that can be hung in their rooms, at a place they will see every day. Encourage them to repeat, repeat, repeat throughout the day, every day, of every week. Perhaps making a print out card of affirmations to carry along in a wallet or purse would be beneficial

I am strong.

I have strength.

I am determined and successful.

I am a good and worthwhile person.

I am a unique and special person.

I have inner strength and resources.

I am confident and competent.

I hold my head up high.

I look good because I am good.



People like me – I am a likeable person and I like myself.

I care about others, I am needed and worthwhile.

I am a loving person.

I have a lot to be proud of.

I have all that I need.

I am in control of my life.

I can achieve anything I want to achieve.

I make wise decisions based on what I know.

I have set my goals and am moving towards them.

I accept myself as a unique and worthwhile person.

My life has meaning and purpose.

I am in control of my choices.

I am strong and healthy.

I am calm and confident.

I have many options and can make wise decisions.

Everything is getting better every day.

I am calm and relaxed.

I am healthy and have all that I need.

Today is the first day of the rest of my life and I will take notice of the many positive things this day has to offer.

I live a healthy and positive lifestyle.

I know I can master anything if I practice it continually.

I have my wise mind – I can seek inner guidance whenever I need to.

(Adapted from Vivyan, 2011)

**Activity(s): Relaxation****Domain(s): 1B, 1C, 2B, 3C****Goal(s):**

1. To learn and practice relaxation skills

**Process:*****Facilitator Review:***

We all have moments when life seems overwhelming and we feel uncertain and insecure. It can feel like we're being tossed around by all the things we have to do, and almost run over by the moods and opinions of others.

For times like these, there's an important set of life skills to learn that can offer a place in the middle of the confusion and commotion where things are calm. Relaxation skills can take you there. They can help to achieve a quiet, deeply restful calm that is soothing and nourishing for your body. These are skills that if practiced, can take you to a quiet place quickly when you sense a "storm of stress" approaching. Relaxation skills:

1. Need to be learned and practiced. This means you might not be good at them at first, and patience is a key.
2. Can create very noticeable and positive physical and mental changes.
3. Invite you to focus your attention on something besides the constant flow of thoughts your mind produces.

Relaxation is allowing physical and/or mental tension to be released. Tension is the body's natural response to threat, part of the body's alarm or survival mechanism. It can be a very useful response, but a lot of the time, we don't need this tension, so it's okay to learn to let it go, and learn some relaxation skills.

Healthy living is a matter of balance. Relaxation is part of the balancing process alongside other aspects of your lifestyle such as what you eat, your physical activity and how you handle stress. It's a great help to learn a relaxation technique, to help us unwind and bring our tensions and anxiety under control. There are several books, leaflets or recordings which we can use ourselves. It's a good idea to practise regularly so we can be more prepared for the more stressful times.

**How relaxation helps**

- *Reduces tiredness* – if you can manage everyday life without excessive tension
- *Improves performance* – your performance in work, sport or music can be raised through self awareness and control of tension
- *Reduces pain* – pain can occur as a result of tension e.g. headaches and backache. Relaxation can help you to cope by raising your pain threshold and reducing the amount of pain



- *Coping with stress* – relaxation helps you to reduce the effects of stress and to breathe effectively
- *Improves sleep* – by allowing you to be calm and peaceful
- *Improves self-confidence* – by increasing your self-awareness and ability to cope with daily life
- *Improves personal relationships* – it is easier to relate well to other people when you are relaxed and self-confident

### **Relaxation and stress**

When we feel anxious or stressed, it's our body's natural response to feeling threatened, the alarm system which helps us deal with danger: our breathing rate increases, as does our blood pressure, heart rate, muscle tension, sweating, state of mental arousal and adrenaline flow. A lot of the time, we don't need those survival responses, so relaxation helps to decrease that adrenaline response, to let it go.

### **Breathing and Relaxation**

Our out-breath releases tension in the chest muscles and allows all muscles to release their tension more easily. Breathing is far more effective when we use our diaphragms, rather than with the chest muscles. Sit comfortably in a chair and place one hand on your chest and the other on your abdomen (hand on navel). Take two or three fairly large breaths – which hand moves first and which moves most? Practise so that it is the lower hand on your abdomen that moves rather than the one on your chest. People often think that their tummy goes in when they breathe in - but the reverse should be the case.

When you're feeling tense or hoping to relax, try breathing out a little bit more slowly and more deeply, noticing a short pause before the in-breath takes over (don't exaggerate the in-breath, just let it happen). You might find it useful to count slowly or prolong a word such as "one" or "peace" to help elongate the out-breath a little (to yourself or out loud).

There are various ways in which to achieve relaxation, and most use breath control in some way. Whichever method is chosen, regular practice will help. Some examples are:

- Progressive Muscle Relaxation – tense/relax muscular relaxation
- Meditation
- Guided Imagery or Visualisation
- Physical Activity
- Tai Chi
- Yoga
- Music (music is very personal, so use whatever helps you relax) either used alone, or with any of the above methods

(Adapted from Vivyan, 2011)



***Working Time: Relaxation***

There are numerous books and websites to explore for scripts and examples of relaxation techniques, so specific scripts and ideas will not be outlined here. However, in an inpatient treatment setting, it is recommended that these skills be optional for clients to engage in daily. For links to relaxation examples, one resource is [www.getselfhelp.co.uk/relax.htm](http://www.getselfhelp.co.uk/relax.htm).

**Remember to be Trauma Informed**

One important issue to be aware of is that many scripts will ask clients to close their eyes. While this is helpful for relaxing and quieting the outside world, for individuals with trauma histories, this can be frightening and overwhelming. It is a good idea to make relaxation sessions optional, and if people choose to participate, remind them that the directions offered from the facilitator are given at the discretion of the participants (i.e. close your eyes).

