INPATIENT GROUP FACILITATION GUIDE:
STAFF DEVELOPMENT AND PROCESSING,
CONNECTING BODY AND BRAIN

by

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Abstract

The purpose of this project is to provide resources for staff development and inpatient group facilitation. The project begins with a literature review on the history and evolution of inpatient group therapy, therapeutic goals and expectations. The effects of patient transference, facilitator countertransference, attachment theory, and social engagement is examined with a focus on the body and brain connection and what it means to be trauma-informed. Evidence-based theoretical approaches that provide safety and stabilization are described and integrated for group members and practitioners alike. Included is a description of the format of the guide, target audience, goals, and resources. Lastly, the resource guide itself contains a list of specialized staff training, short staff development sessions, and safety and stabilization techniques for acute care group therapy.

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When we honestly ask ourselves which person in our lives means the
most to us, we often find that it is those who, instead of giving advice, solutions,
or cures, have chosen rather to share our pain and touch our
wounds with a warm and tender hand. ~ Henri Nouwen

Chapter 1: Introduction

Groups are like a microcosm of life, a community unfolding,
and represent a great possibility of what we can be.
~Avraham Cohen

A group is a gathering of individuals that offers a place for support, newfound awareness, challenge and growth. Since groups are often considered a microcosm for life, it is suggested that the way an individual presents themselves within a group may also provide a hint on how they are in their private life, outside of group. A healthy *group therapy* experience is an opportunity for personal growth, a place to experiment with new ways of being, and a time where feedback is given and reflected on and possibly integrated into one's life. Especially noteworthy is the gift group members receive from one another; within a group, individuals often realize that they are not alone in their experiences and that they have something to offer others (Weiss, 2010; Yalom, 1983; Yalom & Leszcz, 2005).

In this project I intend to clarify why specialized training and self-awareness, along with confidence, flexibility, support and resources are necessary for successful group facilitation experiences. Additionally, I offer a user-friendly resource guide for those professionals leading and co-facilitating group therapy on acute care psychiatric wards.

The first chapter outlines the purpose and rationale for developing this resource guide. In doing so it addresses why typical outpatient models of group therapy are inadequate. The major differences between inpatient and outpatient groups are examined as well as the need for ongoing staff training in facilitation, self-awareness and support. The chapter concludes with a list of terms for clarification and the description of my personal location.

Chapter 2 is the literature review that begins with the history and context of group therapy: outpatient and inpatient, and the goals of inpatient therapy. I then provide background information on attachment theory, how the brain processes trauma and why trauma-informed practice is necessary when working with psychiatric patients. Evidence-based theoretical models are reviewed, along with recommendations for ongoing facilitator training with an emphasis on introspection, confidence building and adaptability of skill set.

Chapter 3 is an outline of what to expect in this resource guide through a project description, explanation of who the target audience may include and the goals of the project. Chapter 4 is the resource guide, including in-house training and development amongst staff, trauma-informed safety and stabilization resources for inpatient groups, and finally listings of where to access continuing education and online supports.

Purpose and Rationale

One of the major goals of this project is to provide guidance to those facilitating groups for clients on inpatient psychiatric wards. Yalom (1983) notes:

> However effective for outpatients, traditional group therapy is not
>
> effective for inpatients: *the contemporary acute psychiatric ward is*
>
> *a radically different clinical setting and demands a radical*
>
> *modification of group therapy technique.* (p. 50)

As Yalom notes above in this powerful quote, traditional group therapy models do *not* translate well to acute care psychiatric settings. Specialized training for group therapists working in psychiatric facilities across North America is sorely lacking, possibly due to availability of training, funding, limited supervision, varying education requirements and differences in interdisciplinary scopes of practice (Lloyd & Maas, 1997). Models of

theoretical orientation are often varied and inconsistent among staff. Co-therapists may include mental health clinicians, nurses, social workers, occupational therapists, psychiatrists and/or psych residents. Practitioners are operating from different scopes of practice, are often unsupervised or working alone and uncoordinated in their programming efforts. It is typical for North American staff to work off-the-cuff, gather resources online, and use community-based group therapy modules/content to adapt on an ad hoc basis (Farley, 1997). Resources may be outdated, not trauma-informed or inconsistent with best practices for *inpatient* care. On a busy psychiatric ward there is also precious little opportunity for debriefing or collaborating with colleagues (Farley, 1997; Llyod & Maas, 1997; Parkinson, 1999; Yalom, 1983).

There are many differences between inpatient and outpatient group work that are expounded upon later, but the purpose and rationale behind this project is two-fold, 1) to address the need for specialized training, personal awareness and staff support for inpatient group therapists, and 2) to provide trauma-informed, evidence-based programming and resources in one manual. I also point out the benefits of integrating somatic and process-oriented-psychoeducational (POP) interventions into *all* group programming; competent practitioners maximizing the interpersonal benefits of groups while adapting specific therapeutic goals in practice.

Differences between inpatient and outpatient groups. There are many significant distinctions between traditional *outpatient* and *inpatient* group settings. As noted by several authors (Hajek, 2006; Razaghi, Tabatabaee, Pouramzani, Mohammadpour, Maghaddam & Yahyavi, 2015; Vinogradov & Yalom, 1989; Yalom, 1983), the experience of acute care psychiatric patients is typically characterized by:

- ***Staff with limited [acute care] group training***. Facilitators that have only *outpatient* models/resources to utilize.

- ***High patient turn over.*** While in hospital, daily changes to group composition, frequent group meetings throughout the day, new patients continually joining groups throughout the week.

- ***Brief hospitalization.*** Length of stay is often 1-4 weeks. Limited therapist stability with rotating staff/shift work.

- ***Ward milieu.*** Patients sharing space 24/7 in a locked unit with strangers, a very unique ecosystem with group dynamics affected by roommate disparity, comorbid diagnoses, safety concerns, sleep issues.

- ***Through inpatient group experiences, people may experience friendship, solidarity, camaraderie and community because of their unique living situation.*** This is an opportunity to develop interpersonal skills. Whereas *outpatient* groups are often discouraged from socializing outside of group time, there are benefits of extra-group socializing for inpatients who often feel ostracized, stigmatized, isolated and lonely.

- ***There is no formal screening or group preparation.*** Group composition is based on availability and scheduling around appointments with other treatment providers. Participation is subject to a clients' ability to participate and they could be disorganized, disorientated, heavily medicated, uncooperative, mandated to attend, or attendance encouraged by psychiatrists and/or nursing staff as part of their treatment plan.

- ***Daily meetings, single session/altered time frame.*** Without operational and structural requirement for appropriate space, there is little time for group cohesion/trust and working through patterns and no time to work on termination. There is a preference to work on *here-and-now* experiences rather than the past (using problem spotting and positive reinforcement).

- ***Heterogeneity of psychopathology.*** Group members differ in co-morbidity (i.e. psychosis, suicidal ideation, anxiety, substance misuse, grief and loss), diagnosis, despair, and motivation. Simultaneously, facilitators endeavor to provide a positive group experience for all, which increases the likelihood of group members continuing treatment as outpatients.

- ***Inpatient group therapists must provide more structure, transparency, active support, and direction than long-term outpatient groups.*** Due to the limited time for treatment, severity of illness and vulnerability of patients, it is vital that the group facilitator is able to create and hold safe space for complex group members.

(Hajek, 2006; Razaghi, Tabatabaee, Pouramzani, Mohammadpour, Maghaddam & Yahyavi, 2015; Vinogradov & Yalom, 1989; Yalom, 1983)

  Ongoing training and self-awareness for facilitators. Education, awareness and supportive environments that are trauma-informed, client-centered and evidence-based are contributors to ensuring the best possible quality of care offered. In order to do this, professionals must take time for reflective processing through regular events like peer supervision, group debriefing and team meetings addressing not only an awareness of skills, knowledge and performance, but also personal factors which might interfere with the ability

to connect with a diverse range of clients (Pantuso, 2016; Shapiro, Brown & Biegel, 2007). Health care professionals must continually work towards fostering therapeutic relationships to treat clients with respect and dignity, provide a sense of safety, structure, support, offer choice, collaboration and empowerment. Understanding and attending to attachment styles, personality styles, areas of resistance, an ability to self-regulate, as well as level of comfort with ambiguity, self-disclosure, and attunement are all essential to the work of *acute care* group facilitators (AGPA, 2007; Herman, 1997; Montgomery, 2002; Vinogradov & Yalom, 1989; Wyatt, Yalom & Yalom, 2006; Yalom, 1983, Yalom & Leszcz, 2005).

My intent for this project is to provide a developing framework to guide facilitator preparation and readiness. This will allow for flexibility when working with diverse, often severe psychopathologies and provide resources for self-reflection, guidance, instructions and integrative techniques. In doing this, there is a focus on the internal process of the clinician. This project also examines issues that arise for facilitators such as countertransference and self-care. Well balanced, self-reflective, confident and healthy practitioners are vital to quality *acute care group therapy*.

Clarification of Terms

Defining the following terms used throughout this manual assists the reader with familiarity and understanding, and provides an index for reference.

Acute care: Used interchangeably with *inpatient,* psychiatric care is short-term, multi-disciplinary treatment and recovery provided in hospital for severe injury to self and/or mental illness.

Attachment: A developmental theory originally proposed by John Bowlby and Mary Ainsworth, whereby the closeness/attachment one has had to their primary or significant

caregivers affects later perception of safety, security and confidence, which in turn affects how one responds to others. Adult attachment can be mapped out on dimensions of anxiety and avoidance that correspond with our level of security in relationship to others. *Securely* attached people are low in anxiety and avoidance, *preoccupied* people tend to be low on avoidance and high on anxiety, whereas *fearful-avoidant* people tend to be highly anxious and high on avoidance and *dismissing-avoidant* people have low anxiety but high avoidance patterns (Marmarosh, Markin & Spiegel, 2013).

Countertransference: All the personal feelings a therapist has towards a client, or the reactions to a client's *transference*, or the therapist's own transferred feelings towards a client (Chan & Noone, 2000; Kottler, 2010). A group leader may respond to their discomfort with conflict or ambiguity to a particular group member by side-stepping further exploration and reverting to advice giving. Repetitive countertransference is when the leader unconsciously repeats or enacts his/her concerns within the group. The leader that encounters frustration by a group might react defensively to protect rather than probe the group (AGPA, 2004). Reparative work can happen within a group when the facilitator is able to remain neutral, grounded and focused rather than defensive, and continue the work of enquiring what is coming up for clients (and possibly the leader), providing space to process, expression of feelings and an opportunity to repair damage from past experiences.

Group therapy: A form of psychotherapy where clients are treated together, rather than individually (CADTH, 2012). Formats vary from structured to unstructured, very few clients to a large group (20+), although studies suggest 6-12 persons is ideal for therapeutic groups (Farley, 1997; Chandler, 2016; Yalom, Wyatt & Yalom, 2006). Groups may be *open* with new people joining the group each session, often ongoing meetings with no end date, or

closed when no new people are admitted to the group once it has started and it runs for a specific length of time in weeks or months. Group therapy has historically been shown to be an effective use of resources, cost effective as well as being a therapeutic tool itself, providing a microcosm in which group member's interpersonal interactions assist their psychological development (Montgomery, 2002; Vinogradov & Yalom, 1989, Yalom, 1983).

- *Cognitive behavioral therapy* (CBT): The most widely used evidence-based practice for treating mental conditions, main principles developed from behavioral and cognitive psychology. An action oriented model which addresses how our thoughts, feelings and behaviors influence one another. Treatment goals include identifying thought distortions and maladaptive behaviors for symptom reduction, identifying patterns, tracking in logs and teaching new coping skills.

- *Psycho-educational:* Educating patients in ways that empower their self-worth, motivation, interpersonal problems, and symptom reduction. To equip and explore various topics related to improving their mental health through information, teaching coping skills, and experiential learning.

- *Process-oriented:* A therapy method that is an interactive developmental process between the group and the individual, integrating doing and being, where feedback is encouraged and learning from one another is expected. Exploring, questioning and analysis of what is heard, seen and felt by the group members to reflect on their present state. For example asking, "How do you feel about what you just heard, what do you notice coming up for you as you share this, is this familiar or new?"

- *Sensorimotor psychotherapy:* Body-oriented awareness to address what's going on internally, to identify sensations and perceive physical states and movement.

Awareness that orients a person to the present by attending to non-traumatic stimuli, discovering new ways to self-regulate and respond to internal sensations, gaining control over their physiological state. This approach "incorporates theory and technique from psychodynamic psychotherapy, cognitive-behavioral therapy, neuroscience and the theories of attachment and dissociation" (Ogden, Minton & Pain, 2006, p. xxviii).

Grounding: The process of removing a charge from an object by means of transfer of electrons. Grounding as a coping skill effectively transfers your body's energy the way a ground wire safely draws away electrical current. In the same way that a ground wire secures physical safety, grounding techniques can bring a sense of security to the body. One strategy consists of planting your feet firmly onto the earth while recognizing stability and security in that action (see Appendix C: 33 Quick ways to ground).

Here-and-now: Focus is on present time, an essential aspect of interpersonal processing to allow group members to pay attention to what is currently happening, for themselves and others, how they feel, what they think, what they see in front of them.

Inpatient: When a person has an acute psychiatric admission, remaining in hospital for treatment as a *voluntary* (at their request) or as a *certified* patient, when two doctors have established that they are at risk of harm to themselves or others due to their mental health status. Client is then admitted to hospital whether they are in agreement or not.

Interpersonal: Relationships between persons, friends, family, groups. Interpersonal group therapy involves interacting, speaking, listening and connection among group members rather than a hierarchical learning experience of group facilitator (expert) and

individual group members. It is inclusive and clients are seen as experts, each with something important to offer the group.

Metaskills: The "ongoing, continuously unfolding and emerging in-the-moment feelings and attitudes" naturally accessed by the facilitator which brings the process-oriented experience to life in ways that the use of mechanical techniques do not (Cohen, 2004, p. 156).

Mindfulness: Self-observation of present moment experience. For example, paying attention to the details of the breath, inhale, pause, and exhale, or holding a warm cup of tea in your hand; stimulating curiosity of present internal or external exploration (Ogden et al., 2006; Van der Kolk, 1994).

Outpatient: When a person is being treated for mental health concerns in the community. Typically an outpatient group is composed of 6-8 clients that meet 1-2 times a week for 90+ minutes for several months or even years (Vinogradov & Yalom, 1989; Yalom, 1983, Yalom & Leszcz, 2005).

Patient/client: Within hospital settings individuals admitted are referred to as either *patients* or *clients* of the health care system. The term patient and client will be used interchangeably in this project to refer to individuals accessing group therapy.

Self-regulation: Using your body to self-soothe, to find ways of regulating physiological arousal and gain a sense of self-control. It is the body's capacity to self-regulate the parasympathetic and sympathetic nervous systems: when arousal is too high, to calm down (down-regulate) and when arousal is low, to self-stimulate (up-regulate) as necessary. For example, an individual may be hyper-aroused and defensive needing to calm down or hypo-aroused and requiring increased alertness. *Interactive regulation* is then the

same ability, but activated through interaction with others. These abilities are developed early on, prior to language acquisition during attachment relationships in infancy (Ogden et al., 2006).

Somatic resourcing: Identifying physical experiences that engage a person's capacities and beliefs with movement of their own body to self-regulate, to provide a sense of well-being and competence. Treatment begins by focusing on observation and control of the body to offer a sense of safety and self-care through movement, sensation and posture for stabilization (Herman, 1992; Ogden et al., 2006).

Transference: When a client projects their unconscious feelings onto a therapist, according to Freud, our early experiences are often replayed, redirected and transferred onto others and that response continues to shape later life (Freud, 2012, as cited in Pantuso, 2016).

Personal Location

Over the past three years I have become particularly interested in *group therapy* in *acute care* facilities while working as a Mental Health and Addictions Clinician for Northern Health (NH) in the Adult Psychiatric Unit (3NE), Adolescent Psychiatric Assessment Unit (APAU) and Adult Withdrawal Management Unit (AWMU, also known as Detox). I started my career with NH as a casual clinician 4 years ago doing short and longer term relief positions on these wards before acquiring a permanent position with Adult Psychiatry in 2016.

Adult psychiatric unit. University Hospital of Northern British Columbia (UHNBC) is located in Prince George, BC. The adult psychiatric unit is a secure, locked, 20 bed unit with four additional beds in the seclusion psychiatric intensive care unit (PICU) which is only available for those who are actively a danger to themselves or others.

From January 1st, 2015 to January 1st, 2017 there were 773 admissions of persons over the age of 18, 49% were males, 51% females. Average length of stay was recorded at 21 days, admitting diagnoses include (but not limited to) Major Depression, Depression with Suicidal Ideation or Attempt, Eating Disorders, Anxiety Disorder, Bipolar, Psychotic, Schizophrenic, Schizoaffective Disorder, and Personality Disorders. Health Canada states that the co-occurrence of substance use and mental health issues is a growing concern for health care. The most common concurrent disorders are substance use and anxiety, followed by substance use disorder and mood disorders (2002).

On the psychiatric unit there are two patients to a room, gender specific, and patients are not to enter another patient's room. There is a large kitchen area with four round tables, sink, fridge and self-serve tea service with cold cereal, toast and fresh fruit. Clients are able to go outside for fifteen minute fresh air breaks approximately every two hours throughout the day and are assigned short passes (1-3 hours), day passes, and overnight passes by their psychiatrist as they prepare for discharge back to the community.

Staffing, programming and group structure. There are 10 psychiatrists and two general practitioners currently on staff, one social worker, nine fulltime registered nurses (RN)/registered psychiatric nurses (RPN) as well as 4.5 licensed practical nurses (LPN), each nurse caring for six to seven patients. Mental health and addiction clinicians (MHAC) are not assigned a patient load but work primarily in planning and leading group programming, meeting with clients one-to-one and/or other specific tasks as requested. There is one occupational therapist (OT) who leads weekly activity groups and attends morning groups when scheduling allows. Nursing staff alternate joining therapeutic groups as needed to

ensure there is always two staff with patients during groups. Occasionally nursing students also participate in group programming.

The weekly programming schedule is posted in the main hallway and includes daily large group check-in at 9 a.m. where clients scale their current mood between 1-10, then describe how they are feeling, create S.M.A.R.T. goals (Specific, Measurable, Attainable, Realistic, and Timely, refer to Appendix K) and discuss personal coping skills. At 10 a.m. there are various psychoeducational small groups on self-esteem, anger management or coping skills. At 11 a.m. a guided relaxation group is held. In the afternoons there are different groups each day at 1 p.m. including a medication education group, peer support, recreation, or art activities. At 3:15 p.m. each day there is a larger health and wellness group offered in the OT room so clients can finish art projects, start new ones, play board games or use the Wii. Daily therapeutic programming is over at 4 p.m. when visiting hours begin. A final check-in group happens at 8 p.m. to share any positive moments from the day, review outcomes or revise S.M.A.R.T. goals and/or share any items they are grateful for. In addition, there is a short relaxation group offered at 9 p.m. for those interested in a relaxing transition to bed before evening medications.

When a clinician such as myself, steps onto a ward, whether for casual relief (1 day) or a block of time in a regular rotation, there are posted expectations and a weekly schedule, as well as resource binders full of creative ideas, topics and skills to utilize. I often find myself spending time researching content, as almost always the materials I locate are intended for individual therapy or outpatient groups. Upon starting work on the unit, I quickly realized that *outpatient* groups are "radically different" than *acute care* groups for all the reasons listed previously (Yalom, 1983, p. 26). This experience has emphasized to me

how critical it is as a facilitator to be aware of areas of expected *countertransference*, be emotionally and physically grounded, active, flexible, directive and *process-oriented* whenever possible. Also, depending on who shows up or stays for group, alternative strategies and back-up plans are essential to quickly adapt to the current group dynamic.

Farley (1998) in his review of *group therapy* practices in six North American psychiatric hospitals, found that "there does not appear to be a consistent method of designing, implementing, and assessing inpatient group therapy programs" (p.1). My experience echoes this and is common among the research nationwide, suggesting that much of *acute care* group psychotherapy is conceptualized on-the-spot by hardworking, multitasking and intuitive staff (Gabrovsek, 2009; Hoge, Migdole, Cannata & Powell, 2013; Marcovitz & Smith, 1983; Yalom, 1983). Such on-the-job learning with little specialized training or supervision can make for a daunting, sometimes isolating, overwhelming and perhaps even unsafe environment for patients as well as staff. There are times when my assumptions or insecurities around my abilities to get the best of me, such that I either over-compensate by placating group members or ignore opportunities for further exploration. Sometimes my level of anxiety, fatigue or patience for others is lacking, and then there can be stressful situations where a "debrief" would be beneficial, but second guessing and ruminating may occur instead.

Staffing of the *acute care* therapeutic groups on UHNBC Adult Psychiatric ward consists primarily of the clinician and the OT if scheduling allows, or someone from the nursing staff. Management is in line with the current research and prefers a co-facilitator be made available for all group meetings, but at times this is not possible. When a second facilitator is unavailable the location of the group is relocated to a more common area such as

the main television lounge, or an open area on the psychiatric unit since the smaller group room is not equipped with cameras.

Acute care group therapy requires co-facilitation, which necessitates securing the support and planning of staff. Two facilitators can model healthy interaction and it is always preferred to have a lead facilitator as well as another set of eyes and ears to assist if a patient needs help orientating, staying present or decompressing (Razaghi et al., 2015). The TV lounge and/or kitchen tables are less than ideal because of constant client and staff traffic flow. A high level of ambient noise is distracting and there are no alternatives (other than patient's rooms) for clients who are not appropriate for group or those that choose not to attend. As a facilitator, I am often challenged by the distractions and uncertainty of location, often wishing for a designated space where members can choose to be open, vulnerable and focused, while feeling safe and protected from hospital commotion. There is one small group room usually available which is appropriate, quiet, private, and comfortably holds 6 to 8 clients for therapeutic groups.

In order to provide safe and effective, evidence-based group therapy by well-informed, knowledgeable and prepared staff, it is suggested that government funders and health authorities recognize that *acute care group therapy* is very different from *outpatient* therapy. Intentional floor plans, furnishings, spacing requirements, staffing and specific techniques must be adapted to patients' therapeutic needs and require evidence-based training and supports necessary to deliver appropriate care for *inpatient* clients.

My facilitation experience. I came into this work with many years of group work experience, leading and co-leading within the special education system (elementary and high school), church environment, university context, and community mental health. Over the

years I have had the privilege to work with diverse groups of people: preschoolers, children, teens, university students, staff and faculty, as well as older adults. My facilitation of small to large groups involved teaching, coordinating social activities, experiential learning, and facilitating spiritual-growth groups to large and small clusters of people. I personally participated in a variety of groups that involved skills-building, education and therapy. Whether leading or participating in groups, often uncomfortable at first, I have always come away pleasantly surprised by what I've learned about a topic, myself and others.

Occupational and academic group training also afforded me a good understanding of group dynamics with the ability to navigate and integrate personality types, conflict, attachment styles and especially trauma awareness (AGPA, 2007; Bath, 2008; Bowlby, 1988; Forsyth, 1998; Myers Briggs, 1980; Tuckman & Jensen, 1977). Yet, I was still unprepared for the complexities of group work on a psychiatric unit, the complications of patient co-morbid diagnoses, fluidity of group composition, and the severity and diversity of illnesses. Obstacles like patient's decreased cognizance and comprehension due to medication interventions, limited time and space necessary for therapeutic work, not to mention the daily busyness of an integrative workplace. Distractions are inherent with an open concept meeting area subject to ongoing activities of doctors, nurses, staff and patients coming and going. I found myself wanting to be more connected to my staff team, to learn from those with more experience, to build trust, and support one another. I desired time to communicate, to provide feedback, share ideas and planning to better serve our patients and advance the breadth of knowledge found in such a multidisciplinary environment.

Complications. More recently, I experienced "post-concussion syndrome" from a fat-biking accident in which I landed firmly on my head. I was off work for ten weeks to

recover, followed by a supportive back-to-work schedule. This experience intensified my appreciation of the specific skill set required when working with groups on a psychiatric ward. As a result of my head injury, my anxiety and depression increased, I found it more difficult to self-regulate my emotions and my memory, concentration, and focus was diminished. My ability to multi-task was significantly impacted and my reduced capacity acutely affected the very skills that are critical to my effectiveness as a group facilitator.