**Activity: Learning How to Say “No”****Domain(s): 2C, 3C, 4A, 4C****Goal(s):**

1. For participants to discuss and learn what a healthy boundary is and how it can present in a relationship.
2. Learn ways to say “no” through discussion and rehearsal.

**Process*****Facilitator Review***

Healthy boundaries in relationships are:

- *Flexible* – You are able to be both close and distant, depending on the situation. You are able to let go of relationships that are destructive and connect with ones that are nourishing.
- *Safe* – In safe relationships you are able to protect yourself against exploitation of others, and read cues if someone is being abusive or selfish.
- *Connected* – Being connected in a relationship allows you to engage in balanced relationships with others and maintain them over time. As conflicts arise, you are able to work them out

*(The following section on boundaries that are too close or too distant can be something explained by the facilitator, or brainstormed as a group on a whiteboard)*

Boundaries are a problem when they are too close or distant. If your boundaries are too close, you may let people in too much and too early. Your boundaries might be too close if you:

- Have difficulty saying “no”.
- Give too much.
- Get involved too quickly.
- Trust too easily.
- Intrude on others (e.g. violate other people’s boundaries).
- Stay in relationships too long.

Boundaries can also be too distant (not letting people in enough, or detaching yourself). Your boundaries might be too distant if you:

- Have difficulty saying “yes”.
- Isolate yourself.
- Distrust too easily.
- Feel lonely a lot of the time.
- Have relationships that end shortly after they begin.

Many people have difficulty in both areas. However, healthy boundaries can keep you **safe**. Learning to say “no” can keep you from using substances, keep you from having unsafe sex, or protect you from abusive relationship.

**It is important to set boundaries with yourself as well as others.** You may have difficulty saying “no” to yourself. For example, you promise yourself you won’t smoke pot, but then you do. Saying “no” and protecting yourself is a sign of self-respect.

**Why is it important to say “no”?** Saying “no” means setting a limit.

***Working Time: Learning how to say “no”***

As a group, discuss situations where you can learn to say “no”. Some examples are:

- Refusing alcohol and drugs.
- Going along with things that you don’t want to do.
- Taking care of everyone but you.

After this list is produced, ask if any participants would like to role play saying “no” in a situation they may have experienced before, or one that they are anticipating facing in their everyday lives. One a white board, write up different way to say “no”, and people can test out which ways feel the most comfortable for them. Remember that how we say “no” will vary between situations.

**How to say “No”**

*Polite refusal* – “No thanks, I’d rather not.”

*Insistence* – “No. Really, I mean it, and I’d like to drop the subject.”

*Partial honesty* – “I can’t drink because I have to drive.”

*Full honesty* – “I can’t drink because I’m in recovery. My life gets too messed up.”

*Stating consequences* – “If I drink, I breach probation, so unless you want to go talk to my probation officer, forget about it.

**Activity: Learning to Say “yes”****Domain(s): 2C, 3C, 4A, 4C****Goal(s):**

1. Learn ways to say “yes” through discussion and rehearsal.

**Process:*****Facilitator Review:***

You also may have difficulty saying “yes” to yourself. For example, you may deprive yourself too much by not eating, not taking time for yourself, or not allowing yourself time to have fun in healthy ways.

**Why is it important to say “yes”?** Saying yes means connecting with others. It is a way of recognizing that we are all human and all need social contact. It means becoming known to others in ways that are comfortable and safe for you.

***Working Time: Learning to say “yes”***

As a group, discuss situations where you can learn to say “yes”. Some examples are:

- Telling your counselor how you really feel.
- Asking someone for a favor.
- Asking someone for help.
- Letting people get to know you.
- Talking to someone about your impulse to hurt yourself before doing it

After this list is produced, ask if any participants would like to role play saying “yes” in a situation they may have experienced before, or one that they are anticipating facing in their everyday lives. One a white board, write up different ways to say “yes”, and people can test out which ways feel the most comfortable for them.

**Activity: Friendship Diagram****Domain(s): 2C, 3B, 3C, 4C****Goal(s):**

1. To discuss and define what a “real” friend is.
2. For participants to reflect on the friends they have in their lives, and begin to think about which ones they will keep and which ones they will need to create space from.

**Process*****Facilitator Review***

Safety nets don’t just happen. The skills needed to be a supportive person/friend, function in a supportive relationship, and create a safety “network” for yourself must be learned and practiced. These skills include the willingness too:

- honestly share what you are thinking and feeling
- listen to someone without being judgmental or critical
- be there when someone really needs you
- offer positive feedback to others to help them see what’s right about themselves and the world
- ask for support or feedback from others when you’re feeling scared, vulnerable, or anxious.

Taken together, these skills are called communication, and honest, open, direct communication is critical in close relationships. In taking the risk to share what you really think or feel, you allow others to see your true self. A safety-net is vital to recovery, and we need friends we can trust, and who will support us to do what’s right for us. This includes supporting your recovery!

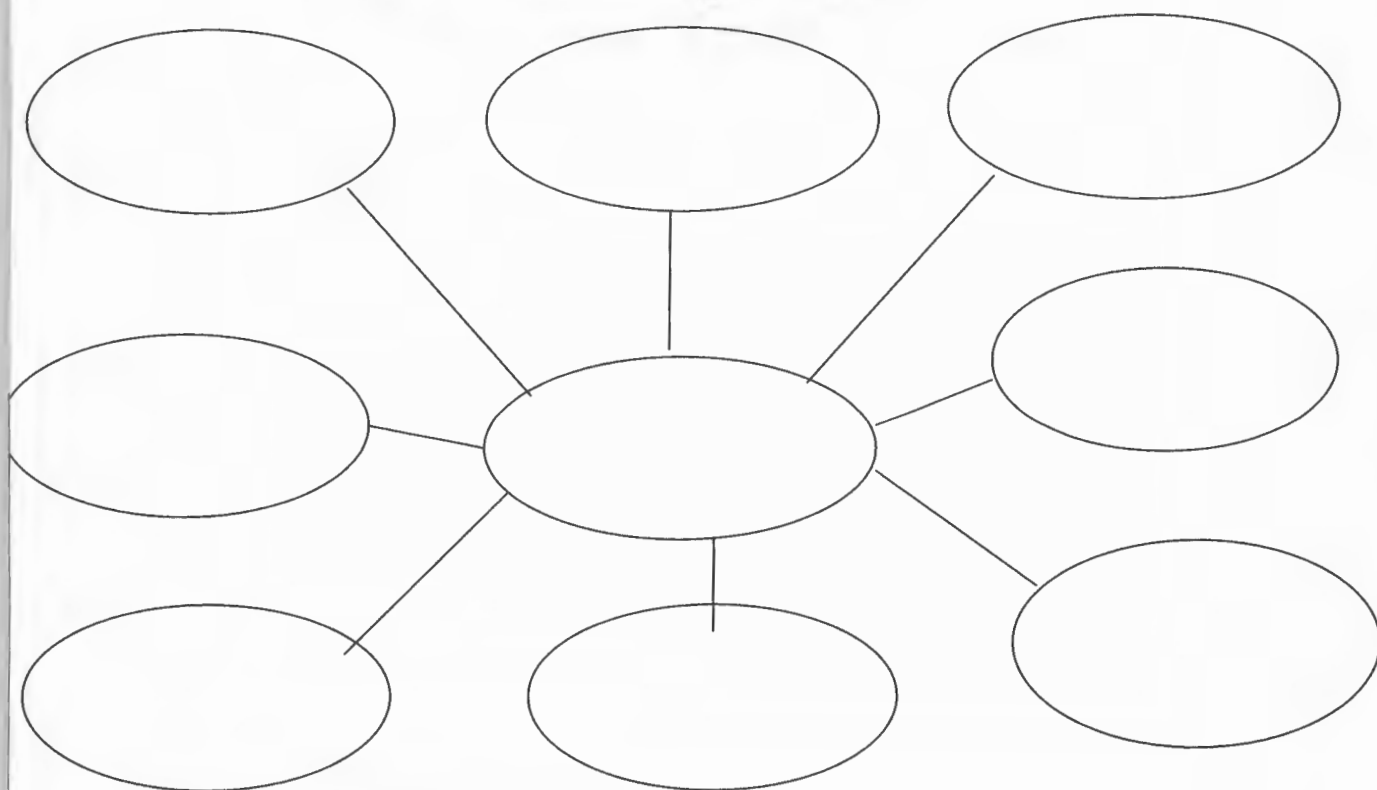
***Working Time: Friendship Diagram***

Give all participants a Friendship Diagram, and ask them to follow the instructions.

Questions to process include:

- Are there friends you know you are going to have to move out of your life? How will you do it? What will you say? (this is a good opportunity to role play specific scenarios).

## Friendship Diagram



1. Write your closest friends in each circle. Use colors to symbolize (a) clean friends, (b) using friends, and (c) friends that will be supportive during your recovery.

**Activity: Values – This is Who I Am!****Domain(s): 3A, 4C****Goal(s):**

1. Identification of values.

**Process*****Facilitator Review*****Values Clarification:**

Your **values** are your **ideas about what is most important to you in your life – what you want to live by and live for**. They are the silent forces behind many of your actions and decisions. The goal of “values clarification” is for you to become fully conscious of their influence, and to explore and honestly acknowledge what you truly value at this time in your life. You can be more self-directed and effective when you know which values you really choose to keep and live by, and which ones will get priority over others.

***Working Time***

Make a list of values with the group using a whiteboard or flip chart so everyone can see and be involved. Some examples of values are:

- |                            |                            |                             |
|----------------------------|----------------------------|-----------------------------|
| -Being loved               | -Being Married             | -Having a special partner   |
| -Having companionship      | -Taking care of others     | -Having someone's help      |
| -Having a close family     | -Having good friends       | -Being liked                |
| -Being popular             | -Getting people's approval | -Being appreciated          |
| -Striving for perfection   | -Fighting injustice        | -Living ethically           |
| -Being a good parent       | -Being a spiritual person  | -Not get taken advantage of |
| -Looking good              | -Being physically fit      | -Being healthy              |
| -Being admired             | -Being independent         | -Being courageous           |
| -Being well organized      | -Living fully              | -Making money               |
| -Having prized possessions | - Growing as a person      | -Being emotionally stable   |

After the group makes a list together, ask all participants to make a list of their own values. Again, creativity is critical, so the sky is the limit! After their lists are complete, ask participants to rank their top three or five.

Possible questions to process:

Based on their top priorities, how does this influence decisions made in life?

Are there values that you have forgotten or “let slip” along the way?

How can you ensure you live your life based on your values?

If you don’t live life based on your values, how do you feel?

This list of values is useful if clients are faced with major decisions in their lives. Part of the decision process is being aware of our values, and making decisions that reflect who we are, or who we are becoming.



**Activity: Communication Styles****Domain(s): 2C, 3B, 3C, 4A, 4C****Goal(s):**

1. For participants to learn and be able to identify different communication styles.
2. For participants to learn the basic tenets of assertiveness, and begin to practice this skill.

**Process*****Facilitator Review***

You may have heard the saying, “What goes around, comes around.” That’s true for relationships. When you make yourself available to others, here’s some of what you get in return:

- **You get to know yourself better** – often it’s not until we say something out loud to someone that we really know where we stand. We have many different and sometimes conflicting thoughts and feelings. When we organize them well enough to express them coherently to another person, they become more solid and clear.
- **You develop a larger vocabulary for communicating your feelings** – the more you share your feelings, the better you get at recognizing and describing them. Eventually, you have a whole new language of emotions, new ways to talk about your complex inner world.
- **You develop close friendships** – when you communicate with others, they communicate with you. Other people start to tell you what they are thinking and feeling. They ask for your perspective on problems they are having, and the trust between you grows.
- **You find out how “normal” you are** – the more people share themselves with others, the more they discover that everyone has similar fears, problems, and embarrassing moments.
- **Connections with people who validate your self-worth and competency**
- **Chance to release pent up stress and avoid stress build-up**

In order for people to be able to communicate effectively, knowing and understanding our own communication styles is important. That way, we can choose to keep the styles we like, and work on changes the styles that haven’t been helpful. A large part of conflict resolution is knowing how to communicate assertively!