In light of my recent situation and reflection on my group leadership skills, I reviewed and found Cohen's (2004) approach to teaching *process-oriented* group facilitation an excellent reference to the significance of these basic facilitation skills:

> (a) the capacity to attend to another's experience, (b) the ability to accept and convey that acceptance to another, (c) the awareness and sensitivity to demonstrate a range of *metaskills* ("the ongoing, continuously unfolding and emerging in-the-moment feelings and attitudes…"), and (d) the ability to facilitate the creation of a "group container" and safe interpersonal connections (p. 156).

To therapeutically and effectively attend to what individuals are experiencing within group, facilitation requires leaders to convey acceptance, detect micro-expressions and maintain multilevel awareness. To simultaneously finesse at least four levels of awareness, leaders' attention is "split" between foreground and background processing, for instance demonstrating a coping skill while checking-in on the group. Or "dual", tracking external processes while staying tuned in to the internal processes of group members and self (countertransference) while noticing "roles" that emerge, the effects on the group, how and when there's a shift to recognize. Also, facilitators need to continually notice, reflect, and

undertake their own "inner work", evaluating and articulating their experience to make use of

teachable moments, on the spot (Cohen, 2004). For instance, a facilitator may address a

participant that just sat straight up and is clenching their jaw by saying to them, "I am aware

that when you lean back in your chair and get quiet, I feel a sense of apprehension. When my

son gets quiet it often means somethings up, and I would like to check-in now and ask you if

something has just shifted for you".

In addition to multilevel awareness, a facilitator is tasked with integrating coping

skills for safety and stabilization and managing up to 20 patients who don't necessarily want

to be in hospital, are isolated from family and friends, are quite possibly feeling frustrated,

fearful, disorganized, embarrassed, all the while undergoing medication changes. As a

practitioner, I need to first recognize what I need to be fully present, so I can be equipped to

be present to group members on a myriad of different levels.

Multitasking on a psychiatric ward involves thinking on your feet, being incredibly

flexible, confident, compassionate and consistent while simultaneously managing and

balancing various agendas and crises. I learned quickly to take action with my health outside

of work and enlist the support of peers to challenge my assumptions, reflect with me on my

ways of being and encourage me to keep learning.

A psychiatric ward is an absolutely amazing place to serve people, to promote healing

through safe connections, stabilization of symptoms and witness substantial changes and

growth in patients over a relatively short period of time. It is a place where I have had the

privilege to learn from others, be encouraged, and experiment with new ways of being for

myself. I have learned that there is always more to comprehend about group dynamics and

that I'm affected in the process. Tailored treatment and management is essential; clients (and

staff) are unique, resourceful and complex beings. It is clear that clinicians who facilitate groups require ongoing specialized training, resources and support.

Summary of Chapter 1

In providing my professional experiences, I highlighted what I believe is necessary for evidence-based *inpatient group therapy*. I intend to provide a resource manual that is trauma-informed with an adaptable framework of body-oriented, interpersonal, psycho-educational group therapies. Key factors to success are sufficient time, structure and support. Staff facilitators need to have an understanding of their own vulnerabilities or perceptions of conflict, control, ambiguity, safety, and explore how these impact their leadership and interaction with clients in group. Appreciating their own vulnerabilities, trained facilitators may process *here-and-now* situations with clients, building a sense of safety and connection while developing a variety of coping skills within an *acute care* setting. I intend for this proposed resource to be informative, accessible (to relief/casual clinicians, as well as permanent staff) and straightforward to implement. It could enhance opportunities for ongoing staff support, collaboration, as well as improve and advance training while recommending evidence-based group therapy interventions for a very distinctive, yet diverse clientele of psychiatric *inpatients*.

Chapter 2: Literature Review

History

Group psychotherapy has been a primary tool for treating psychiatric patients for over 100 years. It began with psychoanalytically-oriented approaches after the First World War that resembled talks/lectures and group exercises with *inpatients*, followed by subsequent implementation of cognitive, existential and interpersonal approaches (Burlingame, Fuhriman & Mosier, 2003). In the 1930's community based aftercare was developed for those recently released patients handling the transition from mental hospital to post-hospital life. Former *inpatients* not sick enough to be re-institutionalized, but not well enough to survive in the community without professional support were the focus. After WWII community based psychiatry was gaining support to replace institutionalized care (Chan & Noone, 2000).

It wasn't until the late 1960's and 70's that authors began to differentiate between *inpatient* and *outpatient* group therapy (Fabian, 2003; Kibel, 1992; Kosters, Burlingame, Nachtigall & Strauss, 2006; Marcovitz & Smith, 1983; Montgomery, 2002; Razaghi, et. al., 2015; Yalom, 1983). In Canada, in the 1950s there was move to de-institutionalize and shift the focus of care from longer term mental hospitals to psychiatric units of general hospitals for briefer psychotherapies and treatment. Eventually, in the 1990s Canadian government planning included capacity for 25 adult psychiatric care beds per 100,000 for British Columbia (Chan & Noone, 2000).

Many psychiatrists including Yalom credited improved communication throughout the hospital to *group therapy*. Length of admission dropped with the advent of neuroleptic medications; significant improvements were seen in patients who were otherwise

unreachable. The benefits of interpersonal integration was realized in the early stages of

acute care group psychotherapy models as staff described reduction of patient fear and

increase in socialization. Therapists emphasized the client's experiential aspect with group

cohesion as an essential form of support.

> The goals of the acute inpatient group are not identical to those of
>
> acute inpatient hospitalization. The goal of the group is <u>not</u> to resolve
>
> a psychotic depression, not to decrease psychotic panic, not to slow
>
> down a manic patient, not to diminish hallucinations or delusions.
>
> Groups can do <u>none</u> of these things. That's the job of other aspects of
>
> the ward treatment program - primarily of the psychopharmacological
>
> regimen. (Yalom, 1995, p. 459)

By the 1980s researchers were looking for models that would frame patient

improvement and fundamental elements of group treatment. The 1990s also included the

development of protocols for specific diagnoses, settings and orientations arose in the

literature (Burlingame et al., 2003). *Inpatient group therapy* is now considered an important

introduction to (outpatient) therapy and a positive inpatient experience is correlated with

better allocation of resources and increased follow-up with *outpatient* therapy (Yalom, 1983).

Clinical efficacy. Group therapy is still considered a cost effective and beneficial

treatment to reduce symptoms, modify behaviors and deal with interpersonal issues for those

with (often co-morbid) severe mental illness. Yet it is difficult to measure exactly *how*

because of numerous complexities and variables with group treatments and contextual factors

in patient outcomes. Obviously there is an absence of controlled studies, due to ethical/moral

reasons: researchers cannot ethically determine a randomized sample of psychiatric patients,

place them in treatment groups, withhold treatment for a control group, and replicate the

exact factors and environment (Burlingame et al., 2003; Farkas-Cameron, 1998; Kosters et

al., 2006; Liebherz & Rahbung, 2014; Llyod & Maas, 1997; Lothstein, 2014; Montgomery,

2002; Phan, Rivera, Volker & Garret, 2004; Vinogradov & Yalom, 1989).

      While there is support for the "theoretical basis for short-term inpatient

psychotherapy", Marcovitz and Smith (1983) found that there is also "variability and

ambiguity with respect to practical, concrete approaches to inpatient groups" (p. 375). Kibel

(1992) concurs, citing great diversity in facilitator practice of inpatient groups, hence the

need for simple, user-friendly, hands-on guidelines for effective evidence-based *inpatient*

group therapy.

Outpatient Group Setting

      Outpatient groups are often offered in community with types of therapy groups

including, but not limited to: grief and loss, substance abuse, family support, anxiety and

depression coping skills, mindfulness, meditation, and/or relaxation, anger management,

parenting or interpersonal process groups.

      Typically 6-12 homogeneous (re: range of psychopathology) clients attend one or

more times a week for 1-2 hours, with individuals committing to the group if it's closed (not

allowing new members to enter the group once the group starts), or if it's an open group

membership fluctuates with a longer term drop-in model. Confidentiality is encouraged and

agreed to, trust and cohesiveness in group identity evolves over months or years and there is

usually an obvious termination or good-bye process. Group facilitators are often much less

active, groups tend to be more self-directed and clients are not necessarily meeting socially

outside of group time (Corey & Corey, 1997; Rutan, Stone & Shay, 2015; Yalom & Leszcz,

2005). See Table 1 below for comparisons between group psychotherapy in *outpatient* and

inpatient settings (Miller & Matthews, 1988, p.22).

Table 1. Factors that affect group psychotherapy in the outpatient and inpatient setting.

Factor	Outpatient	Inpatient
Turn-over of patients	Low	High
Turn-over of staff	Low	High
Range of psychopathology	Narrow	Wide
Confidentiality	Within group	Within ward/ team
Time spent together outside of group session	Limited	24 hours
Length of time in treatment	1-2 years	3-4 weeks

Screening. Interested *outpatient* group members are carefully pre-screened for group

therapy suitability (Fried-Ellen, 1999; Marmarosh et al., 2013; Yalom & Leszcz, 2005). The

American Group Psychotherapy Association's (AGPA) *Practice Guidelines for Group*

Psychotherapy differentiate the issue of selection and recipient of the greatest benefit, with

composition, to determine the blending of clients to produce an effective therapy group

(2007). The AGPA suggests that the determination of who should be excluded from group is

based on the possibility and availability of strong therapeutic alliance, which is by far the

most significant predictor of positive outcomes for individual as well a group therapy

(Yalom, 1983). If perhaps a patient is excluded through group screening, other therapy

options are considered. Vinogradov and Yalom list the following reasons for possibly

excluding a group member: previous failure in group therapy, hostile to the idea of group

work, uses group to seek social contacts, client has unrealistic expectations for outcome of

treatment, and shows manic, agitated or paranoid behavior, or is unable to participate in

group task (1989).

Research suggests that the composition of a group has direct impact on outcomes, and

interactions within the group determine the group dynamics, which in turn affect therapeutic

factors. Ideally, a group experience will promote change and members will find it beneficial. Paradoxical to this are detrimental factors that can alter treatment outcomes like when a person's experience is *not* managed for safety, if they feel alone and not understood, if there is no sense of togetherness, acceptance, or of being of any help to other clients, the individual will not likely engage in further group treatment (Phan et al., 2004).

Practitioners must determine if the potential group member is incompatible with participation goals for group process. Seasoned clinicians recognize the importance of group dynamics on the therapeutic experience. The group itself is the "client" (similar to couple's therapy, where the couple is the client), made up of unpredictable, complex individuals; therefore it can be detrimental to the group's effectiveness as a whole, or harmful to individuals, if a particular person is unfit or incapable of benefiting from the group experience (Corey & Corey, 1997; Dirmaier, Harfst, Koch & Schulz, 2006; Rutan et al., 2014).

For *inpatient* groups, if a patient is actively psychotic, disorganized, violent or threatening, obviously they would not be appropriate for participation in a group (de Chavez, Gutierrez, Ducaju & Fraile, 2000). Important to note, a person's readiness for group may be fluid and needs to be reassessed by staff throughout the day depending on the patient's actions, state of mind and willingness to contribute (Cowls & Hale, 2005; Marcovitz & Smith, 1983; Paley, 2013). Though the attending psychiatrist will initially create an inpatient's treatment plan, determining appropriate groups for participation, an interdisciplinary staff team will communicate and share information throughout the day and use their clinical judgement to collaboratively and continually construct the best possible therapeutic environment for all patients (Farely, 1997; Khorasani & Campbell, 2013).

Inpatient Group Setting

Persons entering a psychiatric unit tend to be disorganized in their behavior, and experience a higher sense of anxiety upon admittance to hospital. Clear explanations, expectations and options for treatment need to be offered repeatedly to lower patients' stress levels (Khorasani & Campbell, 2013; Lloyd & Maas, 1997). The clinical group setting typically offers a combination of large (up to 20+ patients) and small (2-12 patients) diagnostically heterogeneous groups throughout a day. The need to provide distinct levels of care inherently presents challenges in obtaining therapeutic factors which are characteristically borne out of the common experience of a diagnostically homogenous group (Cook, Arechiga, Dobson & Boyd, 2014). Adler (1995) noted that heterogeneity can actually enhance the therapeutic environment chiefly due to diversity of members with mutually complementary traits that function as complementary roles within the group dynamic. Clients are in and out of groups, typically rapid turnover with admissions and discharges throughout the week making cohesion difficult and engagement with patients is an art (Parkinson, 1999). Structure, boundaries, creativity and active facilitation are imperative in heterogeneous multi-leveled *inpatient* groups.

Typically, in most mental health settings, larger groups lean towards more simplistic approaches to review ward expectations and schedules, as well as daily morning and evening check-ins. Art therapy, health and wellness or community groups are also offered. These groups tend to be open—clients choose when to participate, come and go, and have reduced structure. Smaller therapeutic groups lend themselves to increased focus, intentionality and require higher functioning patients who may be expected to arrive on time and to minimize disruption to the group if they choose to leave (Emond & Rasmussen, 2012; Parkinson, 1999;

Wyatt, Yalom & Yalom, 2006; Yalom, 1983). Patients that attend groups may leave for various reasons, to see their psychiatrist or physician, if feeling unwell or overwhelmed with frustration that needs to be dealt with by another staff member. These conditions not only affect the facilitation of group, but can also alter and disrupt the intended group format and cause dysregulation for other patients (or facilitator).

Nursing staff and/or psychiatrists generally determine what types of groups are appropriate given the clientele. Collaboration between staff, group facilitators and patients is beneficial for designing a treatment plan. Research recommends voluntary attendance. This is ultimately dependent upon the patient's readiness of how well s/he feels, possible side effects from medication changes, conflicting appointments and openness to change (Cowls & Hale, 2005; Khorasani & Campbell, 2013; Parkinson, 1999).

Goals of Inpatient Therapy

Historically, inpatient psychotherapy sought to treat mental illness through curative goals, strengthening ego development and relational functioning. The goal was not to remove all symptoms but to help patients shift to more adaptive ways of thinking and behaving (Marcovitz & Smith, 1983). Further changes in treatment models to pharmacotherapy and away from *inpatient* psychotherapy followed the mid nineteenth century with improvements in the development and research of psychotropic treatments. Later, there was yet another shift towards brief hospitalization, pharmacology and specific therapeutic goals, originally led by Dr. Yalom (1983). Responding to the changing therapeutic environment, Yalom suggested that there are four interpersonal goals of acute care therapeutic interventions: 1) to engage the participant in immediate and future therapy, 2) to demonstrate that talking helps, 3) to identify and work on interpersonal problems, and 4) decrease hospital-related anxiety.

Yalom and Leszcz (2005) subsequently added two more goals of "decreasing isolation" and "being helpful to others" (Emond & Rasmussen, 2011, p. 70). Hajek also endorsed Yalom's *interpersonal* model of inpatient therapy goals as "engaging the patient in the therapeutic process", "reducing isolation" and anxiety connected with hospitalization, and "providing experience of universality and of being helpful to others" (2007, p. 11).

Lloyd and Maas (1997) surveyed *inpatients* on Yalom's therapeutic constructs and found they appreciated having things in common, sharing problems, feeling supported, being able to talk more freely, staying in touch with feelings, giving and receiving feedback and increasing their confidence, from comments on post-group therapy questionnaires. These felt benefits were found to be interdependent with shared experience or group cohesiveness, confirming the underlying therapeutic value of *group therapy*. They concluded that it is imperative that proficient group leaders know how to make use of inpatient group structure and process to enhance social interaction and a sense of cohesion/shared experience with co-clients. It was clear that a client's sense of *interpersonal* connectedness and safety is vital to receiving benefit from group experience.

Safety and stabilization. Emond and Rasmussen (2012) cite ward stability as a goal of psychiatric units. This refers to a multitude of research findings that has shown *inpatient* group therapy improves staff-patient relationships, decreases violent behavior, empowers patients, and creates a therapeutic ward milieu. These researchers found that measureable cognitive and behavior outcomes for highly acute populations focused on improving interpersonal skills and decreasing symptoms. The outcomes expedited patient recovery and preparation for discharge.

It is essential for staff to provide a safe trauma-informed environment within group therapy where clients are assisted with tools to *ground* themselves in the present, to regulate their emotions, and better attend to interpersonal relationships with co-clients, staff and supporting family members or friends. Safety and stabilization is a prerequisite to other therapeutic collaborations including psychoeducational groups where patients develop new coping skills, or interpersonal experiential learning, or higher level processing. Therefore, since strengthening *interpersonal* capacity while attending to safety and stabilization techniques is necessary for optimal mental health outcomes, the goals of inpatient therapy (to improve interpersonal capacity) need to be offered in an enriched environment with self-regulated, *grounded*, trained facilitators, who then determine adaptable strategies and techniques (Cowls & Hale, 2005; Kottler, 2012; Ogden & Fisher, 2015; Yalom, 1983).

Significance of cohesion. It is imperative that group cohesion is developed quickly, as *acute care* group work is brief; composition is constantly changing with people being admitted and discharged daily (Cook et al., 2014; Dinger & Schauenburg, 2010; Muskett, 2014; Stone, Clendenin, Zapata & Gonzales, 2012). At the very least, members may only ever attend one group session, or engage in sporadic attendance over many weeks. Progress occurs over a relatively short time span, therefore it is necessary for facilitators be much more directive and somewhat embedded in the group to create that sense of safety and shared experience (Weiss, 2009). Farkas-Cameron (1998) combined Gunderson's (1978) and Yalom's (1985) therapeutic processes for their work with psychiatric nurses and found that containment, support, structure, involvement, validation and education were paramount to effective leadership of *inpatient* groups.

Well over 100 research studies have since assessed Yalom's (1983) therapeutic factors, believed to promote change and contribute to the benefits of group therapy which include "installation of hope, universality, imparting of information, altruism, corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, catharsis, existential factors, cohesiveness and interpersonal learning" (p. 41). Maxmen (1978) identified the top four therapeutic factors that patients found to be most helpful from inpatient psychotherapy to be installation of hope, cohesiveness, altruism and universality. Similarly after comparing eight other studies, Kahn (1986) concluded that regardless of diagnosis, the primary therapeutic benefits for inpatients are installation of hope, interpersonal connections, universality and self-understanding.

Facilitator transparency and self-disclosure. To develop rapport and connect with clients in an *acute care* setting, facilitator self-disclosure or personal transparency is indispensable. Yalom (2002) self describes his own relationship with patients as "fellow travelers", allowing for ways to "dismantle the distinctions between 'them' (the afflicted) and 'us' the healers" (p. 6). When a patient witnesses another individual, especially the group leader, indicating similar thoughts or experiences, a sense of universality expands and they feel less alone in their illness. Of course there may be others who wish to hold the fantasy that the clinician is set apart to heal with wisdom and authority, but Yalom's response to those patients is to explain that having a human encounter with a real person is vital to their healing process. Obviously transparency must be balanced with responsibility, what's best or instrumental for the group as a whole (Yalom, 1983). Rutan et al. (2014) suggest that group leaders consider and commit to two things: to understand more clearly what they are

attempting to accomplish from disclosure and be ready to attend to anticipated or unexpected

reactions from the group.

        Transference and countertransference. Facilitators that participate in shared-

learning experiences through modelling in a process group, reduce client *transference* by

clarifying behaviors in the *here-and-now* (Montgomery, 2002). For example, the facilitator

can make good use of client transference as a tool to address maladaptive beliefs, resistance

or stuck-ness when members are given the opportunity to address patterns, make connections

or corrections in their present experience (AGPA, 2004; Yalom, 2002). Processing *here-and-

now* emotions safely as a group is a wonderful way to authentically connect as humans for a

communal transformative experience.

        Countertransference refers to the emotions a staff member feels towards clients and

may be reactive, induced, displaced or projected (AGPA, 2004; Kottler, 2010). It is present

in all therapies and is a predictable side effect of interpersonal encounters and should be

anticipated, not overlooked or discounted. In *Group Interventions for Treatment of*

Psychological Trauma the AGPA describes common group phenomena to watch for

including group defenses of denial, splitting, dissociation, projection (patient transference),

and projective identification (another patient enacting projected identity). If a facilitator is

not well *grounded*, confident, self-aware or cognizant to such client defenses, they may not

recognize what's going on. The Crisis and Trauma Resource Institute (CTRI, 2014) suggests

that once professionals can ensure self-regulation of their own body, voice, posture and

thoughts they themselves will be grounded, and better able to support clients. Facilitators

who are attuned to their group members, connecting their conscious awareness with physical

and emotional states, strengthen the regulatory capacity in both body and brain to co-regulate.

According to the AGPA (2004) common responses to *countertransference* in terms of working with clients who have experienced trauma include feeling overwhelmed (anxiety, rumination, dissociation) or wanting to distance oneself from feeling overwhelmed (avoidance, rigid neutrality, intellectualizing). Facilitators may experience feelings of depression, despair, sadness, anger, inadequacy, shame, blame, or guilt. They may fear anger, conflict, triggering clients, or connecting with loss. Having an opportunity to address these fears outside of group session is important for staff to understand the complexities of countertransference, how it affects their leadership style, choice of treatment modalities or even their self-care (Chan & Noone, 2000).

An example of countertransference is when a facilitator avoids certain material or experiences, for example, experiences of walking on egg shells with group members, sleepiness, or shame, guilt, hypervigilance and rescue fantasies. Kottler (2010) suggests therapist *countertransference* feelings may not be undesirable complications, but "real assets in the promotion of a true human encounter" (p. 147). He states that intense personal reactions can be turning points, "entanglements that often form the nucleus of therapeutic work" (Kottler, 2010, p. 146).

A few questions a group leader should consider: "Are the feelings that come up conscious or unconscious?", and "are they familiar, unusual, appropriate, defensive?" The caution and skill for an *inpatient* group facilitator is to be comfortable enough with him or herself to identify the source, function and impact of countertransference while monitoring the group-as-a-whole and the individuals, at the same time assess whether disclosure will

facilitate therapeutic attunement or if it underscores the need for further personal processing in supervision.

Attachment Theory and Social Engagement

Attachment theory was developed by John Bowlby who believed that most psychopathology has its origins in problems that occur in early development when children's basic needs for safety and felt security are not met (1988). The ability to emotionally regulate or self soothe is believed to be shaped by that implicit learning from our early attachment experiences with caregivers. According to Ogden et al. (2006) disruptions to that foundational social engagement system effect people's ability to modulate their arousal, develop healthy relationships and cope with stress. Those primary relationships help form the ways in which we understand our self and others (Beihl, 2012). Yalom and Leszcz (2005) have confirmed correlations between persons who are treated for mental health issues and significant interpersonal challenges.

Brennan, Clark and Shaver (1998) came up with a dimensional model of adult attachment. This model identifies dimensions such as anxiety (how fearful one is in relationships) and avoidance (how emotionally avoidant a person is). An individual's high or low levels of anxiety and avoidance determines their placement in one of four quadrants based on levels of security (see Figure 1). For example, an insecurely attached person's "self-protective way of relating to the world" is counterintuitive to a person's basic need for closeness and attachment (Beihl, 2012, p. 18). Brennan et al.'s four quadrants include the following:

Secure. Caregivers were good enough, mostly available and responsive. Adults low on both dimensions of avoidance and anxiety are people that do not avoid intimacy or fear

rejection or abandonment. Secure individuals are more likely to seek help, self-disclose, be emotionally committed and make better use of treatment opportunities within group therapy.

Preoccupied. Caregivers may have been inconsistently available or poorly responsive to the child's needs. Adults exhibiting high levels of anxiety and low avoidance are sometimes described as clingy or needy; they may be hypersensitive to rejection and try hard to maintain intimate contact, demonstrating fear of being alone. In groups, these individuals may fear rejection and become disappointed with the group leader, have difficulty forming alliances and experience more misunderstandings within group sessions (Marmarosh et al., 2013).

Dismissing-avoidant. Caregivers were consistently unavailable and poorly responsive to the child's needs. Adults presenting with low anxiety but highly avoidant seem self-reliant and keep to themselves, they don't seek out others and may actually push them away. Dismissing members tend to be less emotionally connected to the group and prefer simple companionship over group interactions (Marmarosh, et al., 2013).