All of us have and will again experience some kind of conflict, or have moments where we need to communicate effectively how we are doing, and what we need. The following handouts are examples of how facilitators could introduce assertiveness and different communication styles, including “Assertiveness”, “Ten Basic Tenets of Assertiveness Philosophy”, “Assertiveness

Rights and Responsibilities”, “Communication Styles” and “My Style of Communication”. Being assertive is an art, and as with any art, it needs to be practiced.

After participants have a solid understanding of the different styles of communication, do a role play activity.

1. Ask the group to brainstorm a list of scenarios or conversations where communicating effectively would be important. Each item on the list is a possible role play situation.
2. One participant is then asked to leave the room (the “identifier”) and the remaining participants who will be doing the role play can decide which characters they will be, and their character’s “style of communicating”.
3. The participant that was asked to leave is then brought back into the room and is tasked with having to identify the style of communication each character is using.

Rotate this through so each group member has a chance to be the “identifier”. For those doing the role plays, have participants choose communication styles that they are used to, and ones that they would like to use more often or more effectively. After each role play, process with the group what it was like. Use open ended questions such as:

- What was that like for you?
- How did it feel to communicate assertively?
- What were the difficult parts?

## ASSERTIVENESS

### What is assertiveness?

Assertiveness is a communication style that allows your needs and wants to be known to others in a positive and respectful manner. Being assertive allows you to stand up for yourself, have confidence in what you are saying and lets others know where you stand on a particular situation. It does not involve manipulation, putting others down, name calling or yelling and screaming. Assertiveness is not about winning an argument. There are going to be many times where you are going to “agree to disagree”. Although the other person may not agree with you, being assertive allows both individuals to walk away with dignity and respect.

### Two Important Aspects of Assertiveness

1. You are the only one who can control your feelings and behaviors. Although you may feel a certain way about a particular situation, it is up to you to decide how to express that feeling. You cannot control how others act on their feelings. The only person you can control is yourself.
2. Other people cannot read your mind, and you cannot read theirs. Part of assertiveness is standing up for yourself and having the confidence to let others know what you are thinking and how you feel about a particular situation. Do not assume that others know what you are thinking - let them know in a respectful manner.

### The 10 Basic Tenets of Assertiveness Philosophy

- 1) By standing up for our rights, we show we respect ourselves. At the same time one is more likely to gain respect from others.
- 2) By not trying to hurt anyone, we end up hurting ourselves and other people.
- 3) Sacrificing our rights and what we want usually results in destroying relationships or preventing new ones from forming.
- 4) Sacrificing our rights teaches others how to treat us.
- 5) If we do not let others know how their behavior is affecting us, they cannot change their behavior.
- 6) When we do what we think is right for us, we feel better about ourselves and have more authentic and satisfying relationships with others.
- 7) We have a right to be treated with courtesy and respect.
- 8) We have the right to express how we feel, just as long as it does not interfere with the rights of others.
- 9) We can gain a lot more from life by standing up for ourselves and respecting the rights of others.
- 10) When we are assertive, everybody involved usually benefits.

## Assertiveness Rights and Responsibilities

- 1) You have the right to act in ways that promote your dignity and self-respect, and the responsibility to not diminish the dignity of others.
- 2) You have the right to be treated with respect and the responsibility to treat others with the same respect.
- 3) You have the right to experience and express your feelings, and your feelings are your responsibility.
- 4) You have the right to change your mind, and the responsibility to allow others to do the same.
- 5) You have the right to take your time to make a decision. You have the responsibility to not pressure or manipulate others.
- 6) You have the right to ask for what you need, and the responsibility to accept the fact that other people may not be able to give that to you.
- 7) You have the right to say no and set boundaries and the responsibility to respect other people's boundaries.
- 8) You have the right to make mistakes and the responsibility to expect that others will make mistakes as well.
- 9) You have the right to take care of yourself, and the responsibility not to blame others.
- 10) You have the right and responsibility to take time and energy to recover from your substance abuse.

## COMMUNICATION STYLES

<i>AGGRESSIVE</i>	<i>ASSERTIVE</i>	<i>PASSIVE</i>
<i>"too hard"</i>	<i>"just right"</i>	<i>"too soft"</i>
<p><b>Description:</b></p> <p>Expresses feelings, opinions, or needs in a way that <b>ignores</b> the rights and feelings of others.</p>	<p><b>Description:</b></p> <p>Expresses feelings, opinions, and needs in a way that <b>respects</b> the rights and feelings of others.</p>	<p><b>Description:</b></p> <p><b>Fails</b> to express feelings, opinions, and needs and allows others to step on personal rights.</p>
<p><b>Message sent:</b></p> <p><i>I only care about me!</i></p> <p><i>I'm important, but you are <b>not</b> important.</i></p>	<p><b>Message sent:</b></p> <p><i>I care about me and I care about you.</i></p> <p><i>We are <b>both</b> important.</i></p>	<p><b>Message sent:</b></p> <p><i>I don't care about me.</i></p> <p><i>I'm <b>not</b> as important as you.</i></p>
<p><b>Example:</b></p> <p>The waiter brings a cheeseburger when Jack ordered a hamburger. Jack says in a loud, angry voice: "You idiot – do you have wax in your ears? I didn't order a \$#@%&amp; cheeseburger! I'm gonna tell your manager about this!"</p>	<p><b>Example:</b></p> <p>The waiter brings a cheeseburger when Jack ordered a hamburger. Jack says in a calm, polite voice: "I think there's been a mistake. This is a cheeseburger, and I ordered a hamburger. Please change this for me."</p>	<p><b>Example:</b></p> <p>The waiter brings a cheeseburger when Jack ordered a hamburger. Jack says in a low, apologetic voice: "I'm sorry – I guess I didn't give my order right. Uh ... never mind. This is fine. It was probably my fault anyway."</p>

All of us have, and will again experience some kind of conflict. How do you deal with conflict in your life? In the following table, describe how you deal with conflict with people in your life and think about how you might like to change this.