Fearful-avoidant. Primary caregivers were likely frightening or were very frightened themselves. Adults displaying high anxiety and high avoidance alternate between fear of rejection (deactivate) and fear of abandonment (hyper-activation), they seem inconsistent or disorganized because of their conflict as they avoid intimacy but long for connection. Along with dismissing members, fearful-avoidant group members self-disclose the least and are more likely to require crisis intervention (Brennan et al., 1998; Ogden et al., 2006; Marmarosh et al., 2013).

Figure 1. Dimensional Model of Adult Attachment
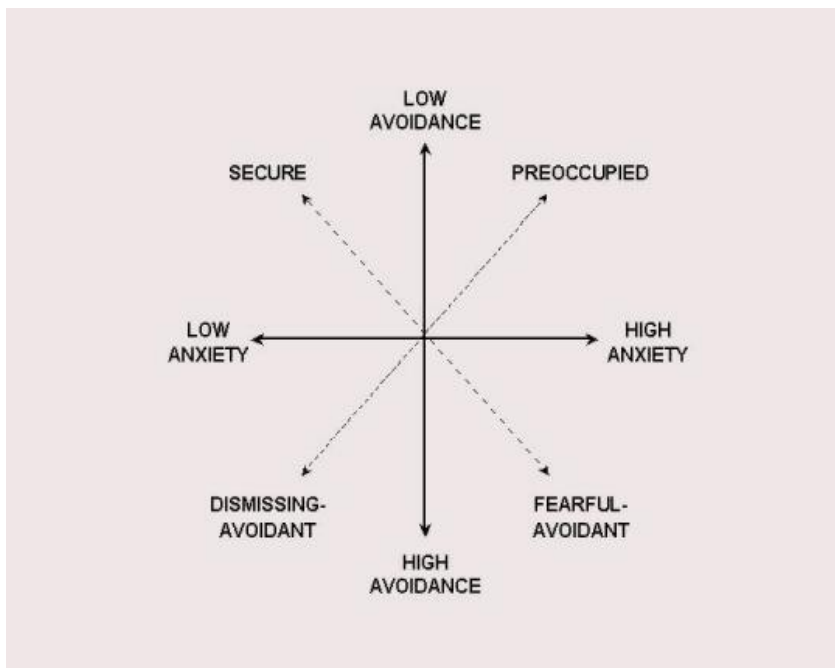
Kirchmann et al. (2012) confirmed associations between psychiatric diagnoses and

insecure attachment and cited several studies revealing that insecure attachment limits

cohesion within group psychotherapy. Adult attachment patterns can change over time, play

a role in symptoms, and can also have a powerful influence on group process. When

individuals are stressed, past attachment experiences are played out implicitly between all

group participants, members <u>and</u> facilitators. Attachment relationships between group

members and facilitators are complex, there's often *transference* and *countertransference*.

Early caregivers shape a group member's perception of another's behavior. Leading groups

is challenging at the best of times, but particularly so if members (or facilitators) are trying to

mitigate fears, look for reassurance, defend themselves by trying to seem superior, or

withdraw but simultaneously long for connection. Understanding how attachment styles

affect patterns of behavior for clients and facilitators, is central to providing reparative or

corrective *interpersonal* experiences within the group context. In order for that to happen,

group leaders need time to explore how unpredictable group situations affect their sense of self, their response to ambiguity, flexibility, comfort level with disclosure, or be aware of their own triggers and blind spots. Health care professionals require a safe place for guidance, challenge and support for reflection and encouragement to continue developing.

A group leader can have a profound effect on the group process, positively or negatively. How facilitators handle emotions, express or appreciate conflict, their ability to empathize, nurture or facilitate a safe group interaction either leads to corrective emotional experiences or it can destabilize group members (Cabecinha, 2017; Marmarosh et al., 2013). Understanding the role of attachment can be a wonderful tool for a facilitator. If a facilitator is familiar with their own style and can make use of transference/countertransference in the *here-and-now* processing within the group, this skill is especially powerful. For instance, when an insecurely attached (preoccupied) facilitator interacts with dismissing-avoidant group members s/he could disclose and address his/her own sensitivity to the push-back/withdraw and enquire what group members noticed, what has shifted or what's needed to restore a sense of security?

As previously stated throughout this paper, it is important to build interpersonal capacity and coping skills which regulate emotions. The more open individuals are to relational intimacy and emotional experiences, the more integral an understanding of attachment styles is to effective group experience, inside and outside of group. To integrate and engage group members Marmarosh et al. (2013) suggest that group facilitators should emphasize *here-and-now*. To avoid flooding and reenactments in group process, keep preoccupied members in the *here-and-now*, and encourage identification of internal experiences for dismissing-avoidant members to minimize dissociation. Ask clients, "What's

coming up for you right now?" Reflect on feelings. Insecure members may be quick to shut down mentally and emotionally. Help people to explore and identify sensations and feelings to better understand their emotions that trigger reactions. Ask, "How is it for you to share that with us?" Structure and integrate group format to teach skills that encourage emotion regulation and improve attachment through *mindfulness*. For example, in group you may want to check-in with the clients to have them notice how they are breathing (or sitting, sensing body temperature, tension, etc.), or to notice and respond to the tension in their body, "How about we pause and address that tension in our bodies right now?"

The Brain: Bottom-Up or Top-down

The brain develops from the bottom up, see Figure 2 for illustration. The reptilian brain or the brain stem develops earliest in the womb and organizes automatic, basic life sustaining activities of heart rate, blood pressure, body temperature, arousal, sleep, hunger and chemical balance. The brain stem is highly responsive to threat throughout our entire lifetime (Van der Kolk, 2014).

The old mammalian brain or the limbic system develops over the first six years of life and continues to evolve in a use-dependent manner (use-it or lose-it). It stores memory of emotional relevance, attachment, responsiveness, categorization, perception and affiliation. The limbic system decides what is safe or dangerous. The prefrontal cortex develops last and can go offline in response to a threat. It is used for executive planning, anticipation, holding a sense of time and context, empathic understanding, concrete thinking and abstract or reflective thought (Ogden et al., 2013; Ogden & Fisher, 2015; Perry, 2013).

Figure 2. Bottom Up: Development of Brain States.

Executive State
Prefrontal Lobes
What can I learn from this?

Emotional State
Limbic System
Am I loved?

Survival State
Brain Stem
Am I safe?

www.childtrauma.org
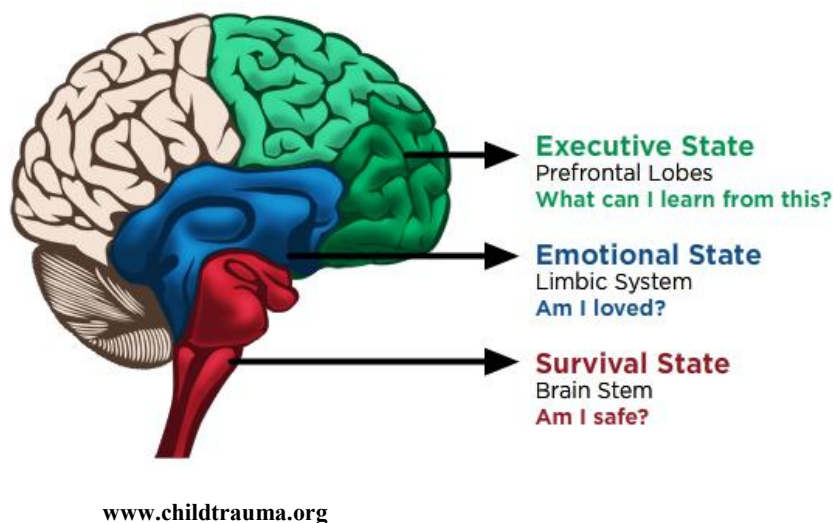
Mindfulness or being present is motivated by curiosity and we can use our "top-down" capacities to observe ourselves and surroundings, make conscious choices to inhibit, organize or modulate automatic responses or to monitor sensations through activities such as meditation and yoga. We can also use "bottom-up" approaches to recalibrate our autonomic nervous system (ANS) through breath, movement or touch (Odgen & Fisher, 2015; Perry, 2013; Van der Kolk, 2014).

Figure 3. Brain Developmental Stages and Corresponding Capabilities

Cortical
Limbic
Midbrain
Brainstem

Abstract Thought
Concrete Thought
Affiliation
"Attachment"
Sexual Behaviour
Emotional Reactivity
Motor Regulation
"Arousal"
Appetite/Satiety
Sleep
Blood Pressure
Heart Rate
Body Temperature
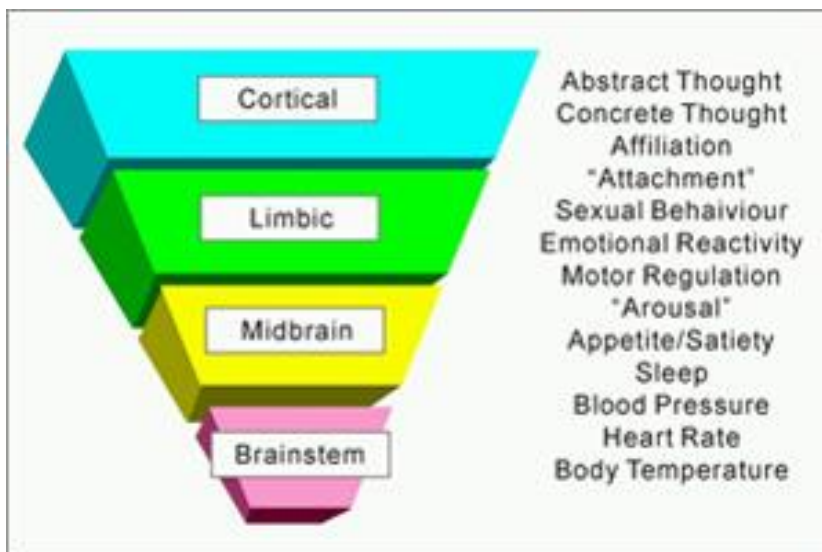
The Occupational Therapy Group's 2017 website *Inside Out* recommends that when planning therapeutic group activities, one must consider normal brain development and what stage an individual (or group) is capable of operating from because if a patient can not regulate their physical, sensory and emotional states (bottom-up) then conventional cognitive therapies (top-down) will be much less effective. As shown in Figure 3 above, group therapy and activities need to be tailored to the patient/group's developmental stage in order for them to access their resources.

Autonomic nervous system and polyvagal hierarchy. Stephen Porge's polyvagal theory of neurobiology provides a framework for understanding the interactions between the autonomic nervous system (ANS), parasympathetic and sympathetic nervous system. Refer to Figure 4 for diagram. His theory describes a hierarchical response and describes how our ANS is governed by neurobiological responses to environmental stimuli.

Figure 4. Stephen Porges' View of the Autonomic Nervous System
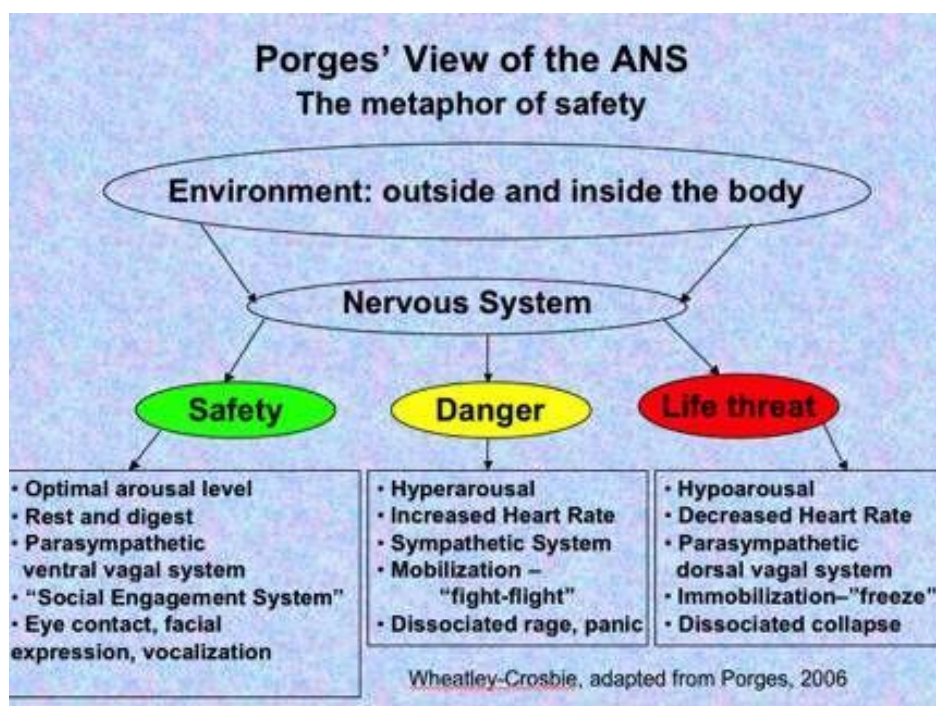
The parasympathetic branch of our vagus nerve responds to social engagement by rapidly engaging or disengaging (optimal engagement when we feel safe). This system can be overridden under stress. The sympathetic branch mobilizes us when we need to adapt to danger (fight or flight) and is evolutionarily more primitive and less flexible that our social engagement system. If the parasympathetic and sympathetic systems are unsuccessful at guaranteeing safety, the most primitive and instinctive system of the dorsal parasympathetic branch immobilizes us (freeze). Immobilization can assure survival or it can be lethal if maintained over long periods of time (Ogden et al., 2006; Rothschild, 2000; Van der Kolk, 2014).

As we subconsciously and consciously absorb information, our bodies react in a split second according to information stored, making the most adaptive (involuntary) survival response for each circumstance. In light of this information, the clinician's role is to help group members *self-regulate*, attune to healthy relationships, and tolerate and continue to integrate bodily sensations, feelings, and thoughts into current situations.

Window of tolerance. To keep group members safe and maintain optimal affect, facilitators need to be watch closely and be aware of somatic signs of arousal when clients receive information from their internal and external environment and integrate that sensory information (micro-expressions may include change in skin color, rate of breathing, posture). If someone is hyper-aroused they will likely look defensive (body tension, shortness of breath, rapid heart rate) or correspondingly if a person is hypo-aroused or dissociative they disengage with group (posture may shift, pale skin tone, fixed stare or glazed eyes). See Figure 5 below. As individuals begin to recognize and take note of their sensory experiences they are able to make necessary adjustments to their level of arousal, maintain dual

awareness (simultaneous attention to perception and sensation states) and utilize somatic

interventions to challenge and repair attachment disturbances. Calm breathing is foundational

for clients and facilitators alike, to mindfully notice the breathe (hands on chest and abdomen

to feel the inhale and exhale), or explore different ways of breathing and how it affects their

experience. For example, an individual can up-regulate by increasing oxygen intake which

brings about alertness, or down-regulate through nasal inhale, pause, and long slow exhale

which optimizes oxygen and carbon dioxide balance to bring a sense of calm and control

(Ogden & Fisher, 2015).

Figure 5. Three Zones of Arousal: A Simple Model for Understanding the Regulation of Autonomic Arousal.

Window of Tolerance

Hyperarousal Zone

2. Sympathetic "Fight or Flight" Response
Increased sensations, flooded
Emotional reactivity, hypervigilant
Intrusive imagery, Flashbacks
Disorganised cognitive processing

Window of Tolerance Optimal Arousal Zone

1. Ventral Vagal "Social Engagement" Response

State where emotions can be
tolerated and information
integrated

Hypoarousal Zone

3. Dorsal Vagal "Immobilisation" Response
Relative absence of sensation
Numbing of emotions
Disabled cognitive processing
Reduced physical movement

Adapted from Ogden, Minton, & Pain, 2006, p. 27, 32; Corrigan, Fisher, & Nutt, 2010, p. 2

Psychoeducational groups offer clients experiential learning opportunities to explore

the interaction between their body and brain, develop coping skills to shift their internal

physiological and emotional states through *grounding* exercises, while building *interpersonal*

skills through the group *process*. If group members are outside of their optimal window of

tolerance they will be unable to contain or tolerate their affect, which in turns effects their ability to participate, process or protect themselves. Group leaders need to be able to teach, equip and empower patients to *self-regulate* their autonomic nervous system for management of symptoms and benefit from group interventions.

      Corrective experiences. Recurrent depression may be found in clients with a history of feeling isolated and disconnected creating downward cycles of mood and increasing anxiety (Beihl, 2012). Researchers Gene-Cois, Fisher, Ogden and Cantrel (2016) recently reported that *sensorimotor* group psychotherapy has shown statistically significant positive results in chronic and severely ill populations. Clinicians demonstrate in the group how to become aware of body sensations by asking questions about what they are sensing (hot, cold, tight, soft, tingly, sharp, pounding, dizzy, tight, butterflies), where are they sensing (head, hands, back, stomach, feet, etc.), regulation of emotions, or identify cognitive processes that maintain symptoms and relationship difficulties (Ogden et al., 2006). Co-regulating emotions in group can be a very fruitful way to enhance trust, foster a sense of self control and build resources.

      With the help of strong a therapeutic alliance, facilitators can prudently challenge behaviors and process outcomes with patients to gain insight into motivations or interpersonal conflicts affecting their mental health. Camu (2013) describes mirroring as a corrective process in which the attuned facilitator, through verbal communication and purposeful inclusion of nonverbal gestures (animation/expression), repeats, reflects, and represents a members remembered experience with great accuracy and correct reflection of the real (subjective), remembered experience. Providing corrective *secure* attachment both

psychologically and physically seems to be the best defense against trauma-induced

psychopathology (Gene-Cois et. el., 2016; Van der Kolk, 2014).

Trauma Informed Practice (TIP)

BC Mental Health and Substance Use Planning Council (2013) defines trauma as any

"experience that overwhelms an individual's capacity to cope" (p.5). A single incident or

Type I acute trauma is an unexpected and overwhelming event that is time limited (sudden

loss of loved one, natural disaster, car accident). Complex trauma or Type II may occur when

physical, sexual or emotional abuse, violence, neglect or betrayal is ongoing occurring at

important developmental times or when a person is emotionally or physically trapped.

Trauma survivors commonly report feeling unsafe, have a pervasive mistrust of

others and/or a sense of hypervigilance. Some individuals develop symptoms of post-

traumatic stress disorder (PTSD) which involves repeated involuntary, triggered, re-

experiencing of helplessness (i.e. flashbacks), avoidance of cues, reminders of trauma,

hyperarousal and hypervigilance, problems with concentration, strong emotions and

exaggerated startle response. Bessel van der Kolk (2014) explains the development of

complex trauma as, "the experience of multiple, chronic and prolonged, developmentally

adverse traumatic events, most often of an interpersonal nature…and early life onset" (p.

402).

Historic trauma includes emotional/psychological wounding over a lifespan for

generations following a massive group traumatic experience (i.e. wars, slavery, residential

schools). Intergenerational trauma may be the after effect for people living with trauma

survivors and is an aspect of historic trauma (TIP Guide, May 2013).

Trauma-informed *group therapy* is an opportunity for clients to learn, develop, express and manage emotions, but it must emerge out of a structured environment where clients can safely connect with others, especially within the context of a strong therapeutic alliance with staff. Effective programming requires experiential learning of basic *interpersonal* skills such as active listening, self-reflection, problem-spotting, labelling, processing impulses and feelings that equip clients to *self-regulate* (Bath, 2008).

Trauma and psychiatric patients. Statistics reveal 76% of adult Canadians experience at least one trauma exposure in their lifetime and 9.2% meet the criteria for PTSD (TIP Guide, May 2013). *Trauma-informed practice* (TIP) recognizes the patient's (or group member's) need for physical and emotional safety, as well as choice and control in decision-making regarding their treatment. Judith Herman in her now classic book *Trauma and Recovery* encourages TIP care providers to ere on the side of providing a sense of safety, empowerment and client collaboration with *all* clients, regardless of whether or not a clinician is aware of a trauma history. Harm reduction, choice and working at the client's pace so to mitigate further trauma or re-traumatizing patients in the process of treatment is essential (1997).

Three pillars of trauma-informed care. Trauma can cause physical stress symptoms which effect developmental attachment, biology, affect regulation, dissociation, behavioral control, cognition, and self-concept (Herman, 1997; Ogden et al., 2006; Rothschild, 2000; Van der Kolk, 2014). Howard Bath (2008) suggests that three critical factors are necessary to create a trauma-informed space where one can begin to experience healing: 1) development of safety, 2) promotion of healing relationships through connection, and 3) teaching self-management of emotions and coping skills. Thus, these are essential

foundations to be developed, taught, supported and experienced in *group therapy* while

treated on an *acute care* psychiatric ward. See Figure 6 below.

Figure 6. Three Pillars of Trauma-informed Care.
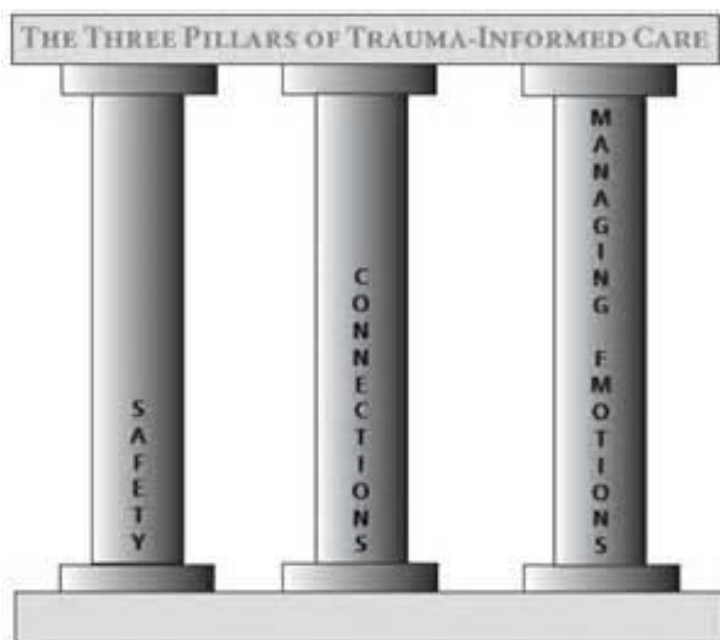
Herman (1997) states that 50-60% of all psychiatric *inpatients* have experienced

childhood physical or sexual abuse, with 70% of emergency room patients reporting abuse

histories. Muskett (2014) has more recently confirmed that a trauma lens is essential to

inpatient group therapy as we may now assume that:

> Up to 90% of people seeking treatment for serious and enduring
>
> personality disorders, substance abuse, and mental illnesses, such
>
> as eating disorders, anxiety, and depressive disorders, and those in
>
> contact with the criminal justice systems, were exposed to significant
>
> emotional, physical and or sexual abuse in childhood. (p. 51)

Childhood trauma is well documented and is linked to long term adverse mental

health issues, therefore *group therapy* practices must take into account the probability of

numerous *acute care* patients possibly lacking in the ability to have effective interpersonal relationships, regulate emotions and learn from their own and others experiences (Chandler, 2008; McDuff, Cohen, Blais, Stevenson & McWilliams, 2008; Muskett, 2014; Ogden et al., 2006). A welcoming and comfortable physical environment is vital, as are quiet rooms to de-stress or take a time-out. Ongoing orientation to the unit, regular review of expectations and boundaries and significant patience and compassion by staff, is essential to inpatients' perception of effectiveness and quality of care. Any expressions of anger within a group should be reframed by the facilitator so as not to scapegoat members and let the group know early on that the leader will deal with and defuse any emotional intensity, providing a safe environment and modeling healthy ways to address emotional content (AGPA, 2004).

Problem of cohesion and single sessions. According to Bessel van der Kolk (1987) it is the group's cohesion that is most therapeutic for trauma survivors, not insights from the facilitators. Cohesion is the essence of meaningful relationship, it's intrapersonal when members have a sense of belonging, acceptance and commitment to the group and interpersonal as members listen, learn from one another and offer feedback (Burlingam et al., 2006; Corey & Corey, 1999). Achieving cohesion is challenging in *acute care* therapy. Patients participate for relatively short stays, clients might only attend a single session and new patients may join therapy groups on a daily basis. Therefore, facilitators have to be active, personal, supportive, directive, and work quickly to create a cohesive environment for patients in each session (Yalom, 1983; Yalom et al., 2006).

Theoretical Approaches and Interventions

Yalom (1983) and others write about the vast array of *inpatient* psychotherapy groups that traditionally meet from 1-3 times per week. Due to variability in staffing, some groups

are led by psychiatrists, occupational therapists, nurses, mental health clinicians, or part-time

health care professionals brought in from outside the hospital. Examples of evidence-based

inpatient groups that I reviewed for this paper include: interactional, analytic, goals,

acceptance and commitment (ACT), mindfulness, time-limited dynamic, movement therapy,

art, transition, relaxation, interpersonal, music, singing, pet, human sexuality, life skills,

crafts, discharge planning, dialectical behavioral (DBT), problem-solving, psychodrama,

self-awareness training, body awareness, psychodynamic, compassionate-focused therapy

(CFT), men's and women's, exercise, activity/recreational, spirituality, horticulture,

medication education, process, cognitive behavioral (CBT), coping skills, assertiveness,

social skills, future planning, decision making, Gestalt, symptom management, solution-

focused, guided fantasy, stress management, and process-oriented psychoeducational (Barker

& Dawson, 1998; Charters, 2013; DiGiacomo, Moll, MacDermid & Law, 2016; Emond &

Ragmussen, 2013; Farley, 1997; Gudiano & Herbert, 2004; Hajek, 2007; Heriot-Maitland,

Vidal, Ball & Irons, 2014; Khorasani & Campbell, 2013; Pollack, Harvin & Roxy, 2001;

Raune & Daddi, 2001: Sullivan, 2003; Veltro, Vendittelli, Oricchio, Addona, Avino,

Figliolia & Morosini, 2008; Weiss, 2010; White, Gumley, McTaggart, Rattrie, McConville,

Cleare & Mitchell, 2011; Wyatt & Yalom, 2006; Yalom, 1983). There is significant overlap

in form and content with the above group approaches and distinctions are dependent on who

is designing, planning or implementing interventions in each particular hospital.

Here-and-now. Patients tend to think they need to review/retell their past repeatedly,

the details of who, what, when, where and how; however, this can be re-traumatizing.

The beauty of the *here-and-now* conversation is that group members are directed to focus on what's happening in the room, within themselves, how they are feeling about others, what they are hearing from others, primarily being aware of the present moment.

> It is new and frightening, especially for the many patients who have not previously had close and honest relationships, or who have spent their lives keeping certain thoughts and feelings – anger, pain and intimacy – covert. The therapist must offer much support, reinforcement, and explicit training. A first step is to help patients understand that the *here-and-now* focus is not synonymous with confrontation and conflict. In fact, many patients have problems not with anger or rage, but with closeness and the honest and non-demanding or non-manipulative expression of positive sentiments. (Vinogradov & Yalom, 1989, p.89)

If group members get stuck problem solving, trying to help each other solve past issues, they are destined to not only disappoint, but get increasingly frustrated and discouraged by overwhelming circumstances (which is likely why they came into hospital in the first place). Effective and beneficial dynamics occur when group members can explore their immediate feelings, address personal boundaries, or offer feedback on the interactions happening in the *here-and-now*. Facilitators listen, observe and attend to the relational exchange of information occurring between clients while paying attention to horizontal disclosure (disclosure about disclosure). Facilitators must be active, diligent "shepherds" who keep the group work "grazing on current interactions. All strays into the past, into outside life, or into intellectualization, must be gently herded back into the present." (Vinogradov & Yalom, 1989, p. 86)

Leaders carefully enquire about feelings and encourage expression while being attentive to and registering incoming data from group members as well as their own reactions, thoughtfully using it all as material for further process. Redirecting the group back to the *here-and-now* provides patients with the opportunity to access and express feelings that might not otherwise be safely explored or validated (Corey & Corey, 1997; Yalom, 1983). Ask, "I noticed you seemed far away just now, what's coming up for you as when X talks about her frustration?"

Sensorimotor psychotherapy. The experience of safety is the core developmental need for *secure* attachment and is paramount in developing and maintaining healthy therapeutic alliance (Herman, 1997; Rothschild, 2000). The integration of *sensorimotor psychotherapy* in the form of *somatic resourcing* brings the whole person into group therapy by building awareness of body sensations and controlled movement, increasing observation skills and a sense of safety while experimenting with somatic interventions (refer to Appendices D – G). Somatic sensations may include: sound, touch, smell, sight, taste, movement, posture and instinctual reactions. If clients can initially become familiar with feeling and identifying sensations on a body level while safely contained (careful pacing, titration and/or use of container imagery), they are better able to name, describe and give meaning to what they are sensing (see Appendix H).

Resource development is foundational to increasing safety and security for clients. This project will include instructions on building resources such as body awareness, containment imagery, calm/safe place, muscle toning, and healthy boundaries (Rothschild, 2000). Bessel Van der Kolk affirms body-oriented approaches, "Sensorimotor psychotherapy is sensitive to the fact that most trauma occurs in the context of interpersonal relationships"

(as cited in Ogden et al., 2006, p. 23). Facilitators teach patients simple ways to observe the present moment, notice what they feel, where they feel it, create a vocabulary that helps them explain sensations, build confidence in their ability to self-regulate internal and external stimulation, and increase or decrease arousal as needed to manage symptoms (Ogden et al., 2006; Rothschild, 2000; Van der Kolk, 2014).

A trauma-informed approach in psychiatric settings ensures a culture of safety, sensitivity and collaboration to reduce patient symptoms, increase acceptance, expression of emotions, and foster *interpersonal* connections with others. Best practices for continual staff development in education, training, role modelling and self-awareness must be continually encouraged and cultivated (Chandler, 2008; McDuff et al., 2008). Van der Kolk and Courtois (2005) noted how a trauma-informed approach is changing current practice, "clinicians have learned to focus on issues of safety, affect regulation, coping and self-management skills as well as on the therapeutic relationship itself" (as cited in Bath, 2008 p. 387).

Psychoeducational groups. For years *cognitive behavior therapy* (CBT) was recommended for *inpatients* with anxiety and depression. Page and Hooke (2003) verified measured improvements in self-esteem, locus of control, depression, anxiety and stress. Another group of researchers completed a four year follow-up study that looked into the effectiveness and efficacy of CBT for *inpatient* groups and compared the impact on patients diagnosed with schizophrenia, major depression, bipolar disorder and personality disorders. Patients with co-morbid substance abuse were not included in the study. They found that readmission rates were reduced, patient satisfaction and ward atmosphere improved. However, CBT was found to be *not* very affective during the first week to 10 days of admission, particularly with depressed patients who are characteristically cognitively passive

and uninvolved emotionally. As could be anticipated, when medications became effective these patients wanted to be discharged and underestimated the importance of issues discussed in group sessions (Veltro et al., 2008).

Psychoeducational groups are opportunities for interpersonal learning, ego support and skill building. Along with CBT, are other interventions that work well for patients with depression, personality disorders and anxiety (Cowls, & Hale, 2005; Montgomery, 2002; Page, & Hooke, 2003; Veltro et al, 2008). Emond and Rasmussen (2012) list dialectical behavioral therapy (DBT) as effective for persons with emotional dysregulation and biological emotional vulnerability. While modules are modified for *inpatient* units, more research is needed to establish efficacy on psychiatric wards. Like medications, not all approaches will benefit every patient.

Cowls and Hale's (2005) qualitative research study found that patients value activities that put them at ease and facilitate connecting with other group members, but they also readily rely on group leaders to limit the intensity and emotional disclosure during psychoeducational groups. Clients appreciate when difficult experiences are safely shared and discussion follows to debrief and develop coping strategies for their feelings.

Interpersonal approach. Hajek (2007) describes Yalom's interpersonal model of *inpatient group therapy* and suggests that a "good group engages patients, reduces their sense of isolation, helps deal with anxiety caused by hospitalization and provides the experience of universality and being helpful to others" (p. 7). By primarily addressing *interpersonal* skills and developing structure for patients to engage with one another, clients are able to give and receive feedback, modify or change maladaptive patterns that affect their ability to manage mental health issues and connect with others in real time. Well-managed interactions within

interpersonal group therapy can alleviate anxiety, shame, stigmatization, staff tensions, expectations, instability, unsettling events, and help with transition to discharge (Khorasani & Campbell, 2015; Lloyd & Maas, 1997; Yalom, 1983). Personal change happens in group therapy by processing the common human experience, intrapsychically (within oneself), interpersonally (between persons) or group-as-a-whole process. The group leader listens for shared experiences and themes and then structures the group to tailor discussions (treatment) to a variety of pertinent needs. Because *inpatient* treatment needs to be brief and efficient, *psychoeducational* models which teach and inform clients about symptom management frame the group structure. The facilitator then integrates ways to *process* the current intellectual and emotional needs of clients to further develop a personal, meaningful and transforming experience for group participants (Cook et al., 2014).

Gonsalez de Chaves et al. (2000) compare Yalom's therapeutic factors in schizophrenic *inpatients* and *outpatients*, concluding that interpersonal learning produced less anguish in patients when they are able to identify as part of the group, experience acceptance, togetherness, less isolation, support and reassurance. Cohesion is difficult to establish in short term heterogeneous groups with rapid turnover, but it is a very powerful condition for change and group effectiveness. For schizophrenic patients, the feeling of social acceptance is a critical factor to fight against demoralization and low self-esteem (Cook et al., 2014). Therefore, facilitators need to take advantage of teachable moments to address disruptions, confusion or distress in a compassionate, respectful and inclusive discussion.

Process-oriented psychoeducational model (POP). Vannicelli (2014) suggests that group leaders encourage free flow discussion by being invitational, avoiding circular go-arounds if possible, and help create space where members speak to one another and not

solely to the facilitator. Rutan et al. (2014) explain the interplay between content and process, "The content (overt meaning) of any association cannot be divorced from the process (the covert meaning) because the two are connected. The content might be a symbolic representation of a group wide issue or an interpersonal transaction, or it might be a direct commentary on the process of the group" (p. 191). Teaching coping skills, relaxation techniques or body awareness in a psychoeducational setting opens up space for developing deeper process interactions that are simple and relatively content free. By tracking the emotional climate of the group, the leader addresses a shift in topic or emotional tone with questions like, "How are things going right now? or "What makes it hard to continue?", or "What's happening in the room right now?" The group facilitator makes every effort to foster reflective observation of how members are caring for themselves without criticizing or requiring change, while encouraging interpersonal engagement and containment for safe exploration during the process (Vannicelli, 2014).

Communication is vital for any group interaction. Bringing up unconscious or internal sensations and addressing them together in the *here-and-now* is the privilege of *group therapy*. Yalom refers to this as "grist for the mill" (2002, p. 70). Gray-Deering (2014) noted that over the past 30 years there has been a trend away from *process-oriented* groups on *inpatient* units due to shorter admissions and increasing acuity levels of patients. Crisis stabilization and brief evidence-based *psychoeducational* and CBT approaches ensued. She currently co-leads groups in a 32 bed locked *inpatient* ward and makes a strong case for *process* groups for any patient who wishes to sit in a circle and participate. Her approach integrates Yalom's single-session framework along with a focused approach to validate and respect where patients are at when approaching discharge. She emphasizes the need for a

group where patients can engage and identify (not resolve) conflicts that brought them into hospital and have a positive experience of *group therapy* that will motivate them to continue with therapy after discharge. She listens for themes, helps the group grapple with stressors of chronic mental illness, relapse, loss of control, faith, hope and difficult decisions. Gray-Deering also emphasizes an existential approach, acknowledging patient's immense strengths in enduring chronic illness and finds that they are motivated to continue with treatment because of "inspiration, hope and greater appreciation of the human race" (p. 170).

Integration of *psychoeducation* with *process* and *somatic resourcing* on various topics provides informative content, member-to-member feedback, and experiential learning in a safe place to try out something new. To be able to witness the *process*, creating time to slow things down, investigate, elaborate and integrate a meaningful experience in real time – is a profound gift. POP requires a flexible, self-assured, self-regulating, trained group facilitator who understands how to tailor treatment needs while allowing for individual capacity within the group milieu (Bernstein & Schultz Duquette, 1995; Cohen, 2004; Cook et al., 2014; Khorasani, 2013; Rutan et al., 2014).

Training, Support, Personal Reflection and Awareness

For years researchers have questioned the credentialing guidelines (or lack there-of) for *inpatient* group facilitation (Cook et al., 2014). Differentiating between *group therapy* and group programming is muddled in the literature and there is no consensus as to who should or should not lead groups. Researchers do agree on the fact that formal training is often limited to *outpatient* group work. The theoretical rationale of what is taught, why and by whom, is not standardized and ongoing education and/or supervision is required to address issues that are commonplace to psychiatric inpatient group work, be it technique,

culture or self-awareness (Hoge et al., 2014; Khorasani & Campbell, 2013; Lothstein, 2014; Vannicelli, 2014). Others have noted how important facilitator self-care and awareness is to quality group experience. A leader's own understanding of attachment styles, comfort with disclosure, conflict, control and ambiguity will have an effect on how they contribute or take away from the competency and safety of the group (Chan & Noone, 2000; Cohen, 2004; Marmarosh et al., 2013; Shapiro et al., 2007).

Co-facilitation. The concept of co-facilitation is debated in the literature. The American Group Psychotherapy Association (AGPA, 2004) suggests that when treating individuals with trauma history, groups require co-leadership. This necessitates one person to work with the group on task, the other to observe and monitor group members for any increase in symptoms or dissociation, and then support or accompany those that may need to leave the session. Some people prefer leading groups on their own, with a myriad of reasons behind this (primary factors being staff allocation, training, or uncomfortable with co-leaders). It remains best practice to have two clinicians for safety and support, not only for the client's sake but also for facilitators. As group facilitators become more familiar and aware of their own *countertransference* and dysregulation due to difficult group scenarios (being triggered themselves by content, aggressive or disorganized clients, etc.), a partner in leadership is essential to share challenging responsibilities and support one another during preplanning, in-session, or debriefs. Debriefs can be a particular gold mine of gathered insights, micro-expressions, mannerisms and shared information that can aide the staff team in care planning and patient consults (Cohen, 2004; Stone et al., 2012).

Peer supervision or learning communities for colleagues that meet periodically to discuss clinical practice, implementation of skills and sharing of best practices, provides

guidance, constructive feedback and meaningful support where *inpatient* group facilitators can learn from one another and reduce feelings of isolation (Foy, Unger & Wattenberg, 2004; Hoge et al, 2014; Marmarosh et al., 2013). Hogge et al. offers substantial evidence that supervision impacts staff retention, skill levels, adherence to evidence-based practices, and improved quality of care. Qualitative studies indicate a positive effect of clinical supervision on staff, citing decreases in stress, burnout and professional isolation, and feelings of competency, efficacy and well-being are increased, as are attainment, retention and application of new learning.

Self-care. Health care providers are notoriously poor with their own self-care and are at risk for occupationally related psychological problems. The helping profession attracts many people who put others first and enjoy being fixers. Yet working with highly distressed clients is often itself stressful, and the negative consequences to caregivers can include increased depression, emotional exhaustion and anxiety (Shapiro et al., 2007). Therefore, self-awareness of why and what is defined as a healthy, sustainable lifestyle will benefit not only clinicians and clients, but also the health and sustainability of staff teams. Empirically supported treatment (EST) and research of exemplary practices of staff supervision encourages explicit attention to self-care. Ensuring there is scheduled work time for staff teams to relax together, with a focus on strengths, provision of practical suggestions for time management and access to supports has been shown to reduce feelings of isolation and minimize burnout (Hog et al., 2014).

Shapiro et al. (2007) researched the contemplative approach of cultivating *mindfulness* as a stress management intervention for therapists in training. Their findings suggest that mindfulness-based stress reduction (MBSR) lowered levels of perceived stress and distress,

enhanced participant's ability to regulate emotional states and increased positive affect and self-compassion. The increase in self-compassion is particularly noteworthy as research has shown that clinicians who lack self-compassion and are critical and controlling towards themselves tend to be more critical and controlling of their patients as well (Henry, Schacht & Strupp, 1990 as cited in Shapiro et al., 2007).

Discovering attachment styles, blind spots, personal complications and triggers is also necessary self-work for practitioners. This helps to understand that health care professionals do not operate in a vacuum and mental, physical and emotional health impacts the effectiveness and outcomes of groups. When group leaders become aware of their own needs, have staff support and appropriate supervision, they are better equipped to interact, nurture, handle conflict, or offer corrective emotion experiences to vulnerable group members (Cabecinha, 2017).

Reflection and action planning for life/work balance, self-regulation and *grounding* skills, therapy for vicarious trauma or stressors, being mindful of ways to reduce stress, engaging with community, healthy eating, exercise and sleep all have a strong effect on work satisfaction and sustainability of overall health (Cohen, 2004; CTRI, 2014, Shapiro et al., 2007). Marmarosh et al. also propose that facilitators' attachment styles can significantly influence the process climate of a group. The authors caution that when group leaders are highly activated in stressful settings, even if they have done the work to become more *securely* attached, most will revert to earlier attachment models. Therefore, reflecting on where you have been and where you would like to be or how you currently function is subject to change due to demanding environments, even for highly trained professionals (2014).

Summary of Chapter 2

The literature review was intended to be an overview of numerous variables tied into inpatient group therapy. The emphasis was on how inpatient group therapy differs from traditional outpatient models and what is needed for facilitators to offer best practices, including being trauma-informed practitioners with appropriate leadership skills, resources and self-awareness.

Implications for groups. All group therapy should be trauma-informed, building capacity for clients to be present with their bodies, acquire the ability to self-regulate, and form personal goals. This can be attained in typical large group check-in sessions that ground clients, giving them a present awareness of where they are, how they currently feel and what they would like to accomplish throughout the day while listening, respecting and responding to others in the group. Research has suggested that as long as group members aren't too disorganized or disruptive, are nonviolent, attentive to instructions and are able to perform the task at hand, most psychiatric *inpatients* will benefit from group participation (Adler, 1995; DiGiacomo et al., 2016; Yalom, 1983). Those who aren't able to benefit from a particular group will receive periodic one to one attention from their nurse and psychiatrist.

As patients become more settled and cognitively aware, daily *process-oriented psychoeducational* groups are great opportunities to increase *interpersonal* connectedness while working on managing symptoms. Topics to consider may include: coping skills, self-esteem, assertiveness (passive, assertive, aggressive differences), relaxation techniques and health and wellness. As patients prepare to be discharged, a more traditional, higher level *process* group may be appropriate for members to meet 1-2 times during the week. Patients that are feeling less vulnerable and more attuned to others, able to give and receive feedback

about their current affect and/or behavior, can benefit from having an opportunity to discuss transitioning to home life, *outpatient* resources and follow-up.

      Implications for facilitators. Those that lead groups want not only to be prepared with programming of group therapy and activities, they need to be grounded, personally aware of their own limitations, yet confident in their abilities. Facilitators should be able to emotionally regulate themselves in stressful situations, be flexible with agendas and content, manifest excellent observation skills, understand, integrate and implement various evidence-based theoretical models as needs arise. In order to manifest all the above skills, one must take the time necessary to internally process through intentional self-reflection, awareness of strengths and weaknesses, blind spots, and identify areas to nurture. The following chapter will outline ways in which facilitators can enrich their leadership experience and provide quality group facilitation for psychiatric inpatients.

      Finally, let's re-examine Yalom's quote, "…*the contemporary acute psychiatric ward is a radically different clinical setting and demands a radical modification of group therapy technique*" (1983, p. 50). Technique is only part of this story. There has been limited examination and exploration into specialized training for facilitation; this too requires radical modification. Inpatient facilitators work in an often demanding, unpredictable atmosphere. They need to be resourced on how to mitigate stressors and stabilize themselves first, in order to mediate multileveled group work. Hence, facilitation is part science, part creative art.

Chapter 3: Project Description

This chapter will be divided into the following three parts:

Part A: Twelve 30 minute sessions for developing self-awareness among staff. Attachment styles, level of comfort with disclosure and ambiguity, countertransference, self-care and safety will be addressed.

Part B: Safety and stabilization techniques for facilitators to use in inpatient groups. This will include somatic resources to ground clients (and facilitators), process-oriented psychoeducational topic ideas, outlines for groups including a higher level transition/discharge planning process group and relaxation suggestions.

Part C: Training and networking opportunities for inpatient group facilitators. Professional associations, websites, and online resources are included.

Target Audience

This resource guide is aimed at accredited professionals and/or master level clinicians and their co-facilitators working on inpatient psychiatric wards. Facilitators will likely include mental health and addictions clinicians, social workers, or occupational therapists. Co-facilitators may include registered nurses, registered psychiatric nurses, licensed professional nurses, mental health and addictions clinicians, occupational therapists, mental health workers, nursing students, or psychiatric residents.

Resource Guide Goals

The goal of this resource guide is two-fold. It is to provide simple, accessible, training sessions that promote self-reflection and self-awareness for staff and offers trauma-informed materials to use in acute care groups. Resources from Part A include twelve 30 minutes sessions designed to be implemented during monthly staff meetings (or modified for

½ day workshops or retreats for more in-depth staff team development). Resources in Part B consist of the trauma-informed "do's and don'ts" in acute care groups, guidelines for leading various groups on how to use simple, accessible, quick activities and handouts for clients during daily check-ins or higher level process-oriented psychoeducational groups or reintegration (discharge readiness) process groups. Because the majority of inpatients will have some trauma history, it is imperative that facilitators be cognizant of group members who may be triggered, dysregulated or dissociative before, during or after a group session. Attuned staff can help patients co-regulate and ground themselves to avoid re-traumatization.

Part C is intended as a referral list of outside training and networking opportunities for continuing education and professional development as well as online training resources.

Expectation of Facilitators

Professionals are expected to act ethically when engaging with clients as well as other staff members. Confidentiality is anticipated but can never be guaranteed, so utilization of this resource guide must be undertaken with informed consent. Participants (facilitator training or inpatient group members) are encouraged to respect one another, foster growth and provide space for themselves and others as they work towards enhancing their well-being in the company of others.

Part A: Twelve 30 minute single sessions for staff development

- The Power of Vulnerability

- Know your attachment style

- Balanced Life: POD

- Six core strengths for healthy development

- Listening to Shame

- Understanding self-disclosure, ambiguity and blind spots through the Johari Window

- Awareness, expression and location of feelings

- TIP Personal preparation plan for facilitators

- Hazards Self-assessment

- Addressing countertransference and other personal reactions

- Building and maintaining support for self-care

- Safety in Groups

Part B: Safety and stabilization techniques

- Do's and don'ts of trauma-informed inpatient group work

- How to facilitate a large group daily check-in

- How to facilitate a somatic and process-oriented psychoeducational group

- How to facilitate a re-integration (higher level) process group

- How to facilitate a relaxation group

- CBT manuals, worksheet and information for discharging clients

Part C: Training and networking opportunities

- Continuing Education and networking opportunities

- Online resources

Summary of Chapter 3

This chapter briefly outlines the manual to be presented in Chapter 4. Description of the professionals that might benefit from this resource guide, its goals, and the three separate parts for facilitators to access are also listed. The compilation of resources in the final chapter is designed to address facilitator preparation, staff development and techniques, strategies and tools for quick reference.

Chapter Four: Resource Guide

When you have means of reflecting on yourself,
then you do not lose sight of the conditions and feelings of others.
If you have no means of reflecting on yourself,
then confusion comes into play when you act.
~Lo-tzu, Chinese philosopher

This chapter provides twelve single-session resources for professional development as well as suggestions, directions and outlines for inpatient group therapy.

Part A: Twelve 30 Minute Sessions for Staff Development

The following section contains twelve 30 minute sessions for staff development which can be implemented during monthly staff meetings (with staff team leads, mental health clinicians, nurses, social workers, and occupational therapists) to engage clinicians and their co-facilitators in activities that promote self-awareness, reflection and self-care. These sessions are designed to be incorporated into an already functioning team meeting (no need for warm-up or ice breaker exercises) to inform, educate and offer an experiential learning experience to staff that will be co-leading inpatient groups. It may be helpful to get participants to identify a goal on an index card at the beginning of each exercise, what are they hoping to learn from the topic? Staff will then be better prepared to discuss their fears and concerns and how those link to leading inpatient groups. The exercises and activities can be experienced in pairs, small groups of 3-4, or easily modified for a larger group context.

The Power of Vulnerability

Materials needed: Computer/ipad and screen to play You Tube video. Index cards for each

participant.