Relationship	Style of Communication	Desired Style of Communication
With Parents:	_____	_____
With Siblings	_____	_____
With Friends	_____	_____
With Girlfriend / Boyfriend	_____	_____
With Strangers	_____	_____
With Authority Figures	_____	_____

**Activity: Clear Messages****Domain(s): 2C, 3B, 3C, 4A, 4C****Goal(s):**

1. For participants to learn and practice the ability to use “clear messages”.

**Process*****Facilitator Review***

Another important part of assertiveness, as well as an important skill to have in communication, is the ability to respond with a clear message. It is much easier to communicate with someone when the message you are trying to express and receive is understandable. Clear messages allow you to effectively communicate, and allows the receiver of the message to better understand your point of view.

***Working Time: Clear Messages***

The following is an example of a handout that could be given to participants to introduce what “clear messages” are. As always, the intent of this handout is to provide a basis for an interactive activity, and is not the activity itself.



## Giving Clear Messages

1. State the behavior (When you...)

Example: “**When you** come to the group late.”

2. State the feelings (I feel...)

Example: “**I feel** angry.”

3. Tell why or how it has affected you (Because...)

Example: “**Because** when you come to group late, it disrupts people when they are sharing, waists time and is disrespectful.”

4. Say what it is you want from the other person (What I wish is...)

Example: “**What I wish** is that you would be on time.”

## Responding To Clear Messages – Three Options

1. *Acknowledge the behavior and agree with the message.*

Example: “I hear that you are angry about me being late. I know that I have been late for group and I will be on time from now on.”

2. Disagree with the message but ask for further help

Example: “I hear that you are angry. I know that I was late today but I don’t think that I am usually late. I would like you to point out to me if you see this happening so I can work on changing this behavior.”

3. *Work together on solving the problem.*

Example: “I hear that you are angry. I know I was late today, and I might have to be late occasionally because of my other commitments. Is it alright if I let the group know about these ahead of time?”

**Clear Message Exercise**

Below is an opportunity for you to try a clear message. Think of times in your life when you could have used a clear message and fill in the blank lines with your responses.

When you \_\_\_\_\_  
(describe behavior)

I feel \_\_\_\_\_  
(how you feel)

Because \_\_\_\_\_  
(impact on me)

What I would like \_\_\_\_\_  
(my solution)

**Activity: Decision Making – Taking Charge of Your Life****Domain(s): 1B, 2C, 3C****Goal(s):**

1. For participants to be able to identify different types of decisions.
2. For participants to understand and practice using the “Decisional Balance” tool.

**Process:*****Facilitator Review:***

Have you ever felt as if your life is like a ride on a two-seated bike and you’re always stuck in the back seat? Whenever you try to look ahead, someone blocks your view. You’re screaming down the road of life, and all you get to do is pedal.

It’s perfectly normal to ask yourself, “Where am I going? Why am I going in that direction? What’s really important for me?” These big questions in life can be difficult to answer – so difficult that some people choose not to think about them. But not having answers sometimes has serious consequences. When you go through life without a sense of direction or purpose and without being in charge, the stress can be immense.

You can always let others make your decisions for you. There are probably plenty of people who are sure to have ideas about what you should do or who you should be. But when you’re following someone else’s vision, the only decision you get to make is how hard to pedal and how much energy to invest. It’s hard to maintain enthusiasm and passion for someone else’s dream, and sooner or later the journey loses its meaning.

Many decisions about your life will be made by other people – that’s the way it is when you’re young. You can probably go along with a lot of them without sacrificing too much. The ones you need to worry about are the Big Decisions – those that have to do with who you are becoming and what you will do in life.

How can you take charge of Big Decisions in your life? Here is a list of statements about decision making to give to participants, or have on a whiteboard:

- There's no way not to decide.
- If I don't decide, someone else will.
- I can change my mind.
- I can make more than one decision about something.
- I don't have to live or die with every decision.
- I don't have to decide for anyone but me.

- I can decide even if I don't have the perfect answer.
- I can decide even if I'm unable to eliminate all the risks.
- I may have to make some decisions that won't please others.

***Working Time: Decision Making – Taking Charge of Your Life***

Below are examples of handouts for facilitators to discuss types of decision, as well as what and how to do a “decisional balance”.

Following are five (5) types of decision making styles. Please provide one example that you have done for each type of style listed.

### Types of Decisions

- 1) **Impulse Decision:** Made quickly without taking time to learn the facts. The results will often be surprising or regretful once the facts are learned.

Example: \_\_\_\_\_

\_\_\_\_\_

- 2) **Habit Decision:** Made out of habit ("That's what I always do!"). Other options are not considered.

Example: \_\_\_\_\_

\_\_\_\_\_

- 3) **Non-Decision:** No decision is made; you just wait for the problem to go away. You may think about other options, but cannot decide or are afraid of making the wrong choice. The decision is put off until it is too late.

Example: \_\_\_\_\_

\_\_\_\_\_

- 4) **Pressure Decision:** You make the choice other people want you to make. Often your own point of view is ignored because you feel forced to go along with what others say.

Example: \_\_\_\_\_

\_\_\_\_\_

- 5) **Careful Decision:** A decision that involves taking all the available information into account, looking at all the various options, choosing the best decision, and applying it before the problem grows.