Goal: Watch and then discuss together Brené Brown's TED Talk 2010

The Power of Vulnerability (20:19 minutes)

https://www.ted.com/talks/brene_brown_on_vulnerability

Purpose: To explore the "power of vulnerability" and to understand the strength of

connection. Brené Brown studies human connection — our ability to empathize, belong and

love. In a poignant, funny talk, she shares a deep insight from her research, one that sent her

on a personal quest to know herself better as well as to understand humanity.

Leader presents: Before you view the YouTube video, take a moment to write out on your

index card what you feel in your body when you think about topic of vulnerability. Also

write down the first words you think about when you hear "vulnerability".

Watch the video together and then share your thoughts with the group. Some topics for

discussion might include:

1) What makes it easy to be vulnerable, what makes it difficult?

2) What prevents you from being vulnerable in this group?

3) What would increase your sense of safety, connection or commitment to this group?

What's Your Attachment Style?

Materials needed: Copy handouts for each participant (see Appendix T) and index cards.

Goal: To identify and reflect on individuals early attachment style and if it has changed over the years.

Purpose: To explore attachment style and its effect on current interactions with staff team members and/or clients in group sessions.

Leader presents: Figuring out your attachment style may help, not only understand yourself better, but also to consider if there's a pattern of how you react or respond to group members or your staff team. According to Cabecinha (2017), to know one's original attachment style (impact of how they were parented and childhood experiences) and to understand if it has changed over time (with corrective experiences) is impactful. One can make better use of ways to self-regulate emotions, connect with others and comprehend why an individual may revert back to earlier *insecure* ways of being. Interestingly, when individuals are in highly stressful environments, most if not all of us, will react out of our earlier attachment style, even if we have had corrective experiences and are currently more *securely* attached as adults.

What questions or thoughts come up so far? Please take a moment to write out on an index card what you are looking for from this session.

Take a moment to listen to and review each of the four attachment style descriptions and see if you can figure out where you would place yourself on the graph below between 1-7. Consider the center to be 4, low anxiety is 1, high anxiety is 7, low avoidance is 1, high avoidance is 7.

Fearful-avoidant individuals: Those high on both dimensions of avoidance and anxiety, experience attachment-related anxiety yet avoid intimate contact with others. In essence, these people alternate between deactivation (because of fear of rejection) and hyper-activation (because of fear of abandonment). Some theorists have referred to this style as disorganized because persons with this style engage in both activating and deactivating strategies. Indeed, these individuals are uniquely conflicted because they may withdraw and avoid intimacy with others in relationships while simultaneously longing for closeness and connection. Their inconsistent behaviors make it particularly hard for them to maintain healthy relationships and regulate emotions under duress (Mikulincer & Shaver, 2007b as cited in Marmarosh et. al., 2013).

*Dismissing-avoidant individuals***:** Those high on avoidance but low on anxiety, they often keep to themselves and can appear self-reliant. They deny fear of being alone or abandoned and do not generally seek out emotional support from others. They tend to use deactivating strategies—that is, they push others away—to deflect intimate contact, such as making a joke or changing the subject after someone shares something vulnerable. These individuals withdraw and minimalize attachment-based needs, and they deny anxiety about rejection and abandonment (Mikulincer & Shaver, 2007b as cited in Marmarosh et. al., 2013).

Preoccupied individuals: Those low on avoidance but high on anxiety and are often described as clingy or needy. They report more anxiety about relationships and are hypersensitive to signs of rejection or abandonment. These individuals engage in hyper-activation strategies—that is, they exert intense efforts to achieve and maintain intimate contact—and they are preoccupied with fears of being alone. These individuals tend to seek

out others for comfort but are often dissatisfied with the support they receive (Mikulincer &

Shaver, 2007b, as cited in Marmarosh et. al., 2013).

     Secure individuals: Those low on both dimensions of avoidance and anxiety, neither

avoid intimacy with others nor fear rejection or abandonment. They feel capable of seeking

out support and trusting others, they tend to report caring connections with attachment

figures and compassion and empathy for romantic partners and family members. Even when

there are challenges within a relationship, these individuals tend to forgive others

(Mikulincer & Shaver, 2007b as cited in Marmarosh et. al., 2013).

LOW
AVOIDANCE

SECURE   PREOCCUPIED

LOW
ANXIETY   HIGH
ANXIETY

DISMISSING-
AVOIDANT   FEARFUL-
AVOIDANT

HIGH
AVOIDANCE
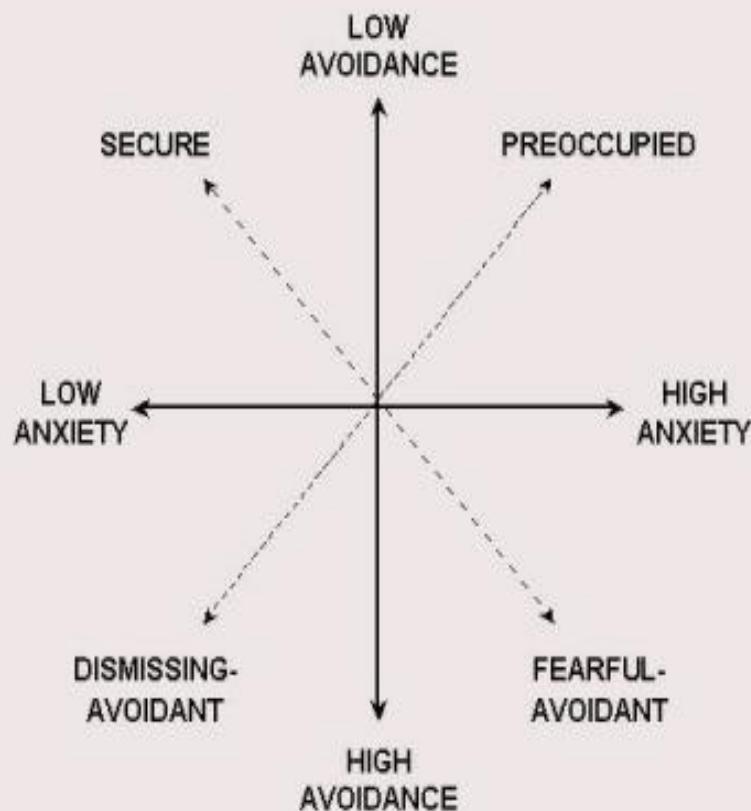
Questions to discuss in pairs and/or in a group:

(If you have the time, view a (4:39 minute) clip on You Tube explaining *Attachment Theory and its Effect on Adult Relationships* https://www.youtube.com/watch?v=uSAPfiSw_Ic)

1. What's your attachment style? Or, what would those that know you well or live with you say?

2. Has is changed over time, if it has, how so?

3. How is your attachment style affected when you are highly stressed? (What's your default style?)

4. How do you think your attachment style impacts the groups you facilitate?

   What attachment style do you have difficulty dealing with in other people?

   How do you usually react to those people?

   What would help you to respond differently?

Balanced Life: POD

Materials needed: Computer/ipad and screen to play You Tube video, index cards for each participant.

Goal: Watch: Dr Shimi Kang, TEDxKelowna. Discuss as group.

 What One Skill = An Awesome Life? https://www.youtube.com/watch?v=IEHZAQmw2JA

Purpose: To explore the idea of health and wellness, what are the basics?

Dr. Shimi Kang is an award-winning, Harvard-trained doctor, researcher, media expert, and lecturer on human motivation. She is the author of the #1 Bestseller, *The Dolphin Way: A Parent's Guide to Raising Healthy, Happy, and Motivated Kids Without Turning Into A Tiger* (Penguin Books 2014). Dr. Kang is the Medical Director for Child and Youth Mental Health for Vancouver community, a Clinical Associate Professor at the University of British Columbia, and the founder of the Provincial Youth Concurrent Mental Health and Addictions Program and BC Children's Hospital. She has helped thousands of children, adolescents, and adults move toward positive behaviors and better health.

Leader presents: Before we watch the video, write out on the index card what you are hoping to take away from this session. We will watch this TED Talk together and then discuss as a group.

1) What gets in the way of having a balanced life?

2) What change can you make this week to have more of what you need: PLAY, OTHERS, or DOWNTIME?

Understanding Self-disclosure, Ambiguity and Blind Spots Through the Johari Window

Materials needed: Copies of Johari Window handouts for participants to <u>complete before meeting.</u> Refer to Appendix V. Index cards for participants.

Goal: To develop self-awareness and understanding of participant's comfort level with ambiguity, disclosure and feedback.

Purpose: To have a group experience with colleagues. To discover where an individual's openness to others can grow and gain access to previously "unknown" potential through the giving and receiving of feedback.

Leader presents: Using the index cards presented, take a moment to write out a couple of things you are concerned about regarding self-disclosure, ambiguity or blind spots. How do you feel about self-disclosure, ambiguity and blind spots?

Yalom (2002) suggests that feedback can be a powerful gift of group experience. But how is one to lead others safely if one's own blind spots are unexplored? This is an opportunity to explore, understand and practice using *here-and-now* comments (talking about what we see and hear of one another in the present moment, not venturing into the past or future, but remaining here-and-now). By listening and sharing your feelings and observations within a small group you can bear witness to and appreciate the impact of your own behavior on others. This is an experiential learning opportunity for you as a leader <u>and</u> as group member. Please refer to your questionnaire (completed ahead of meeting time) and discuss together the ways in which the results may influence your working relationships.

1) You have completed the questionnaire (handed out and completed ahead of time).

2) You will share your insights from this exercise with at least one other staff member.

The Johari Window

It's all about me...	My view		
Your view	Open to both of us	I'm blind to this	**Known by you**
	Hidden from you	Unknown to both	**Not known by you**
	Known by me	**Not known by me**	

Johari window (Yalom, 2009) is a personality paradigm exercise. Individuals reflect on their relationship with them self and others, their comfort with self-disclosure, ambiguity and to take notice of blind spots. It was developed by psychologist Joseph Luft and Harrington Ingham in 1955 (Jo-Hari). There are 4 quadrants: public, blind, secret and unconscious which are either known or unknown to the individual and others and vary in size depending on person's level of awareness.

To develop healthy relationships with others Kottler (2010) encourages our secret self to shrink and public self to increase so we can see ourselves as others see us. Feedback is very important during this task, as people share, quadrants expand, what's hidden becomes less and personal understanding grows.

Johari Window

The Johari Window is a disclosure/feedback model of awareness, first used in an information session at the Western Training Laboratory in Group Development in 1955. The four panes of the "window" represent the following:

Open: The open area is that part of our conscious self - our attitudes, behavior, motivation, values, way of life - of which **we are aware** and which is **known to others**. We move within this area with freedom. We are "open books". It is through disclosure and feedback that our open pane is expanded and that we gain access to the potential within us represented by the unknown pane.	**_Blind_**: There are things about ourselves which **we do not know**, but that **others can see more clearly**; or things we imagine to be true of ourselves for a variety of reasons but that others do not see at all. When others say what they see (feedback), in a supportive, responsible way, and we are able to hear it; in that way we are able to test the reality of who we are and are able to grow.
Hidden: Our hidden area **cannot be known to others unless we disclose it**. There is that which we freely keep within ourselves, and that which we retain out of fear. The degree to which we share ourselves with others (disclosure) is the degree to which we can be known.	**_Unknown_**: We are more rich and complex than that which we and others know, but from time to time something happens – is felt, read, heard, dreamed - something from our unconscious is revealed. Then we "know" what we have never "known" before.

Take a few moments to review the 4 quadrants again.

Johari Window Questionnaire

Instructions:
• Carefully read each numbered item and its statements marked "A" and "B."
• Assign a point value to the A and B statements as follows:
    • The total point value for A and B added together is **five (5).**
    • If statement A is most similar to what you would do, mark **5** for A and **0** for B (**0**, very unlikely, **5** very likely).
    • If A is not wholly satisfactory, but in your judgment better than B, mark **4** or **3** for A and **1** or **2** for B.
    • The converse is true: if B is best, mark **5** for B and **0** for A and so on (choose best fit/true for you between 0-5).

Calculating Your Scores:
Copy your point values from the questionnaire to the appropriate spaces below. Add up the total points for each column.

Solicits Feedback:	**Willing to Give Feedback:**
2B_____	1A_____
3A_____	4B_____
5A ____	6B ____
7A ____	9B ____
8B ____	11B____
10B____	13A____
12B____	15A____
14B____	17B____
16A____	18B____
20A____	19B____
Total _____	Total _____

Charting Your Scores:

• On the top line of the graph below, mark your score for Solicits Feedback, then draw a vertical line downward.
• On the left line of the graph below, mark your score for Willingness to Self-Disclose/Gives Feedback, then draw a line across horizontally (left to right).

<u>In pairs or as a small group please discuss the following questions:</u>

1) What did you learn about yourself from this questionnaire/graph? Were you surprised

    by anything?

2) Describe a previous experience with disclosure or feedback.

3) Take turns give and receiving feedback from your partner or group members on what

    you experienced of them while you each answered questions 1 and 2.

4) How do you think others are affected by your blind spots?

5) How will you use what you learned today in your professional practice?

As people get more comfortable sharing information about them self their *public*

quadrant grows and the hidden secret quadrant shrinks when communication and trust is

built. Welcomed feedback grows one another's *blind* quadrants and helps to decrease what is

unknown to self and others.

Six Core Strengths for Healthy Development

The core of all violence is a lack of respect, for oneself and for others.
~ Dr. Bruce Perry

Materials needed: Computer/ipad and screen to view You Tube video with participants.

Index cards for each participant.

Goal: Watch the YouTube video by Dr. Bruce Perry who explains the six core strengths for

healthy child development. http://www.youtube.com/watch?v=skaYWKC6iD4

Purpose: To self-reflect on personal development and the effects on work relationships (with

clients and co-facilitators, team members).

Leader presents: Take a moment to write out what you think is needed for healthy

childhood development. Watch the You Tube video together. Take about 10 minutes each to

share a story or two with a coworker, describing an experience from one of the levels noted

below. Spend the final 10 minutes sharing insights with the larger group.

Dr. Bruce Perry (2013) suggests that as children grow there are six core strengths that

are required for healthy development, beginning with attachment:

Respect: Finding value in differences
Tolerance: Accepting differences in others
Attunement: Being aware of others
Affiliation: Being part of a group
Self-regulation: Containing impulses
Attachment: Making relationships with others.

1) Upon reflection, what did you notice about the experiences you shared?

2) How did you feel when you shared your stories? What surprised you?

3) How difficult is to relate to your patient's stories? Why or why not?

Awareness, Expression and Location

This is a group activity that needs a bit of floor space (large room to walk around in or hallway at least). Participants will need to move, think and speak. This activity should be done with staff team prior to trying it out on patients ☺

Feeling Card Exercise ~adapted from Dayton, 1990 as cited in Pantuso, 2016, p. 73-75

Materials needed: Appendix O and list of questions (see below or create your own).

Goal: To allow participants to identify, label, express and assess the intensity of their feelings and stimulate self-awareness. To teach and develop emotional intelligence.

Purpose: This exercise will allow participants to explore their own emotions through movement.

Leader Presents: This activity is designed to facilitate learning as well as understanding the importance of recognizing emotions when working with clients while experiencing your own emotional intelligence. The feeling floor check allows participants to get in touch with what they are feeling and make sense of their inner world, which can help them to better identify with the world of patients/clients.

- Explain to participants that this activity assists in exploring their own emotions and vulnerability. Encourage participants to pay attention to how they are feeling as they are engaging in this exercise. Explain the purpose of moving from their "head to their heart" with the use of movement around the room.

- Prepare, print and cut up feeling cards and distribute around the room (Appendix O).

- Place word cards a couple of feet apart from each other, scattered around the floor.

To begin: Ask participants to "stand on or near" the *feeling* that best describes their mood at the present moment.

- Repeat the process and ask them to stand on another feeling card they might also be experiencing. (Note: learning to "hold" more than one feeling at a time helps participants to tolerate living in the "gray" rather than "black and white"). As previously noted, participants are free to pass on sharing at any point during this exercise. Encourage participants to focus on how they are feeling in the *here-and-now* present moment.

- Repeat and ask them "to stand near the feeling card that you usually avoid".

- Repeat and ask them "to stand near a feeling that you avoid in others".

    o Alternate questions:

        ▪ How were you feeling before this activity?

        ▪ How are you feeling right now?

        ▪ What would you like to be feeling?

        ▪ How does sharing by movement in the group make you feel?

        ▪ How do you feel about conflict?

        ▪ What would you rather feel about conflict?

        ▪ How do you feel about anger?

        ▪ How would you like to feel about anger?

        ▪ What type of feeling comes up for you when working/being with someone who is sad?

- How do you feel about ambiguity (uncertainty)?

- How do you feel about change?

- What feeling do you think describes you most often?

- What word describes how you would like to feel?

Process questions following an activity (sit down and discuss as a group).

Refer to Appendix P to expand feeling/emotion vocabulary. Copy and distribute to group members.

- What was this activity like for you?

- Were there any surprises or new insights during this activity?

- What was it like for you to name your emotion?

- How do you think this exercise will benefit you in your work as a _____?

- What was it like for you to share your emotion to the group?

- What did you learn about yourself?

    (Convey to participants that recognizing how they are feeling is helpful in identifying any countertransference that is occurring. Countertransference is defined as your reaction to feelings that are projected onto you as a practitioner. By identifying countertransference reactions, practitioners may be able to work with them and through them with the group and this can be a reparative process.)

Listening to Shame

Materials needed: Computer/ipad and screen to show You Tube video. Index cards for each participant.

Goal: To watch Brené Brown's 2012 TED Talk and discuss together as a group.

 Listening to Shame (20:38) https://www.ted.com/talks/brene_brown_listening_to_shame

Purpose: To explore the concept of shame and how it affects our ability to relate to others. Shame is an unspoken epidemic, the secret behind many forms of broken behavior. Brené Brown, whose earlier talk on *Vulnerability* became a viral hit, explores what can happen when people confront their shame head-on. Her humor, humanity and vulnerability shine through every word.

Leader presents: Take a moment to write out what you sense in your body as you think of the word "shame", and then also write out the first few words that come to mind. **You will not be asked to share your index card with anyone else.

Watch the You Tube video together and share your thoughts with the group.

Vulnerability is NOT weakness. Vulnerability is the most accurate measure of courage.

Shame is the swampland of the soul.

Shame–about self: "I am bad"   Guilt–about behavior: "I did something bad"

Shame is highly correlated with: addiction, depression, violence, aggression,

bullying, suicide and eating disorders. Guilt is inversely correlated.

1) What stood out for you in this TED Talk?

2) What is one take away to remember this week about SHAME?

TIP Personal Preparation Plan for Facilitators

Materials needed: Copy and handout Appendices C, N and W for each participant. Index cards for each participant.

Goal: To prepare oneself for group facilitation.

Purpose: To increase self-care strategies and sense of safety at work.

Leader presents: Take a moment to write out how prepared you feel (or how prepared you felt if you been leading groups) to facilitate inpatient groups and 3 things that you think would increase your preparedness.

Read over and discuss Appendix N <u>or</u> Appendix C as a group for about 20 minutes. Then for the final 10 minutes of this session complete Appendix W questionnaire individually. Consider sharing your ideas with the group.

1) How important is the concept of self-care to your own life/work balance? How has it changed over time?

2) What are some of your "go-to", effective ways to ground yourself?

Addressing Countertransference Self-assessment

Materials needed: Make copies of Appendices X &Q.

<u>Have participants complete Appendix X questionnaire prior to session</u> (more time for

discussion in session). Handout copies of Appendix Q for participants during session.

Goal: To understand and identify countertransference. Increase self-awareness, decrease

discomfort and blind spots. Increase self-confidence and ability to model immediacy.

Purpose: To be aware of, normalize and utilize countertransference in group situations.

Leader presents: Countertransference includes the personal feelings a clinician has towards

a client, or the reactions to a client's *transference*, or the therapist's own transferred feelings

towards a client (Chan & Noone, 2000; Kottler, 2010). A group leader may respond to their

discomfort with conflict or ambiguity to a particular group member by side-stepping further

exploration and reverting to advice giving. Repetitive countertransference is when the leader

unconsciously repeats or enacts his/her concerns within the group. The leader that encounters

frustration by a group might react defensively to protect rather than probe the group (AGPA,

2004). Reparative work can happen within a group when the facilitator is able to remain

neutral, grounded and focused rather than defensive, and continue the work of enquiring

what is coming up for clients (and possibly the leader), providing space to process,

expression of feelings and an opportunity to repair damage from past experiences.

Please review Appendix Q in session (5 minutes).

With a partner or in groups of 3-4, discuss the questions you had difficulty answering.

    1.) Share what you learned about yourself in the process.

    2.) Are there things you find helpful that you could add to the self-care wheel?

Hazards Self-assessment

Materials needed: Copy and handout Appendix Y for participants. Index cards for each participant.

Goal: Self-reflection and understanding hazard areas to work on.

Purpose: To take time to assess, reflect on and share areas of personal concern with your staff team. Acquire feedback and take a few risks with one another, challenge and validate one another for what is known as well as unknown (remember the Johari Window).

Leader presents: Take a moment to write down on your index card a few hazards to leading inpatient groups for you personally. What do you think would help reduce those hazards? Read over and rate the hazards on a scale of 1 to 3, being as honest as you can with yourself about the extent to which each of them is or may be a problem for you. If you sense that you may be denying or disowning some of these issues, discuss them with others you know well and trust to be truthful.

1) Take 10 minutes to complete the assessment (or complete it ahead of time).

2) When you were choosing your answers, what areas were easiest/quickest to answer, which were more difficult?

3) What are you sensing in your body as you review your answers, is there any discomfort or tension? How are you feeling about your self-diagnosis?

4) What actions can you take this week to address the hazards that you have identified?

5) Take a moment to ground yourself with relaxation/calm breathing or your favorite at-work grounding technique.

Building and Maintaining Support for Self-care

Materials needed: Copy and handout Appendix Z and Appendix N. White board and markers or flip chart to map barriers, ideas and future plans. Index cards for each participant.

Goal: To reflect on and work towards building and maintaining healthy support systems.

Purpose: To increase self-care of staff team through healthy relationships with others inside and outside of work environment.

Leader presents: Take a moment to write on your index card at least 2 things you value most about your support network/family/friends who you rely on. Also, what or who is currently missing in your life?

Now review and complete this preliminary inventory, it should represent those current relationships that sustain you most effectively. They are hardly enough to provide all the support you need—and deserve—but they are models for what you care about the most. Read over and answer the inventory for the next 10 minutes or so.

Brainstorm and discuss as a large group what the barriers are to building and maintaining healthy relationships, what fosters new/continuing relationships and who is one person you can commit to connect with this week on a personal level?

Safety in Groups

Materials needed: White board and markers or flip chart.

Refer to Appendix A: Belly Breathing, Appendix I: Visualization of Safe Place or Appendix

N: Skills and Strategies for Teaching Self-care and/or Appendix Q: Self-care Wheel and

make copies of handouts.

Goal: To gain a better understanding of what will assist staff members to feel safe,

competent and confident when leading inpatient groups.

Purpose: To foster a supportive environment, to increase communication, trust and

accountability among staff.

Leader presents: Self-care and prevention of burnout is vital as mental health care

professionals are highly susceptible to burnout and vicarious traumatization. One area of

focus is a person's safety at work, both physically and emotionally.

Let's discuss and list the different resources people utilize to increase their comfort level in a

group:

1) What internal resources do you possess that help you to feel safe at work (both
   physically and *emotionally*)?

2) What external resources do you make use of to increase your level of safety at work
   (both *physically* and *emotionally*)?

3) What do you need to know from your co-facilitator before you begin a group session,
   as well as after?

Issues of Special Concern

(examples of topics of discussion to debrief in team meetings)

- Vicarious traumatization

    o McCann and Pearlman (as cited in AGPA, 2004) define vicarious

       traumatization:

       a. the transformation of the inner experience of the therapist that comes

          about as the result of empathic engagement with clients' trauma material

       b. the cumulative transformative effect upon the trauma therapist of working

          with survivors of traumatic life events.

- Secondary trauma

    o The emotional stress from hearing about firsthand trauma experiences and

       may include increase in arousal or avoidance reactions related to the indirect

       trauma experience.