Example: \_\_\_\_\_

\_\_\_\_\_

Which of all these examples of past decisions turned out the best? #

Why?

## DECISIONAL BALANCE

When approaching any kind of decision, it is often useful to be able to lay out all the factors that may influence your decision. Every decision you make will have consequences, some of them good, and some of them bad. While not every decision you make will be as hard as another, a decisional balance can help you organize your thoughts when you are faced with one of those big decisions. Seeing all of the good points and bad points laid out in front of you can help cut through some of the confusion you may be feeling.

Here is an example of some of the factors that might come up when facing a big issue like drugs and alcohol:

<b>Using drugs or alcohol</b>	<b>Pros (the good side)</b>	<b>Cons (the bad side)</b>
	Allows you to avoid feelings and conflicts	No money
	Have fun	Hangovers
	Feel like you have lots of friends	Withdrawal
	Feel more relaxed	Problems at school
	More outgoing	Get into fights
	Party with friends	Stop caring
	Nothing bothers you	May get addicted
		Don't always know what you are taking
		Health Problems
<b>Not using drugs or alcohol</b>	<b>Pros (the good side)</b>	<b>Cons (the bad side)</b>
	Have more money	Have to face feelings
	Feel healthier	Have to work out conflicts
	Better memory	Boredom / lack of things to do
	Real friends	Loose friends
	Do better at school and at work	Less outgoing
<b>Your Decision</b>		

Based on the tool you have just seen, create your own decisional balance chart that shows the issues involved in a decision in your life.

**DECISION:** \_\_\_\_\_

[illegible]

***Versus:***

[illegible]

### Evaluating Consequences

Every decision has consequences; they can be positive or negative as well as short-term or long-term. Some actions may be more complex, where they may have immediate costs or gains, but also have longer-term consequences that may not take effect for a long time. The following model illustrates possible short and long-term results of a decision.

<b>Decision</b>	<b>Payoff (PRO)</b>	<b>Cost (CON)</b>
Get high at a party		
<b>Short Term</b>	Feel good Have fun Fit in with group Escape from worries	Uses up money Sets bad example for others Crash afterwards Might not remember actions Hurt people while high Legal problems
<b>Long Term</b>	May have memories of fun times	Want to do it again Want to do something more intense the next time Might get other people addicted May get addicted → Health Problems → Go into debt for drugs → Steal money for drug → Severe legal problems



On the following table outline some of the short and long term consequences of a decision in your life.

<i><b>Decision</b></i>	<i><b>Payoff</b></i> (PRO)	<i><b>Cost</b></i> (CON)
<i><b>Short Term</b></i>		
<i><b>Long Term</b></i>		

**Activity: Where Do You Stand?****Domain(s):** 2C, 3B, 3C, 4A, 4C**Goal(s):**

1. To challenge participants to explore their views of certain topic areas, utilizing an assertive way of communicating.
2. To offer participants a venue to express their opinion and have their voice heard in a respectful, non-judgmental environment.

**Materials:**

1. One line of masking tape on the floor, one end labeled “agree” and the other end “disagree”. The middle is “neutral”
2. A list of questions.

**Process*****Facilitator Review***

1. Review different styles of communication. Reflect on which styles each person has gravitated towards in the past (this would have happened in a previous group).
2. Explain to youth that several statements will be read aloud to the group, and ask each person to stand on the floor representing their answer to the statement. Each participant is given the opportunity to explain the stance they have taken on the particular issue. Some of the topics are fairly controversial so use your judgment based on the group you are working with.

Topics for discussion may include the following:

- Alcohol should be illegal for everyone.
- There are many things I would like to change about myself.
- Running away can solve some of my problems.
- I like spending time at home.
- Parents are generally good to their children.
- Adults caught drinking and driving should be put in jail.
- All in all, I’m a pretty good person who usually does what is right.
- School is a pretty good place to be.
- Most teachers are fair and care about their students.
- Talking about your feelings is very important.
- You shouldn’t let people know when you are angry with them.
- Things at home are better now than they were a year ago.
- Men should not work as correctional officers in women’s prisons.
- Men commit more violent crimes than women.
- Women are better parents than men.
- It’s usually because of a teen’s peer group that they start drinking or doing drugs.

- A friend with weed is a friend indeed.
- Women and men should earn the same amount of income and have access to the same jobs.
- People should not trust youth today because more youth steal, do drugs, or commit more crime than adults.
- Adults do not understand youth.
- Youth are treated way too leniently by the criminal justice system.
- Bullying in schools is normal.
- Stealing causes higher prices in stores.
- People should not have sex until they are married.

**Activity: Migration of Identity****Domain(s): 3A, 3B, 3C, 4C****Goals:**

1. To have participants create a picture that depicts the tools and awareness needed by each individual to engage in a new way of living.
2. To explore how changing our lifestyle habits are related to who we are, how others see us, and our sense of belonging.

**Materials:**

1. Poster board or large piece of charting paper for each person.
2. Items to draw and write with (pencil crayons, felt markers, pens etc.)

**Process*****Facilitator Review***

Explore with the group what they would like their future to hold. Why are they working for change? What has been holding them back?

***Working Time: Migration of Identity***

1. Explain the exercise is about moving from one lifestyle to another. It is about exploring and viewing the changes you can make. Making changes may mean dramatically changing lifestyle habits. Explain that the following exercise is about leaving what is familiar and journeying to the unknown new land and new experiences. Along the way there will be choices to make, hope in what the new land holds, encouragement, as well as times that may tempt you to turn back.
2. Explain what to include in their own migration of identity, including: (45 minutes)
  - A) The Old Lifestyle: Is drawn as the "old island", and asks "What is in this island?" Examples – violence, lies, fair-weather friends, neglect, crime, low self esteem, impatience, negative self talk, anxiety etc. NAME THE ISLAND.
  - B) Barriers: Draw X's down one side of the island and ask "What keeps you on this island? "What are barriers to leaving the island? Examples: fear of being alone, boredom, friends, fear of failure, uncertain future, lack of supper, peer pressure, doubt, denial etc.
  - C) Suitcase/Ship/Boat: The ship is coming. "What do you need to take with you?" "What will you need for your journey?" What are you going to put in the suitcase?" "What if the ship stopped on an island with people you know, using friends, stress"
  - D) Rough water: The rough waters represent some of the challenges that many face who are leaving the old life. Examples are old friends, stress, triggers etc.
  - E) The New Lifestyle/Island: Draw your new island. "What do you want to call it?" "What's on the new island?" Explain that it can't all be perfect and good, but "What

is different about this island?" Example: coping skills, communication skills, self forgiveness, work, home etc.

F) Motivators: "What will anchor your boat?"

3. Have participants present their "Migration of Identity" to the group and share only what they are comfortable with. Questions may include "Why did you want to get off the old island?" Why do you want to change?" What gives you the courage and drive to make a change?"



## **Conclusion: Only a Humble Beginning...**

The topics and possible activities that have been outlined in this document are absolutely not exhaustive or static. The purpose of offering suggestions for programming was to give examples of interactive ways to help clients build their own coping strategies so that they can begin to explore and understand life on their own terms, and not be constantly subjected to the turbulence of unpredictable affective states, physical functioning, or relationships.

Whenever a clinician is facilitating a group or having a 1:1 conversation, there should always be a voice reminding one to be guided by intent. This framework provides a tool for multidisciplinary teams to build programming from a space full of intent. Whenever a new activity or program idea is brought forward, teams can ask themselves:

1. Why are we doing it? What is the goal?
2. What domains will it fall under using this framework?
3. How can we ensure it is interactive, creative, and flexible enough for clients currently in programming?

Clinicians working with individuals whose lives have been adversely affected by substance use and/or trauma have a large responsibility to always be aware that “abnormal behaviors” are very often the result of unthinkable, traumatizing events. In other words, what we are seeing are normal responses to abnormal events. For too many children, the world is not a safe place, and services need to offer every opportunity for clients to be able to shift their experience of the world. It will not be a job everyone can do, but those who can, should.

*Appendix A**National Treatment Strategy Tiered Model****Tier 1***

Services and supports in Tier 1 are broad efforts that draw on natural systems and networks of support for individuals, families and communities. They provide a foundation for a healthy population and have broad eligibility criteria, allowing anyone access to them.

***Tier 2***

Services and supports in Tier 2 provide the important functions of early identification and intervention for people with substance use problems that have not previously been detected or treated. These may include screening, brief intervention and referral.

***Tier 3***

Services and supports in Tier 3 are intended to engage people experiencing substance use problems who are at risk of secondary harms (e.g., HIV, victimization). They include active outreach, risk management, and basic assessment and referral services.

***Tier 4***

Tier 4 comprises services and supports that are more intensive than those in Tier 3 and in many cases offer specialized services for people with substance use problems. People seeking services in this tier may have multiple problems and need services and supports from more than one sector or tier.

***Tier 5***

Services and supports in Tier 5 are intended to address only the needs of people with highly acute, highly chronic and highly complex substance use and other problems, for whom lower-tier services and supports are inadequate.

(Adapted from National Treatment Strategy, 2008)



*Appendix B**Consensus Proposed Criteria for Developmental Trauma Disorder*

**A. Exposure.** The child or adolescent has experienced or witnessed multiple or prolonged adverse events over a period of at least one year beginning in childhood or early adolescence, including:

- A. 1. Direct experience or witnessing of repeated and severe episodes of interpersonal violence; and
- A. 2. Significant disruptions of protective caregiving as the result of repeated changes in primary caregiver; repeated separation from the primary caregiver; or exposure to severe and persistent emotional abuse

**B. Affective and Physiological Dysregulation.** The child exhibits impaired normative developmental competencies related to arousal regulation, including at least two of the following:

- B. 1. Inability to modulate, tolerate, or recover from extreme affect states (e.g., fear, anger, shame), including prolonged and extreme tantrums, or immobilization
- B. 2. Disturbances in regulation in bodily functions (e.g. persistent disturbances in sleeping, eating, and elimination; over-reactivity or under-reactivity to touch and sounds; disorganization during routine transitions)
- B. 3. Diminished awareness/dissociation of sensations, emotions and bodily states
- B. 4. Impaired capacity to describe emotions or bodily states

**C. Attentional and Behavioral Dysregulation.** The child exhibits impaired normative developmental competencies related to sustained attention, learning, or coping with stress, including at least three of the following:

- C. 1. Preoccupation with threat, or impaired capacity to perceive threat, including misreading of safety and danger cues
- C. 2. Impaired capacity for self-protection, including extreme risk-taking or thrill-seeking
- C. 3. Maladaptive attempts at self-soothing (e.g., rocking and other rhythmical movements, compulsive masturbation)
- C. 4. Habitual (intentional or automatic) or reactive self-harm
- C. 5. Inability to initiate or sustain goal-directed behavior

**D. Self and Relational Dysregulation.** The child exhibits impaired normative developmental competencies in their sense of personal identity and involvement in relationships, including at least three of the following:

- D. 1. Intense preoccupation with safety of the caregiver or other loved ones (including precocious caregiving) or difficulty tolerating reunion with them after separation
- D. 2. Persistent negative sense of self, including self-loathing, helplessness, worthlessness, ineffectiveness, or defectiveness
- D. 3. Extreme and persistent distrust, defiance or lack of reciprocal behavior in close relationships with adults or peers
- D. 4. Reactive physical or verbal aggression toward peers, caregivers, or other adults
- D. 5. Inappropriate (excessive or promiscuous) attempts to get intimate contact (including but not limited to sexual or physical intimacy) or excessive reliance on peers or adults for safety and reassurance
- D. 6. Impaired capacity to regulate empathic arousal as evidenced by lack of empathy for, or intolerance of, expressions of distress of others, or excessive responsiveness to the distress of others

**E. Posttraumatic Spectrum Symptoms.** The child exhibits at least one symptom in at least two of the three PTSD symptom clusters B, C, & D.