What happens to us as Mental Health professionals if we <u>don't</u> recognize secondary trauma

and deal with it?

- Trauma group defenses to be aware of and respond to:

    o Denial

    o Splitting

    o Dissociation

    o Projection (patient transference)

    o Projective identification (another patient enacting projected identity)

When you witness the above happening in a group what do you usually do? How do you feel

when it's happening? What is your default response when stressed?

How do you repair or come back to the issue in group? What happens if you don't address

these issues, to you and to your group members? What are some other group facilitation

issues you would like to discuss as a staff team?

For a longer, more intensive self-awareness training workshop, see Pantuso's (2016)

The development of self-awareness in counselling students: Three day workshop. UNBC.

Part B: Safety and Stabilization Techniques

The following section includes a quick reference list of Do's and Don'ts to consider

as you prepare to lead trauma-informed inpatient groups as well as outlines for the various

levels of acute care groups offered within psychiatric wards: daily check-ins, somatic and

process-oriented psychoeducational groups and discharge preparation process groups, and

relaxation groups.

The meeting of two personalities is like the contact of two chemical substances;
if there is any reaction, both are transformed. ~ Carl Jung

Do's and Don'ts of Inpatient Group Work
What to be mindful of as you lead *trauma-informed* groups:

<u>**Do**</u>	<u>Do</u> ***NOT***
✓ Ground yourself before beginning.	
✓ Start and end on time.	✗ Make participation mandatory.
✓ Introduce co-facilitators.	✗ Wander into past trauma.
✓ Explain group format/expectations (beginning, middle and end).	✗ Make assumptions about patient's behavior (use trauma-informed lens).
✓ Invite members to participate.	
✓ Facilitate.	✗ Forget that many symptoms may be their attempt to cope with life experience, history and culture.
✓ Be active, structured and respectful.	
✓ Redirect to present situation.	✗ Allow patients to slander/split staff or other group members.
✓ Encourage members to speak to *one another* rather than to leaders.	✗ Let clients overshoot their window of tolerance.
✓ Be prepared with back-up content.	✗ Let patients speak over top of each other.
✓ Stay in the present, remind members to consider the *here-and-now* over there-and-then traps.	✗ Marginalize or minimize content. It's all "grist for the mill".
✓ Watch for signs of dysregulation or dissociation (eyes, posture, rate of breathing).	✗ Run a group in isolation, out of view of staff.
✓ Assess and adapt. Anticipate and respond.	✗ Monopolize the conversation; leaders are *not* the only experts in the room.
✓ Take time necessary to regulate group, advocate use of self-soothing coping skills.	✗ Encourage conflict or violence.
	✗ Let clients story on and on.
✓ Enquire about feedback between clients.	✗ Belabor time allotment if goals have been met and clients are disengaging.
✓ Empower group members with choices, collaboration.	
✓ Allow time to process and summarize.	✗ Miss opportunities to address or hear from quiet members.
✓ Be curious.	✗ Forget to encourage, empower and thank group members.
✓ Debrief with co-facilitator after group.	✗ Lead alone.

Empathy has no script. There is no right way or wrong way to do it.
It's simply listening, holding space, withholding judgement, emotionally connecting,
and communicating that incredibly healing message of "you're not alone."
This is why empathy is so difficult and important.
It's not always our default response – it's a skill and a choice to be connected.
Even when it's hard.
~Brene Brown

How to Facilitate a Large Daily Check-in Group
(30-45 Minutes, 10-20+ group members)

Introductions
Group norms/expectations
Scale (btw 1-10) and describe current mood
Experiential learning /coping skills (see Appendices A-J)
SMART goal (see Appendix K)
Final questions and thanking members for participation

- Let patients know when a group will start and where over the PA system and/or by going

    to their rooms and personally inviting them to the group.

    <u>Ground yourself.</u> See Appendices C for ideas.

- First 5-10 minutes. Introduce yourself and your co-facilitator and any other guests

    (student nurses).

- Have brief instructions, displayed on white board.

- Give a verbal overview of what the group is, how long it will take and how clients can

    participate. Ask if anyone has any questions before beginning.

- Next 15 minutes. Ask clients to introduce themselves, scale their current mood between

    1-10, one is as low as you can go, 10 highest. (**refer to Scale Your <u>Current</u> Mood, at the

    end of these instructions) and also give 2 words to describe how they are feeling at

    present. (Explain why we do this exercise, why it is a helpful tool to track their mood and

    compare it to other times/days and what they can learn from paying attention to how they

    are feeling throughout the day.)

- Go around the room or ask for volunteers, making sure that everyone has an opportunity

    to share. Thank clients for sharing or passing or showing up, affirm their efforts.

- Another 5 minutes. Take a moment to talk about a coping skill. Come prepared to share

    (relaxation breathing, journaling, grounding, gratitude ect.), but ask patients for one

example. Try it out, something clients can experience right then. Or, at the check-in at the

end of the day, ask clients to share something (or 3 things) they are grateful for and

expand on the details (i.e conversation with a friend, sitting in the sun, laughing together).

Do it together. Check-in again and ask, how was that (sharing, listening to others)?

- Next 10-15 minutes. Introduce concept of S.M.A.R.T. goals and ask for patients who

  have been in group for awhile to explain what it stands for and an example. Invite people

  to share a SMART goal for the day. (Or, if it's the end of the say, ask people to evaluate

  their SMART goal, was it attainable, does it need to be revised or what did they learn

  from attaining it.) See Appendix K for information on S.M.A.R.T. goals.

- Final 5 minutes. Enquire if there are any other questions, concerns? Thank clients for

  sharing, let them know what, when, and where groups are happening that day (be sure to

  describe the types of groups available and who might be interested). Highlight where that

  information is also posted on the ward.

**Scale your current mood between 1-10

10   Indicates the "best" mood you can imagine.

This number would only be used on the happiest moments of your life and therefore

will probably rarely be used but also consider it may be more common during manic

episodes.

5   Indicates an "average" mood.

The kind of mood many people feel most of the time. It is likely used often.

1   Indicates the "worst" mood you can experience.

This number would only be used on the worst moments of your life and therefore not

as often typically but may be common on first few days on the unit.

How to Facilitate a Somatic and Process-oriented Psychoeducational Group
(30-45 minutes, 6-12 group members**)**

For more information on somatic interventions refer to Ogden, P., & Fisher, J. (2015). *Sensorimotor psychotherapy: Interventions for trauma and attachment*. New York: W.W. Norton & Company Inc.

Introductions
Group norms/expectations
Psychoeducation and experiential learning of somatic resource (see Appendices A-N)
Group processing of experience, final questions
Closing and thanking members for participation

- Let patients know when a group will start and where over the PA system and/or by going to their rooms and personally inviting them to the group.

  Ground yourself. See Appendix C for ideas.

- First 5-10 minutes. Always introduce yourself and your co-facilitator and any guests (student nurses), and give a brief overview of what the group is about (topic and purpose), what to expect (expectations of participant involvement, grounding exercise, introductions, content) and how long it will be (approx. time). Encourage patients to participant and let them know they can quietly leave at any time. Check if anyone has any questions before starting.

Begin group sessions by helping clients hold an awareness of what's happening around them as well as within them (help "ground" them to ensure dual awareness).

- Now take 5 minutes to begin with a *grounding* exercise (see Appendices A—J for ideas), either mindful breathing, stretching or something that will engage patients and their bodies. This also acts as development of a coping skill.

- Next 10 minutes. Have patients introduce themselves to the group and describe *how* they are feeling (emotionally) and *where* they are feeling it (in their body). The

facilitator is supportive and validating, asks open-ended questions, normalizes and reframes statements to link themes and topic to be covered.

Group members experience that talking helps, they identify and locate feelings, give and receive feedback, reduce their isolation and anxiety by sharing and listening to others. Facilitators listen for themes to help with connection of experiences, ways to tailor the psychoeducational approach and monitor client's capacity to be safely engaged in the process.

- For next 15-30 minutes. Discussion continues directed on a particular topic (i.e. self-esteem, assertiveness, anxiety coping skills, sleep hygiene, healthy eating, ect.), getting insights and experiences from group members. Facilitation is flexible, directive, goal oriented and client-centered (what's going to work for the people in front of you, not your agenda). Remind clients to provide support to one another as appropriate.

- Final 5-10 minutes. Check-in with members before closing group, review insights and experiences to validate and thank them for their participation. Close with another round of grounding exercise (or 3 cycles of calm/relaxation breathing, etc.). Close group on time, letting clients know they can talk to their nurse or facilitators if they have any questions or concerns. Let clients know the time and location of the next group session. Again thank them for the work they did in session.

You can find simple, informative, interactive tools, guides, videos and 1-2 page worksheets

to download and/or copy for group discussion at www.therapistaid.com. Topics include:

anger, anxiety, art, CBT, communication, DBT, depression, education, goals, grief,

motivational interviewing, parenting, relationships, self-esteem, substance use, suicide and

self-harm, and values.

For more online resources see:

Center for Clinical Interventions http://www.cci.health.wa.gov.au/resources/consumers.cfm

Good Therapy http://www.goodtherapy.org/resources-for-therapists.html

Psychology Tools http://psychology.tools/

How to Facilitate a "Reintegration" (higher level) Process Group
(30-45 minutes, 2-5 group members)

Introductions
Group norms and expectations
Grounding exercise
Here-and-now concerns, feelings, sensations
Closing questions, review grounding exercise again
Thank clients for their participation

- **Only personally invite those who have overnight passes approved and are preparing for discharge. Let patients know when a group will start and where.

- Ground yourself. See Appendix C for ideas.

- First 5-10 minutes. Introduce yourself and your co-facilitator and any other guests (student nurses) and give a brief overview of what the group is about (preparing for discharge), what to expect (they are the experts on their situation, they will benefit from talking with one another and facilitators will guide the discussion) and how long it will be (approx. time). Encourage patients to share their concerns, expectations and questions.

Begin group session by helping clients hold an awareness of what's happening around them as well as within them (help "ground" them to ensure dual awareness, if possible).

- Take 5-10 minutes to begin with a grounding exercise. Either mindful breathing, stretching, or something that will engage patients and their bodies. (This also acts as development of a coping skill, refer to Appendices A-J)

- Next 15-30 minutes. Have patients introduce themselves to each other and describe *how* they are feeling (emotionally) and *where* they are feeling it (in their body). The facilitators guide the conversation, are supportive and validating, ask open-ended

questions, normalize and reframe statements to link themes around discharge and transition to community concerns, next steps.

Benefits of group: talking helps, they identify feelings, help others by giving and receiving feedback, reduce isolation and anxiety by sharing and listening to others. Facilitators listen for themes to help with connection of experiences and monitor client's capacity to be safely engaged in the process. Begin group sessions by helping clients hold an awareness of what's happening around them as well as within them (help "ground" them to ensure dual awareness).

- Final 5-10 minutes. Check-in with members before closing group, review insights and experiences to validate and thank them for their participation. Close with another round of opening grounding exercise (3 cycles of relaxation breathing, etc.). Close group on time, letting clients know they can talk to their nurse or facilitators if they have any questions or concerns. Let clients know the time and location of the next group session. Again, thank them for the work they did in session.

Resources to download and copy for clients who are ready for discharge:

Anxiety BC www.anxietybc.ca

Center for Clinical Interventions http://www.cci.health.wa.gov.au/resources/consumers.cfm

Cognitive Behavior Interpersonal Skills Manual(CBIS)

Crisis and Trauma Resource Institute, Anxiety Prevention Strategies www.ctrinstitute.com

General Practice Services Committee (CPSC)
http://www.gpscbc.ca/sites/default/files/uploads/AMH_004.0_CBIC_Manual_v3.0_PR.pdf

Good Therapy http://www.goodtherapy.org/resources-for-therapists.html

Primary Care Psychology http://primarycarepsychology.com/patient-self-help/workbooks-guides/relaxation-resources/

Psychology Tools http://psychology.tools/

Therapist Aid http://wwwtherapistaid.ca/therapy-worksheets

101 Trauma-informed interventions www.gopesi.com/trauma101

How to Facilitate a Relaxation Group
(20-30 minutes, 2-8 clients)

Introductions
Group norms/expectations
Relaxation video/experience
Final questions and thanking members for participation

- Let patients know when a group will start and where over the PA system and/or by going

  to their rooms and personally inviting them to the group.

  Ground yourself. See Appendix A for ideas.

- First 5-10 minutes. Introduce yourself and your co-facilitator and any other guests

  (student nurses).

  Review expectations for group participation. Group members may participate for as long

  as they are comfortable, if they wish to leave early, leave quietly and then check-in with a

  staff member. Participants can always keep their eyes open or choose to close them,

  whichever is better to focus. Encourage members to try to hold "dual awareness"

  knowing they are presently in the room as well as able to use their imagination.

  **CAUTION This activity can be too dysregulating for someone who dissociates or a

  person with PTSD.

  Always remind clients to use grounding techniques (push feet into floor, feel seat in the

  chair, etc.) to bring themselves back into the room.

Choose from a variety of You Tube videos for relaxation:

Anxiety Relief Practice (12:47) https://www.youtube.com/watch?v=q2_UfFIszkY

Progressive Muscle Relaxation (10:33)

http://www.bing.com/videos/search?q=progressive+muscle+relaxaton+you+tube&&view=de

tail&mid=74784D7191D4FC87946074784D7191D4FC879460&rvsmid=1326EA2ED7C75

D00806E1326EA2ED7C75D00806E&fsscr=0&FORM=VDFSRV

Mindful Meditation for Anxiety (9:22) https://www.youtube.com/watch?v=Fpiw2hH-dlc

Simple Breathing Exercise (5:13) https://www.youtube.com/watch?v=kzzb3jHhgeU

Mindful Meditation: Breathing Anchor (8:10)

https://www.youtube.com/watch?v=fUeEnkjKyDs

Mindful Meditation: The Body Scan (14:47)

https://www.youtube.com/watch?v=LgbVrSk0n4

Body Scan (8:32) http://www.bing.com/videos/search?q=body+scan+youtube+10+-

20+minutes&&view=detail&mid=C149675166DA4E1B3C84C149675166DA4E1B3C84&r

vsmid=CC7CBEE1366E7B05D677CC7CBEE1366E7B05D677&fsscr=0&FORM=VDFSR

V

Body Scan for Relaxation (15:50)

http://www.bing.com/videos/search?q=Body+Scan+Relaxation&&view=detail&mid=180F9

8AD51FDCEC9AD8B180F98AD51FDCEC9AD8B&FORM=VRDGAR

Body Scan (12:39) https://www.youtube.com/watch?v=figoOOXxn5s

Guided Imagery –"The Seat" (16:47)

http://www.bing.com/videos/search?q=guided+meditation+the+seat&view=detail&mid=16F

B70CEB94037E7771A16FB70CEB94037E7771A&FORM=VIRE

Guided Imagery – "The Sanctuary" (30:07)

https://www.youtube.com/watch?v=Y7rCDZXSgxI

Guided Imagery – "A Walk Along the Beach" (12:39)

https://www.youtube.com/watch?v=ar_W4jSzOlM

Guided Imagery – "A Walk in the Forest" (10:08)

https://www.youtube.com/watch?v=lgSbF_xH9LU

Part C: Training, Networking and Resources

      Continuing education and networking opportunities. The final section to this

chapter includes a listing of organizations and opportunities for training, networking and

online resources for group facilitators.

      American Group Psychotherapy Association (AGPA) www.agpa.org *AGPA* serves

as the voice of group therapy for mental health clinicians and the public-at-large, both

nationally and internationally. The AGPA provides vital information on group psychotherapy

in a variety of ways. These efforts provide global access to group psychotherapy education

and professional development, research, and outreach services. AGPA promotes awareness

about the healing power of group.

      Canadian Crisis and Trauma Resource Institute https://ca.ctinstitute.com *CTRI* is a

leading provider of training and consulting services for individuals, school, communities and

organizations affected by or involved in working with issues of crisis and trauma. CTRI's

purpose is to provide exceptional training and resources to better lives. CTRI believes mental

health, counselling and safety resources should be accessible to everyone. Workshops and

resources are geared to a wide range of care and service providers including social service,

health care, education, employment and other organizations.

      Canadian Counselling and Psychotherapy Association (CCPA)

https://www.ccpa-accp.ca/continuing-education/webinars *CCPA* is a national bilingual

association providing professional counsellors and psychotherapists with access to exclusive

educational programs, certification, professional development and direct contact with professional peers and specialty groups.

   Canadian Group Psychotherapy Association (CGPA) www.cgpa.ca *CGPA:* Group Therapy, Group Training, Group Facilitation. A multi-disciplinary Canadian association of professionals and students that believe change happens through connection and belonging. Offering educational opportunities including teleconference seminars, mentorship, local and national workshops and our premier event the CGPA Annual Conference. Group therapists, group educators and group facilitators all appreciate the organization's acceptance of diversity and openness to new ideas.

   Prince George CGPA http://princegeorge.cgpa.ca Training Workshops and Experiential Process Groups for Therapists. For more information contact Dr. John Sherry PhD, 250 960-5961.

Online Training and Resources:

   Center for Clinical Interventions

http://www.cci.health.wa.gov.au/resources/consumers.cfm

   Crisis and Trauma Resource Institute*, Anxiety Prevention Strategies*

www.ctrinstitute.com

   Irvin Yalom Inpatient Group Psychotherapy Video (2009)

www.youtube.com/watch?v=05Elmr65RDg

   Professional Training in Somatic Psychology https://sensorimotorpsychotherapy.org

   PsychotherapyNet – You Tube Videos

www.youtube.com/user/PsychotherapyNet/videos

   Psychotherapy.net: Online Psychotherapy Magazine www.psychotherapy.net

Somatic Experiencing Institute https://traumahealing.org

Somatic Resourcing Training www.somaticresourcingtraining.com

101 Trauma-informed Interventions www.gopesi.com/trauma101

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Appendix A: Belly Breathing

Appendix B: Mindful Breathing

Mindful Breathing

By Zhen-Phang

1. Gently invite our attention to rest on the breathing, as indicated by the movement of tummy, chest, shoulder; tiny air sensations around the nostrils or throat; sound of breathing, etc...

2. It's not necessary to change the breathing; just pay attention to it with curiosity and kindness, as though we're observing children playing. Smile to the breath...

3. Notice how the experience changes on in-breath and out-breath. See if we could follow the whole cycle of breath, observing any changes moment-to-moment. On each out-breath, you're relaxing more and more in the present moment...

4. If the attention drifts away, it's OK. Gently bring it back to the breathing. At times, labelling the breathing, "breathing IN, I know I'm breathing in; breathing OUT, I know I'm breathing out" could be helpful in anchoring attention...

5. Anchoring the breath with positive attitude could also be helpful, e.g. "Breathing IN, I see myself as a flower (imagine), breathing out, I'm fresh and energized," or "Breathing IN, I see myself as a tree (imagine), breathing OUT, I'm strong and stable."

Breathing Exercises

Four In, Four Out Slow Belly Breathing
1. Close your eyes.
2. Breathe through your nose.
3. Deliberately slow your breathing down.
4. Breathe from your relaxed belly.
5. Keep your breaths smooth, steady, and continuous.
6. Breathe in while counting slowly "1-2-3-4."
7. Pause.
8. Breathe out while counting slowly "1-2-3-4."
9. Pause.

Whole Body Muscle Tensing and Relaxing
1. Take a very deep breath in with your mouth open; fill your lungs up.
2. Hold your breath.
3. Tense muscles all over your body.
4. Count 5-10 seconds.
5. Let go of all the tension in your muscles and slowly let your breath out.

4-4-4-4 Breathing
1. Breathe in while counting to 4. Make it a deep, belly breath.
2. Hold your Breath while counting to 4.
3. Breathe out while counting to 4.
4. Hold your Breath while counting to 4.
5. Do this sequence 2 more times.

4-6-4-6 Breathing
1. Breath in for a count of 4.
2. Hold for a count of 6.
3. Breathe out for a count of 4.
4. Hold for a count of 6.

The Sigh
1. Breath in.
2. When you breath out, open your mouth and let the air out so you hear the sound of the air releasing, a soft sigh sound.
3. As you let the air out, relax your shoulders, neck and other muscles and let go, like you're melting.

Buteyko Small Breath Holds
1. With your mouth closed, take a small, but calm and relaxed, breath in.
2. Take a small breath out.
3. Hold your nose closed with your hand.
4. Hold for a count of 5.
5. Release.
6. Gentle, soft breathing in-between sets.
7. Tongue rests at the roof of the mouth; Teeth slightly apart; jaw relaxed; Drop shoulders; relax chest and belly; Relax facial muscles.

Alternate Nostril Breathing
1. Close the right nostril with your right thumb. Then inhale slowly through your left nostril.
2. Then close the left nostril with your right index finger and open the right nostril by removing the right thumb. Exhale very slowly through the right nostril.
3. Then draw the air through the right nostril as long as you can do it with comfort and exhale through the left nostril by removing the right index finger.
4. This is one round. Do 12 rounds.
5. Breathing in and out should be as slow, soft, steady and long as possible. But don't force.

4-7-8 Breathing
1. Exhale all the air out through your mouth.
2. Curl the tip of your tongue up to touch the hard ridge behind your upper front teeth and hold it there for the duration of the exercise.
3. Close your mouth and inhale through your nose for a count of 4. Don't force it, but take a good breath as this has to last for the next 15 counts.
4. Hold your breath for a count of 7.
5. Open your mouth and exhale through your mouth (still pressing the tip of your tongue to the hard ridge behind your upper front teeth) for a count 8. of You will make a sound as the air moves around your tongue. You may want to purse your lips if this helps you to direct the flow of your exhalation.
6. Repeat 4 times.

(instructions written by madlyinlovewithlife.com)

The Complete Breath
1. First, inhale completely at the abdomen.
2. Continue to inhale by filling in the mid-section, the area of the diaphragm.
3. Continue to inhale by filling the chest, allowing the upper chest and the shoulders to rise.
4. Then systematically release and empty from the upper portion, then the mid-section, and finally empty completely at the abdomen.

(www.swamij.com)

Relearn How To Breathe (Don Campbell)
1. Inhale deeply
2. Exhale with a short burst (as if blowing out a candle). This helps activate your diaphragm.
3. Exhale with a long, slow finish to empty the lungs. Breathlessness is from not expelling enough CO_2.
4. Inhale, filling your lungs from the bottom to the top, instead of taking short sips. Most use a third of their lung capacity.
5. Hold for a moment to allow oxygen to saturate the cells.
6. Exhale slowly and completely.
7. Repeat steps 4 through 6 for five minutes.
8. Do this exercise five times a day

Appendix C: 33 Quick Ways to Ground

TIP guide, BC Mental Health and Substance Use Planning Council, May 2013

Regular practice of favorite grounding technique(s), when *already* feeling calm, helps you to:
- shift focus-of-attention and strengthen access to positive memory networks
- establish personal safety, choice, and power by identifying, containing, and/or eliminating any intrusive thoughts/feelings/sensations
- immediately connect to this present moment, time, and place, here and now
- feel into the senses and the body's way of knowing
- offer safety, hope, and choice with others, when you can remain connected and grounded

1. Drink 3 glasses of water, slowly.

2. Use strong sensory input to quickly ground. Place your hands in a bowl full of ice and water. Suck on an ice cube.

3. Peel an orange or a lemon; notice the smell; take a bite.

4. Change your environment. Get outside. Go for a walk.

5. Breathe slowly, consciously, in 4 part awareness: breathe in for a count of two; hold for a count of two, breathe out for a count of two, hold out for a count of two.

6. Spend time with a pet. Watch a squirrel. Study a colony of ants.

7. Take an unhurried shower or a bath. Sense a full connection with the water.

8. Dig in the dirt in your garden.

9. Play your favorite upbeat song and sing along.

10. Move around. Feel your body. Experience a full stretch of your arms, hands, fingers.

11. Splash water on your face.

12. Turn lights on.

13. Hug a tree.

14. Describe what is around you in the smallest detail.

15. Picture your calm place. Look at an actual picture of a vacation spot, child, or pet. Carry this picture with you.

16. Carry a grounding object in your pocket. Touch it for grounding.

17. Get down on the floor and stretch like a cat.

18. Walk *very* slowly, noticing the sensations as your heel lifts, your weight shifts through the arch and into your toes, the foot lifts. Marvel at the body's precision.

19. Buy one beautiful flower.

20. Light a candle and study the flame. Notice the darker inner flame.

21. Go out in the middle of the night and watch the stars. Embrace the intelligence of the universe where everything belongs and has its place.

22. Turn off the TV. Go outside. Develop a pattern, then, walk it into new environments. 'I'll turn right after 3 blocks, left after 2, right after 1'. Repeat. Make sure you can find your way home.

23. Feel the aliveness of green grass on bare feet.

24. Name your 3 favorite colors, foods, animals, etc.

25. Really listen to nature's sounds: waves, wind, birds, rain.

26. Hum your favorite upbeat song.

27. Boil cinnamon in water. Enjoy the fragrance. Google the exotic history of cinnamon.

28. Sample flavors in an ice cream store.

29. Suck on a piece of your favorite hard candy.

30. Really taste the food you eat; chew slowly and mindfully.

31. Put clean sheets on the bed.

32. Blow bubbles.

33. Develop an inner smile.

Appendix D: Learning the Language of the Body – Sensation

The raw data of the lower brain is pure body sensation information. This comes in through our senses cued to the outside world (sight, sound, taste, smell, touch) and our internal perception of sensation within our bodies.

Strategy: Choose one sense and immerse into it deeply – absorb it.

- Sight – watch a sunset; gaze at the clouds; look at a favorite picture.

- Sound – listen with your eyes closed to music; notice all that you hear right now.

- Smell – track the sensation of breathing in a pleasant aroma; notice the reaction of the rest of your body while connecting with different smells.

- Touch – give your own arm a massage; notice the feel of grass under your feet; run cool water over wrists; drink tea; feel the sensation of support from a chair.

- Taste – slow down and take in all the sensations of tasting – try to describe the sensation rather than naming the item you are tasting (e.g., sour, sweet, tangy, etc.).

Expand and deepen the experience by asking:

1. *Where do you feel this sensation in your body?*

2. *What other qualities can you describe about this sensation?*

3. *Take your time and imagine really letting this sensation soak into you and permeate or take up more space.*

Appendix E: Movement and Connection with the Body

Strategy: Stretching exercises

Moving and stretching muscles and ligaments allow the release and flow of built-up stress hormones and chemicals in the body and brain. Increasing general flexibility and agility in daily activities interrupts the pattern of tensed and braced muscles, which then helpfully stimulates the parasympathetic system.

- Intentionally yawn and stretch the jaw and face muscles. This pairs well with

  remembering to do some regular breathe exercises.

- Sit or stand with spine upright, stretching shoulders back, opening up chest.

- Do shoulder and arm circles, going from small to big exploring directions

Strategy: Neck rolls and stretches

Stand or site with your spine upright and so you are well supported. Gently release your head so that it tips forward – only as far as is comfortable. Explore small, gentle neck rolls from side to side (caution going back) and stretching. Find what is comfortable right now. Clicks and cracks in the neck muscles are normal as they release and let go.

Strategy: Tense and release

Systematically go through general muscle areas focusing on one at a time. Intentionally tense and squeeze those muscle groups for about 5 seconds, then release and breathe fully. Go through head and face, shoulders and arms, fists, abdomen, legs, feet and toes. It can be useful to experiment starting from the feet up as well.

Strategy: Finger push-ups

Place the fingertips of one hand against those from your other hand. Gently, slowly and firmly push your palms toward and then away from each other while keeping your fingers strong – like a push-up. Try to take at least five seconds for each "push-up".

Appendix F: Movement and Checking-in with the Body

Retrieved from Curran, L. (2013) *101 Trauma-informed Interventions: Activities, exercises and assignments to move the client and therapy forward.* Eau Claire, WI: PESI Publishing and Media.

After purchase of the above guide, go to www.go.pesi.com/trauma101 for step-by-step instructions, photos and handouts.

Yoga for PTSD.

"…research has shown that yoga practices, including meditation, relaxation, and physical postures, can reduce autonomic sympathetic activation, muscle tension, and blood pressure, improve neuroendocrine and hormonal activity, decrease physical symptoms and emotional distress, and increase quality of life. For these reasons, yoga is a promising treatment or adjunctive therapy for addressing the cognitive, emotional, and physiological symptoms associated with trauma, and PTSD specifically."

~from *The International Journal of Yoga Therapy*

Sitting/easy pose (p. 102)

Seated neck rolls (p.103)

Corpse pose (p.103)

Standing mountain pose (p.104)

Forward bend (p.105)

Child's pose (p. 106)

Cat tilt (p. 107)

Regulating the dysregulated autonomic nervous system.

"The body's autonomic nervous system (ANS) governs many of the body's internal functions, through its two branches: the *sympathetic branch* (SNS) ("fight-orflight") of this ANS activates or increases the heart's action, while the *parasympathetic branch* (PNS) ("rest" and "digest") acts as a brake slowing down the action of the heart… The balance between this acceleration and braking system produces an ongoing oscillation, a systematic increase and decrease in heart rate." (Curran, 2013, p.131)

Exercises for <u>activating</u> the PNS:

Yawning (p. 133)

The mammalian diving reflex (p. 134)

Hand warming (p. 135)

Shoulder griping chant.

(p.156) By extending an lengthening neck muscles it relives muscle tension, by reducing the proprioception of the neck and should muscles, it improve auditory skills, overall improvement in attention, focus and memory.

Improving right/left hemispheric communication.

(variations on these exercises can be found on various websites, such as http://innersource.net/ep/ and www.learnenergymedicine.com

Cross crawl (p. 148) – contralateral exercise, similar to marching in place, the participants move one arm and opposite leg and then the other arm and opposite leg.

Walking meditation.

A mindful walk (p. 180)

Mindful eating exercise.

(p. 181) Try to remain "vigilantly aware of your own bodily sensations" as you eat something, being mindful of the sight, scent, texture, smell and taste.

After you have taken in the details of what you ate, ask group members,

"How was that experience for you? Was anything surprising about it? How did it differ from the way you typically eat? Is there some way for you to bring this quality of 'awareness' into your day to day life?"

Appendix G: Redirecting Onto a Positive or Productive Pathway

The interruption of an anxious worry loop is very important and will need a compelling stimulus to hold one's attention and compete with the adrenalized pattern of worry.

- Contain the worry or anxiety by drawing or writing it out and then physically place it in a "container" – this can be a journal, box, envelope, drawer or an imaginary container of any size, shape and material.

- Shift focus onto something else. This is intentional distraction and is different from reactive avoiding.

  o Turn on music
  o Go for a walk
  o Do some laundry
  o Watch TV, movie, or play a video game
  o Sing or talk out loud
  o Change your location
  o Focus on a positive poem, affirmation or picture (i.e Safe Place exercise)

Be careful not to let these distraction strategies take over. Key is that you feel better.

- Use mindfulness strategies to refocus on the task at hand or on another mindful activity.
- Make a list when not anxious of positive and pleasant things to think about (a prior or dream vacation, favorite movie, the steps of a favorite recipe, etc.)
- Brain – shift – intentionally engage the "left mode" (analytic thought) by doing crossword puzzles, sequencing tasks such as lists, math problems or reading technical information.
- Individualize these strategies into a personal plan.

Strategy I Plan to Use: Write out the strategy in as much detail as you can.

- *Visualize Stop Sign – like the one on the end of my street.*
- *Write in my journal for maximum of 10 minutes.*
- *Go on my "vacation to Hawaii" in my imagination.*
- *Practice positive self-statements: I am working on taking care of myself; I have a family I love and I know they love me; I'm aiming for "good enough", not perfect.*

When did I use my strategy?   **How did it affect me?**

Monday at lunch   *after 10 minutes I felt calmer, was able to go back to work.*

Appdendix H: Containment Exercise

~Adapted from *Countainment Imagery* https://trauma101.com/ufiles/a-container.pdf

 "The Container" is an imaginal resource that addresses the need to compartmentalize distressing material, in order to be present in the *here-and-now*, attending to what one needs to. This is not a repression or suppression of memories, thoughts, affect, emotion; this is a technique employed to allow one to attend to what s/he needs to attend to.

Containment Imagery
Allow yourself to be comfortable...either lying down or sitting up- with your back, neck and spine fully supported. Knowing that you will not be interrupted for the next little while, begin by gently closing your eyes or keep your eyes open and focus on something in front of you.

(Breathe audibly with the exhalation longer than the inhalation)

Now begin to bring your attention to your breath, the direct experience of your breath, however it is... and however it changes. Allow yourself to softly focus your awareness on to the breath that is arising right now...the in-breath and the out-breath... the rising and the falling. If you can, try to follow one full cycle of the breath, from the beginning of the in-breath, through its entirety...the beginning of the out-breath through its entirety. Allowing yourself the time and the space to be in direct contact with the breath throughout one entire cycle.

(Breathe audibly with the exhalation longer than the inhalation)

As you continue to pay attention to the breath, you may notice distractions that arise. Just allow yourself to notice... those distractions...any bodily sensations... any thoughts that may arise. If possible, allow yourself to become aware of the separateness of those bodily sensations –notice how those sensations are separate, distinct from your thoughts, your ideas and your words.

(Breathe audibly with the exhalation longer than the inhalation)

Now, as you continue with this focused awareness, you will notice how often you lose contact with the breath... maybe you become caught in a thought or an idea or plan or maybe some other bodily sensation has pulled your attention. ...When this happens, simply notice that you have lost connection with the breath, and, gently bring your awareness back to the breath.

(Breathe audibly with the exhalation longer than the inhalation)

We'll begin now with a deep breath in through your nose...inhaling slowly and deeply. Exhale through pursed lips until all the air has been released.

(Breathe audibly with the exhalation longer than the inhalation)

Now we are going to create a container. It doesn't matter what kind of container it is, as long as it can hold "any and all disturbing material". If you were going to develop something like that, what kind of container would it be? Some people have used boxes, safes, trunks or chests, others have used book bags, knapsacks or other pieces of luggage. It can be anything really, a tank, a submarine, an underground well... anything that suits you.

(Breathe audibly with the exhalation longer than the inhalation)

Can you bring to mind an image of something like that? Something that would be able to contain any and all disturbing material? When you have one in mind, take a good look at it. What material is it made out of? How is it held together? How big is it? What color is it? Are there any markings on it? If there are markings, notice them, if not that's fine. But I'd like you to add something to this container. I'd like you to add in some way...whether it is a note or a sign or an inscription of sorts on it... I'd like you to add a note to indicate that this container will remain tightly sealed. It will remain tightly sealed, until you wish to open it and retrieve something from it, otherwise it will remain sealed. It can be opened-but **only by you**.... and it should be opened **only** in the service of your healing.

(Breathe audibly with the exhalation longer than the inhalation)

So once again, look at your container. Does it have already have a message on it? If not, place one on there now. (Pause)

Now, how does this container open? Are you able to open it by yourself, or do you need help? Is there a lock on it? If not, feel free to put one or several on it now.
(Pause)

(Breathe audibly with the exhalation longer than the inhalation).

Once the locks are in place, we'll experiment with opening and closing it, locking and unlocking it. As you do that, notice how much, or how little effort it takes to open and close.

(Breathe audibly with the exhalation longer than the inhalation)

When you feel comfortable handling it, I'd like you to think of something only *slightly* uncomfortable or disturbing that you might put into the container... just for practice. Do whatever is necessary to open it up, and then place something in there. When I say "something"...I mean anything, really, anything that may be distressing or disturbing to you right now.... it could be thoughts or worries, bad feelings or bad memories . . . it could be something that you have to do, but not right this minute, or it could be something that keeps you from being present with this exercise. It could be self judgement, doubt or pain...whatever it is you can put it into the container...whatever you need to do to get it in there, do that now. ... (Pause)

(Breathe audibly with the exhalation longer than the inhalation)

Once the *slightly* disturbing material is in, close it up and lock the container. (Pause) Now, breathe deeply as you look at the locked container, securely holding anything that you need or want it to hold.

(Breathe audibly with the exhalation longer than the inhalation)

Notice how you feel in your body having set aside whatever distressing thing you put in your container. Can you sense that it is fully contained? Is there something that keeps it from feeling fully contained? If so, can we try opening your container and putting that in there as well? Remember that this container is yours and will hold any and every thing that you need it to hold for as long as you need it to.

(Breathe audibly with the exhalation longer than the inhalation)

Now imagine walking away from your container... so that it is no longer in your sight. Notice the feeling in your body now that you are no longer burdened by what you put in the container. Notice your breath, your in-breath . . . your out-breath . . . and any sensations of relief you feel in your body, maybe your shoulders have dropped a bit, or some of the tension in your neck has subsided. Whatever feelings of relief you notice, breathe deeply and just notice. Whatever you put in the container is now securely locked inside. It is for you to open whenever you wish to put things in or take them out. So now, just for practice, let's go back to your container. Once you have it in sight, look closely...see if you can read what is written on the outside. (Pause) Continue focusing on your breath as you continue to approach the container. When you are in reach, unlock it and open it up. ... As you open it notice that what you put in there, is still there, separate from you. You might want to put something else in, or maybe even a few things. Or you may just wish to lock it back up. Whatever feels right and safe to you, you can do that now. (Pause)

 (Breathe audibly with the exhalation longer than the inhalation)

And once you're finished practicing putting things in your container and securely locking it back up …you can walk away from the container ... as you walk away begin to bring yourself and your awareness back to this room. Knowing that this resource, this secure container is available to you at any time, knowing that you can use it to hold any and all disturbing things, knowing that all of the things that you have chosen, or anything that you choose to contain in the future, will be secure and will remain secure. You can access the material whenever you feel resourced to do so, but for now, you may leave it, knowing it is safely and securely contained.

(Breathe audibly with the exhalation longer than the inhalation)

And now, whenever you are ready, gently bring yourself back to the room by counting up from one to five. When you reach the number five, gently open your eyes. You will be alert and feeling only at peace. One…. two…. three. Take a deep breath…. four…. and five.

Appendix I: Visualization of a Safe Place

The *safe place* exercise is a very common technique to help learn, practice and access a state of relaxation. You may know it already, but it is always worth reviewing. (I recommend reading the script over very slowly, allowing time to imagine and be present.)

Close your eyes and pay attention to your breathe.
Breathe in, fill your abdomen with air and exhale a little longer than you inhale.

Try to clear your mind. If there are distracting thoughts gently sweep them away.

Picture yourself in a safe place. Go to a place in your mind that feels calm and safe. It can be a place that you have been to before, or it can be a place you've never been to.

What do you see? What colors are there? What objects do you see?

Do you see any textures? Can you feel the textures? What is the temperature in this place?

Are there any sounds or noises? Can you hear anything in this place?

Can you smell anything? Are there any fragrances?

Is there anything to taste in your safe place? Taste it, what does it taste like?

Are there any beings in your safe place with you?

How do you feel in this place? How does it make you feel to be here in your mind?

Remember all the things that you saw, heard, smelled, touched or tasted. Engage all your senses. Remember how you felt in this safe place.

Remember that you can come back here anytime; that it is in you, so you can come here whenever you want and bring back the feelings that it gives you.

Whenever you are ready, return your attention to your breathe.
And then whenever you're ready, open your eyes.

If you are able to develop a safe place, and it helps you feel relaxed, practice this exercise so it will be like a sharpened tool, ready for use at any time. You can do the *safe place* to help you relax before you go to sleep, to manage anxiety in a tense situation (like if you're afraid of flying, etc). Use the safe/calm/happy/secure place whenever you want to get in touch with relaxed, calm feelings.

Appendix J: 4 Elements Exercise for Stress Reduction
Earth – Air – Water – Fire
(Elan Shapiro, 2012)

Instructions:

Clients need to be familiar with calm belly breathing (Appendix A) and "Safe Place" (Appendix I) before doing this exercise. Before you start the exercise ask clients to rate their current level of stress. Subjective Units of Distress scale (SUDs) pick a number between 0-10, zero is completely calm and 10 is completely distressed.

1-EARTH: GROUNDING, SAFETY in the PRESENT /REALITY…. *"Take a minute or two to "LAND"… to be here now… place both feet on the ground, feel the chair supporting you….Look around and notice 3 new things…What do you see…. What do you hear ?"*

Don't ask this if it draws attention to on-going dangers. Attention is directed outwards to the reality of safety in the present.

2-AIR: BREATHING for CENTERING

Breathing – you can do your favorite breathing exercise here. Option: *"Breathe in through your nose* (for abdominal breathing) *as you count 4 seconds, then pause for 2 and then breathe out for 4 seconds. Take about a dozen deep slower breaths like this"*.

Attention is directed inwards to your center.

3-WATER: CALM & CONTROLLED – to switch on the RELAXATION RESPONSE

*"….Do you have saliva in your mouth?...Make more saliva….when you are anxious or stressed your mouth often dries because part of the stress emergency response (Sympathetic NS) is to shut off the digestive system. So when you start making saliva you switch on the digestive system again (Parasympathetic N S) and the relaxation response **that is why people are offered water or tea after a difficult experience- when you make saliva your mind can also optimally control your thoughts and your body).*

Attention is directed to producing saliva and becoming calmer, focused and controlled.

4-FIRE Light up the path of your IMAGINATION.

"Bring up an image of your SAFE PLACE (or some other RESOURCE such as a memory

when you felt good about yourself) – what do you feel and where do you feel it in your

body?"

Attention is directed to the feelings of safety/calm/etc. in your body. **You can always add

some butter fly hugs here. Cross your arms and alternate patting the opposite bicep muscle

while going over the details of your safe/calm/happy place in your mind.

<div align="center">Additional Explanations</div>

• *Rationale:* external and internal stress triggers have an accumulative effect during the day.

• We cope better with stress when we stay within our arousal window of tolerance (see

explanation below).

• An *antidote* to stress triggers: frequent random monitoring of stress level with simple stress

reduction actions to keep stress levels within our window of tolerance.

• *Wear a 4 Elements bracelet* (colored silicon band or elastic band) *on your wrist and every*

time you notice it take a <u>quick reading of your current stress level (SUDs)</u> *and perform the 4*

Elements Exercises and <u>then take a second SUDs reading</u>.

Alternative: place a small sticker or label on your watch or mobile phone

• The (modest) goal is to reduce your stress level by 1 or 2 each time and to do this at random

times and at various initial stress levels. By preventing your stress responses from

accumulating, you may be better able to stay within your window of tolerance.

<div align="center">Tips</div>

The sequence of the 4 Elements Earth-Air-Water-Fire is designed to follow the body up from
the feet, to the stomach and chest, to the throat and mouth, to the head.
As each new "element" is presented briefly review the previous ones ("*as you continue
feeling the SECURITY now of your feet on the GROUND, and feel CENTERED as you*

BREATHE in and out, and feel CALM and in CONTROL as you produce more and more SALIVA, you can let the FIRE light the path to your IMAGINATION to bring up an IMAGE of a place where you feel SAFE /or a memory in which you felt good about yourself.")
The rubber band can be stretched (gently) and released to stop negative thoughts and to ground quickly in the present (thought stopping).

Window of tolerance explanation:

Window of Tolerance

Hyperarousal Zone

2. Sympathetic "Fight or Flight" Response
Increased sensations, flooded
Emotional reactivity, hypervigilant
Intrusive imagery, Flashbacks
Disorganised cognitive processing

**Window of Tolerance
Optimal Arousal Zone**

1. Ventral Vagal "Social Engagement" Response

State where emotions can be
tolerated and information
integrated

Hypoarousal Zone

3. Dorsal Vagal "Immobilisation" Response
Relative absence of sensation
Numbing of emotions
Disabled cognitive processing
Reduced physical movement

Adapted from Ogden, Minton, & Pain, 2006, p. 27, 32; Corrigan, Fisher, & Nutt, 2010, p. 2

Appendix K: S.M.A.R.T. Goals

SMART Goals

Specific	What **exactly** will you do?
Measurable	How will you know if you **meet** your goal?
Achievable	What **steps** are you going to take to reach your goal?
Relevant	What about your goal makes it **important** to you?
Timely	**When** do you want to complete your goal?

Appendix L: Food & Anxiety

AVOID THESE
ANXIETY TRIGGERS
LURKING IN YOUR FRIDGE

CAFFEINE

Too much caffeine can increase anxiety since caffeine stimulates the body's **"fight or flight"** response.

These symptoms typically occur when people consume **four or more cups of coffee.**

SUGAR

Sugar can create changes in the body by destabilizing brain activity—which heightens **symptoms of anxiety** and can even **trigger anxiety attacks.**

ALCOHOL

Alcohol changes levels of **serotonin** in the brain.

Serotonin is a **feel-good chemical** for the body.

SALT

Eating foods with too much salt **increases blood pressure,** which makes the heart need to **pump harder.**

When that happens, the body releases the stress hormone **adrenaline**—which paves the way for **anxious feelings.**

PROCESSED FOOD

Studies show a **connection** between processed food and an increase in **anxiety levels.**

Another study showed a link between a diet of **processed and fatty foods** and depression.

BEAT ANXIETY — WITH — THESE ANXIETY REDUCINGFOODS

ALMONDS
B vitamins
Selenium
Magnesium

ASPARAGUS
Folic acid

AVOCADOS
Vitamin B12

BLUEBERRIES
Anthocyanin
Vitamin C

DARK CHOCOLATE
Flavonoids

GREEN TEA
L-theanine

KEFIR
Probiotics

OATMEAL
Complex carbs

SALMON
Omega-3s

TURKEY
Tryptophan

TURMERIC
Curcumin

Appendix M: Sleep Hygiene

Healthy Sleep Hygiene

BEFORE BEDTIME

Avoid caffeine, nicotine and alcohol before bedtime

Avoid heavy meals within two hours of bedtime

Avoid energetic exercise within three hours of bedtime

GETTING READY TO SLEEP

Develop a bedtime ritual so that your body knows you are getting ready to go to sleep

Reduce extreme light, temperature, and noise in your bedroom

Include an hour of quiet time before bed such as reading, watching TV or listening to music

SLEEP TIME

Keep your sleep regular – same bedtime, same rise time. Aim for 8 hours of sleep each night.

Bedrooms are ONLY for sleep and sex

How many screens do you have in your bedroom?

If you can't sleep after 20 minutes, get up and do something boring until you feel tired, then try again.

Remember everyone has nights where they can't sleep.
The more you worry, the worse this worry can become.
If you are concerned about your sleep contact your family doctor.

AUCKLAND

Sleep Disordered Breathing Unit
Respiratory Services

sleep hygiene

What is Sleep Hygiene?

'Sleep hygiene' is the term used to describe good sleep habits. Considerable research has gone into developing a set of guidelines and tips which are designed to enhance good sleeping, and there is much evidence to suggest that these strategies can provide long-term solutions to sleep difficulties.

There are many medications which are used to treat insomnia, but these tend to be only effective in the short-term. Ongoing use of sleeping pills may lead to dependence and interfere with developing good sleep habits independent of medication, thereby prolonging sleep difficulties. Talk to your health professional about what is right for you, but we recommend good sleep hygiene as an important part of treating insomnia, either with other strategies such as medication or cognitive therapy or alone.

Sleep Hygiene Tips

1) **Get regular.** One of the best ways to train your body to sleep well is to go to bed and get up at more or less the same time every day, even on weekends and days off! This regular rhythm will make you feel better and will give your body something to work from.

2) **Sleep when sleepy.** Only try to sleep when you actually feel tired or sleepy, rather than spending too much time awake in bed.

3) **Get up & try again.** If you haven't been able to get to sleep after about 20 minutes or more, get up and do something calming or boring until you feel sleepy, then return to bed and try again. Sit quietly on the couch with the lights off (bright light will tell your brain that it is time to wake up), or read something boring like the phone book. Avoid doing anything that is too stimulating or interesting, as this will wake you up even more.

4) **Avoid caffeine & nicotine.** It is best to avoid consuming any caffeine (in coffee, tea, cola drinks, chocolate, and some medications) or nicotine (cigarettes) for at least 4-6 hours before going to bed. These substances act as stimulants and interfere with the ability to fall asleep

5) **Avoid alcohol.** It is also best to avoid alcohol for at least 4-6 hours before going to bed. Many people believe that alcohol is relaxing and helps them to get to sleep at first, but it actually interrupts the quality of sleep.

6) **Bed is for sleeping.** Try not to use your bed for anything other than sleeping and sex, so that your body comes to associate bed with sleep. If you use bed as a place to watch TV, eat, read, work on your laptop, pay bills, and other things, your body will not learn this connection.