**F. Duration of disturbance (symptoms in DTD Criteria B, C, D, and E) at least 6 months.**

**G. Functional Impairment.** The disturbance causes clinically significant distress or impairment in at two of the following areas of functioning:

- Scholastic: under-performance, non-attendance, disciplinary problems, drop-out, failure to complete degree/credential(s), conflict with school personnel, learning disabilities or intellectual impairment that cannot be accounted for by neurological or other factors.
- Familial: conflict, avoidance/passivity, running away, detachment and surrogate replacements, attempts to physically or emotionally hurt family members, non-fulfillment of responsibilities within the family.
- Peer Group: isolation, deviant affiliations, persistent physical or emotional conflict, avoidance/passivity, involvement in violence or unsafe acts, age-inappropriate affiliations or style of interaction.
- Legal: arrests/recidivism, detention, convictions, incarceration, violation of probation or other court orders, increasingly severe offenses, crimes against other persons, disregard or contempt for the law or for conventional moral standards.

- Health: physical illness or problems that cannot be fully accounted for physical injury or degeneration, involving the digestive, neurological (including conversion symptoms and analgesia), sexual, immune, cardiopulmonary, proprioceptive, or sensory systems, or severe headaches (including migraine) or chronic pain or fatigue.
- Vocational (for youth involved in, seeking or referred for employment, volunteer work or job training): disinterest in work/vocation, inability to get or keep jobs, persistent conflict with co-workers or supervisors, under-employment in relation to abilities, failure to achieve expectable advancements.

## *Appendix C*

### *Domains and Associated Core Issues for Complex Trauma*

#### **Domain 1: Self Regulation**

##### **1A. Impaired Affect Identification/Hypervigilance to Threat**

- Vigilance to clinician expression; observed lability or sudden mood changes
- Reports of sudden shifts in mood
- Abrupt loss of motivation/withdrawal in face of perceived failure

##### **1B. Impaired Ability to Modulate Arousal**

- Observation of “ADHD”-like behaviors or consistent/inconsistent low arousal
- Physical attempts to modulate arousal (fidgeting, shifting in seat)
- Impulsive responding (talking out of turn, jumping up)
- Low levels of arousal (“spacing out,” daydreaming)
- Reports of “feeling bored,” trouble concentrating

##### **1C. Extreme Mood States**

- Observed anxiety: fidgeting, frequent need for reassurance, clinginess with staff/caregivers, “freezing” in groups or other activities
- Test patterns, in academic classroom tests, or during standardized testing, that shift depending on child’s emotional state at time of testing
- Overall depressed academic performance, discrepant from known cognitive ability
- Child report of feeling sad, irritable, anxious, angry

##### **1D. Dissociation/Fragmentation**

- Glazed/dazed appearance
- Sudden or unexpected shifts in mood state; sudden shift from hyper-arousal to constriction
- Markedly different personality across time, situation, and person

#### **Domain 2: Physical Functioning**

##### **2A. Disconnection From Body**

- History of enuresis or encopresis, especially if secondary and physical etiology is ruled out
- History of poor coordination, poor hygiene, weight issues, or other symptoms without medical or other etiology

- Observation of poor motor coordination

## 2B. Physical Holding of Stress

- History of frequent somatic complaints
- Themes/preoccupation of illness/injury, body image

## 2C. Physical Integrity/Boundaries

- History/observation of sexualized behaviors
- History/observations of inappropriate physical boundaries
- Limited response to redirection or “teaching” of appropriate boundaries; repetitive compulsion to engage in behaviors
- Poor peer relationships and limited social skills

## 2D. Trauma-Related Injuries

- History of both neglect and developmental delays
- History/medical records of specific injuries procured during traumatic event
- Reports of developmental delays (e.g., speech/language, neuropsychological, academic evaluations)

# Domain 3: Relationships

## 3A. Sense of Self

- Difficulty labeling internal states and emotions in self and others
- Unrealistically low scores on self-report, psychosocial measures such as behavior rating scales
- Behavioral observation of negative reactions to challenges during activities, including negative self-statements, loss of motivation in the face of perceived failure, etc.

## 3B. Trust and Safety

- History of attachment and relationship difficulties
- Incident or other reports indicating physical or verbal altercations with peers or adults
- Peer isolation

## 3C. Social Skills and Competence

- Observed difficulty or distress during unstructured time
- Reports of bullying or rejection by peers, or by child toward peers
- Difficulty completing tasks requiring social perspective-taking or problem solving

# Domain 4: Cognitive Functioning

## 4A. Information Processing and Language Development

- Difficulty following directions across settings (e.g., at home or at school)
- Difficulty with verbal response and expression, particularly in response to open-ended questions
- Difficulty organizing coherent written or verbal narratives

#### 4B. Executive Functioning

- Observer reports of socially inappropriate behaviors, with little self-awareness
- Difficulty by child in organizational strategies required to complete tasks that are at the child's level of cognitive/academic capacity
- Observations or testing indicating challenges with working memory, attention, planning and organizing, processing speed, complex problem solving

#### 4C. Worldview and Personal Agency

- Child self statements indicating lack of confidence (e.g., "I can't")
- Passivity in task initiative and social interactions
- Defiance/hostility toward caregivers/peers
- Avoidance of tasks

#### 4D. Learning Disorders

- Academic achievement that is discrepant from measured cognitive ability
- Achievement deficits that are insufficiently explained by intellectual and socioemotional contributions

(Adapted from Tishelman et al., 2010)

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