7) **No naps.** It is best to avoid taking naps during the day, to make sure that you are tired at bedtime. If you can't make it through the day without a nap, make sure it is for less than an hour and before 3pm.

8) **Sleep rituals.** You can develop your own rituals of things to remind your body that it is time to sleep - some people find it useful to do relaxing stretches or breathing exercises for 15 minutes before bed each night, or sit calmly with a cup of caffeine-free tea.

9) **Bathtime.** Having a hot bath 1-2 hours before bedtime can be useful, as it will raise your body temperature, causing you to feel sleepy as your body temperature drops again. Research shows that sleepiness is associated with a drop in body temperature.

10) **No clock-watching.** Many people who struggle with sleep tend to watch the clock too much. Frequently checking the clock during the night can wake you up (especially if you turn on the light to read the time) and reinforces negative thoughts such as *"Oh no, look how late it is, I'll never get to sleep"* or *"it's so early, I have only slept for 5 hours, this is terrible."*

11) **Use a sleep diary.** This worksheet can be a useful way of making sure you have the right facts about your sleep, rather than making assumptions. Because a diary involves watching the clock (see point 10) it is a good idea to only use it for two weeks to get an idea of what is going and then perhaps two months down the track to see how you are progressing.

12) **Exercise.** Regular exercise is a good idea to help with good sleep, but try not to do strenuous exercise in the 4 hours before bedtime. Morning walks are a great way to start the day feeling refreshed!

13) **Eat right.** A healthy, balanced diet will help you to sleep well, but timing is important. Some people find that a very empty stomach at bedtime is distracting, so it can be useful to have a light snack, but a heavy meal soon before bed can also interrupt sleep. Some people recommend a warm glass of milk, which contains tryptophan, which acts as a natural sleep inducer.

14) **The right space.** It is very important that your bed and bedroom are quiet and comfortable for sleeping. A cooler room with enough blankets to stay warm is best, and make sure you have curtains or an eyemask to block out early morning light and earplugs if there is noise outside your room.

15) **Keep daytime routine the same.** Even if you have a bad night sleep and are tired it is important that you try to keep your daytime activities the same as you had planned. That is, don't avoid activities because you feel tired. This can reinforce the insomnia.

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HEALTHIEST SLEEPING POSITIONS

Your most loved sleeping pose could be giving you back & neck pain, tummy troubles, even premature wrinkles. Discover the best positions for your body—plus the one you may want to avoid.

GOOD: SLEEPING ON THE BACK

Prevents Neck & Back Pain
by maintaining a neutral position for head, neck & spine.

Reduces Acid Reflux
by keeping your head elevated above your stomach.

Minimizes Wrinkles
as nothing pushes against your face.

Bad for: Snoring

Your perfect pillow:
1 puffy one.
To keep your head & neck supported without propping your head up too much.

OR: SLEEPING ON THE SIDE

Bad for: Face and Breasts
Constant mushing of face from one side, & sagging of breasts is prominent.

Your perfect pillow
1 **thick** one.
To fill the space above your shoulder so your head & neck are supported in a neutral position.

Reduces Snoring
by elongating your spine.

Reduces Acid Reflux
by keeping your head elevated above your stomach.

Useful During Pregnancy
sleeping on the left side is ideal for blood flow.

BAD: FETAL POSITION

TRY NOT TO CURVE YOUR BACK TOO MUCH!

Increases Arthritic Pain
knees are bent for a long time during night, bad neck & spine posture

Restricts Diaphragmatic Breathing

Premature Facial Wrinkles
too much stress on the face and breasts

Useful During Pregnancy

Your perfect pillow
1 **thick** one.
To fill the space above your shoulder so your head & neck are supported in a neutral position.

AVOID: SLEEPING ON THE STOMACH

Difficult To Maintain A Neutral Spine Position

Puts Pressure On Joints & Muscles
which can irritate nerves & lead to pain, numbness, & tingling

Constant Incorrect Head Position May Lead To Aching

Keeping the face down keeps your upper airways more open. So if you snore & aren't suffering from neck or back pain, it's fine to try sleeping on your belly.

Your perfect pillow:
Either a 1 thin one or none at all.

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Appendix N: Skills & Strategies for Teaching Self-Care

TIP Guide – BC Mental Health and Substance Use Planning Council, May 2013
Individuals are encouraged to build on the positive things they are already doing to create healthier lifestyles and strengthen resources, capacities, and balance. When a particular strategy becomes a regular part of their day or week, they have a ready resource for difficult and distressing situations. The practitioner helps the individual build on current strengths and passions, and focus on small steps to sustain momentum.

1. **Eat regular, healthy, and balanced meals** including breakfast and a variety of fruits and vegetables. Minimize or eliminate refined sugars, carbohydrates, and caffeine.

2. **Get adequate sleep**. Getting enough sleep is as important as nutritious food or water. (http://www.health.harvard.edu/newsletters/Harvard_Mental_Health_Letter/2009/July/Sleep-and-mental-health.) When developing regular sleep habits, consider including the following guidelines: don't nap during the day; get exercise every day; reduce evening activities that disturb your sleep (caffeine, alcohol, watching TV); develop a bedtime routine (calming drink, face washing, teeth brushing); go to bed at the same time every night (before 11pm) and wake up at the same time every morning; if not asleep within 30 minutes, get up and do something rather than lying there tossing and turning (repeat as necessary).

3. **Meditation/mindfulness** strengthens your capacity to stay centered and watch sensations, thoughts, images, and emotions come and go. With no judgment, you can practice bringing your attention again and again to the space between your thoughts; the blue sky behind the clouds; the watcher who is watching the thoughts; the horizon. The benefits of meditation (a sense of calm, peace, and balance) can help carry you more calmly through your day. The emotional benefits of meditation include a new perspective on stressful situations; skills to manage stress; increased self-awareness; and attention and focus in the present moment. Types of meditation include guided visualization, mantra meditation, mindfulness meditation, Qi gong, Tai chi and Yoga (http://www.mayoclinic.com/health/meditation/HQ01070).

4. **Yoga** has benefits that are far-reaching: reduced stress; sound sleep; reduced cortisol levels; allergy/asthma symptom relief; lower blood pressure; lower heart rate; spiritual growth and sense of well-being; reduced anxiety and muscle tension; increased strength and flexibility; slowed aging (**http://www.mayoclinic.com/health/yoga/CM00004**). Before retiring at night, rest in the Child's Pose. With your head touching the ground, intentionally release any impressions you have absorbed through the day that are no longer helpful.

5. **Rhythmic physical activities and movements to support self-regulation and grounding**. Music, movement, singing, and use of rhythm have been noted to help with dysregulation of internal physiological rhythms [85]. In addition, regular, safe aerobic movement increases the 'feel-good' natural endorphins and helps the blood nurture and refreshes every organ and fiber of your being.

6. **Worry once**. There are a number of strategies to help manage worrying:
   • Ask "is this a problem that I can solve now or not?" If it is a problem that can be solved, you can engage in concrete problem-solving strategies. If it is not solvable (e.g., what if there's an earthquake?) then encourage riding the wave of emotions and tolerating the uncertainty.
   • Know the difference between planning and worrying. Scale your confidence levels after completing a well-thought out plan. This will support success and prevent the constant revisiting of worry.
   • Carry a worry notebook with you. Notice everything you worry about and every time you worry. Write it down in your worry book.
   • Give yourself a daily worry time. Pull out your notebook and "fly at it." The rest of the day, when worry surfaces, write it down and promise yourself that you will worry, but only in the designated worry time.
   • Instead of worrying 'on demand,' do something that takes your undivided attention where unwanted thoughts can't 'drive the bus': work on a puzzle, play an instrument, dance.

7. **Consult a spiritual advisor**. Many people have cultural and religious beliefs that include traditional methods of healing and spiritual connection. Check to see whether people identify with such beliefs and whether they are aware of how they can access this type of support.

Practice Traps—Skill Building and Self-Care Strategies

Some of the possible practice traps to be aware of when supporting skill development, include:

• Jeopardizing collaboration and safety by becoming the expert and telling those you are supporting what they need to do next.
• Not tailoring the approach; telling the individual what skill is needed without first asking what they are already doing, what they are interested in trying.
• Overloading and identifying too many skills or tools to practice and overwhelming the individual.
• Being too general or not providing enough direction. Containing overwhelming and distressing emotions requires regular practice and purposefulness.

Appendix O: Feeling Cards (print/write on 8x11 papers)

SAD	BITTER	TENSE
ISOLATED	PLEASANT	JEALOUS
SKEPTICAL	INADEQUATE	AMUSED
MAD	SHY	EMPTY
STIMULATED	EXHAUSTED	THANKFUL
SURPRISED	OPTIMISTIC	PLAYFUL
TRUSTING	PROUD	CRITICAL
HATEFUL	CONTENT	PRESSURED
AWARE	ENERGETIC	ANGRY
CHEERFUL	REJECTED	IMPORTANT
HOPEFUL	SLEEPY	HURT
STUPID	CHALLENGED	CLOSED
DISTANT	RELAXED	WARM
AWKWARD	ALONE	WITHDRAWN
HAPPY	FRUSTRATED	WORRIED
SCARED	INSPIRED	EXCITED
DETERMINED	APPRECIATED	ALIVE
PEACEFUL	DISTRACTED	ADEQUATE
FEARFUL	EAGER	LOVING
VULNERABLE	FRIGHTENED	UNCOMFORTABLE
THRILLED	JOYOUS	HATEFUL

Appendix P: Feeling Wheel

The Feeling Wheel

6-13-1

7/98

Appendix Q: Self-care Wheel

SELF-CARE
WHEEL

Physical
Safe housing
Regular medical care
Eat Healthy • Exercise
Be sexual • Get enough sleep
Take vacations • Take time off
Massages • Acupuncture
Bubblebaths • Kiss
Ask for nurture
Take a walk • Turn off
cell phone
Get "me" time

Psychological
Self-reflection
Therapy • Journal
Self-awareness • Sensory engagement
Aromatherapy • Draw
Paint • Go to symphony or ballet
Relax in the sun • Garden
Read a self-help book • Join a
support group • Think about
your positive qualities
Practice asking and
receiving help

Emotional
Affirmations
Self-love • Self-compassion
Cry • Social justice engagement
Laugh • Say "I Love You"
Watch a funny movie
Find a hobby • Flirt
Buy yourself a present
Cuddle with your pet
Tell yourself
"You are gorgeous!"
Practice Forgiveness

Professional
Take time for lunch
Set boundaries • Do not work overtime
Leave work at work
Do not work during your time off
Get regular supervision • Get
support of colleagues • Take mental
health days • Learn to say NO
Plan your next career
move • Take a class
Take all vacation
and sick days

Personal
Learn who you are
Figure out what you
want in life • Plan
Short and Long-term Goals
Make a Vision Board
Foster friendships • Go on dates
Get coffee with a friend
Write a poem or a book • Just relax
Get out of debt • Spend time
with your family • Cook out
Learn to play guitar

Spiritual
Self-reflection
Go into nature
Find spiritual
community • Self-cherish
Meditate • Sing • Dance
Play • Be inspired
Take yoga • Play with children
Bathe in the ocean • Watch sunsets
Pray • Find spiritual mentor
Volunteer for a cause
Foster self-forgiveness

LIFE
SELF-CARE WHEEL
BALANCE

This Self-Care Wheel was inspired by and adapted from "Self-Care Assessment Worksheet"
from *Transforming the Pain: A Workbook on Vicarious Traumatization* by Saakvitne, Pearlman & Staff
of TSI/CAAP (Norton, 1996). Created by Olga Phoenix Project: Healing for Social Change (2013).
Dedicated to all trauma professionals worldwide.
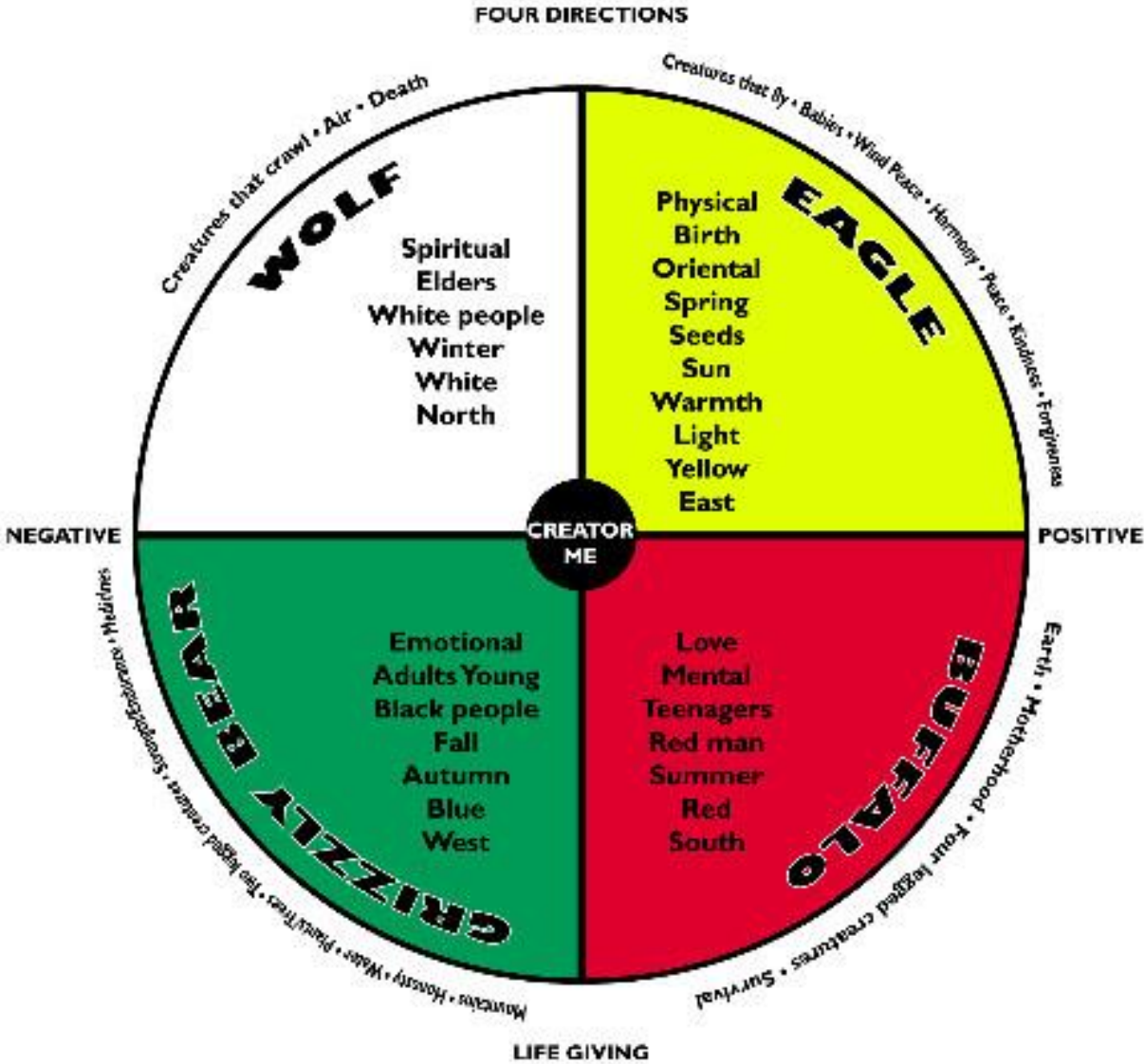**www.OlgaPhoenix.com**
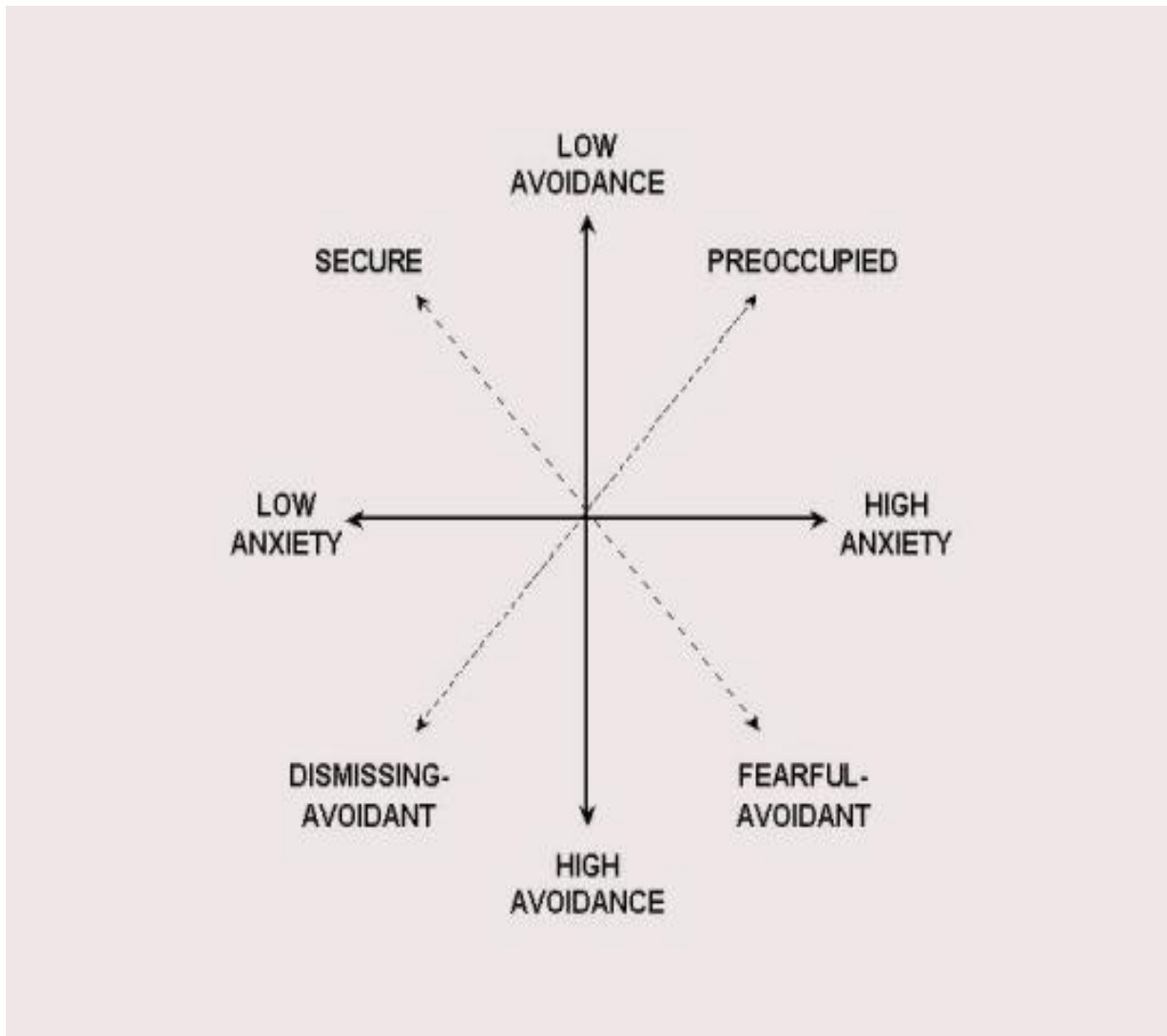
Appendix R: The Grieving Wheel

Appendix S: Medicine Wheel

Appendix T: Attachment Styles

Fearful-avoidant individuals: those high on both dimensions of avoidance and anxiety, experience attachment-related anxiety yet avoid intimate contact with others. In essence, they alternate between deactivation (because of fears of rejection) and hyper-activation(because of fears of abandonment). Some theorists have referred to this style as disorganized because people with this style engage in both activating and deactivating strategies. Indeed, these individuals are uniquely conflicted because they may withdraw from therapy and avoid intimacy with others in relationships while simultaneously longing for closeness and connection. Their inconsistent behaviors make it particularly hard for them to maintain healthy relationships and regulate emotions under duress (Mikulincer & Shaver, 2007b as cite in Marmarosh et. al., 2013).

***Dismissing-avoidant individuals*:** those high on avoidance but low on anxiety, often keep to themselves and can appear self-reliant. They deny fears of being alone or abandoned and do not generally seek out emotional support from others. They tend to use deactivating strategies—that is, they push others away—to deflect intimate contact, such as making a joke or changing the subject after someone shares something vulnerable. These individuals withdraw and minimalize attachment-based needs, and they deny anxiety about rejection and abandonment (Mikulincer & Shaver, 2007b as cited in Marmarosh et. al., 2013).

Preoccupied individuals: those low on avoidance but high on anxiety, are often described as clingy or needy. They report more anxiety about relationships and are hypersensitive to signs of rejection or abandonment. These individuals engage in hyper-activation strategies—that is, they exert intense efforts to achieve and maintain intimate contact—and they are preoccupied with fears of being alone. These individuals tend to seek out others for comfort but are often dissatisfied with the support they receive (Mikulincer & Shaver, 2007b, as cited in Marmarosh et. al., 2013).

Secure individuals: those low on both dimensions of avoidance and anxiety, neither avoid intimacy with others nor fear rejection or abandonment. They feel capable of seeking out support and trusting others, and they tend to report caring connections with attachment figures and compassion and empathy for romantic partners and family members. Even when there are challenges within a relationship, these individuals tend to forgive others (Mikulincer & Shaver, 2007b as cited in Marmarosh et. al., 2013).

Questions to discuss in pairs or in a group:
What's your attachment style?
Has is changed over time, if it has, how so?
How is your attachment style affected when you are highly stressed? (What's your default style?)
What affect does your attachment style have on the groups you participate in?
What attachment style do you have difficulty dealing with in other people?
How do you usually react to those people? What would help you to respond differently?

Appendix U: Relationship Questionnaire (RQ)

For more information on adult attachment, visit this website:
http://psychology.ucdavis.edu/labs/Shaver/measures.htm

Bartholomew, K., & Shaver, P. R. (1998). Methods of assessing adult attachment: Do they converge? In J. A. Simpson & W. S. Rholes (Eds.). *Attachment theory and close relationships* (pp. 25–45). New York: Guilford Press.

In recent years, several streams of research have emerged from Bowlby's (1988) and Ainsworth's (1982) attachment theory. Originally, the theory was aimed at explaining child and adult psychopathology in terms of non-optimal relationships between children and their caregivers, or "attachment figures." According to attachment theory, the long-term effects of early experiences with caregivers are due to the persistence of "internal working models" -- cognitive / affective schemas, or representations, of the self in relation to close relationship partners (Bartholomew, 1990; Shaver, Collins, & Clark, 1996). Theoretically, these representations influence a person's expectations, emotions, defenses, and relational behavior in all close relationships. Although the theory does not assume or require that internal working models persist without change across the life span, both theory and empirical evidence from longitudinal studies have led researchers to suspect that the effects of childhood attachment relationships extend into adulthood, where they can be seen in the domains of parenting and close peer relationships, including romantic relationships (e.g., Bartholomew, 1990, 1993; Main, Kaplan, & Cassidy, 1985; Shaver, Hazan, & Bradshaw, 1988; Weiss, 1982).

Scale:
Following are four general relationship styles that people often report. Place a checkmark next to the letter corresponding to the style that best describes you or is closest to the way you are.

____ A. It is easy for me to become emotionally close to others. I am comfortable depending on them and having them depend on me. I don't worry about being alone or having others not accept me.

____ B. I am uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I worry that I will be hurt if I allow myself to become too close to others.

____ C. I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them.

____ D. I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me.

Now please rate each of the relationship styles below to indicate how well or poorly each description corresponds/fits to your general relationship style.

Style A

1	2	3	4	5	6	7
Disagree Strongly			Neutral/Mixed			Agree Strongly

Style B

1	2	3	4	5	6	7

Disagree   Agree
Strongly   Neutral/Mixed   Strongly

Style C

1	2	3	4	5	6	7

Disagree   Agree
Strongly   Neutral/Mixed   Strongly

Style D

1	2	3	4	5	6	7

Disagree   Agree
Strongly   Neutral/Mixed   Strongly

Share your thoughts with a partner or in small groups for 10 minutes then come back to the large group and share any highlights or "ah ha: moments.
What did you *think* about during this activity, how do you *feel* about your style?
Any surprises, discomfort? Was it easy, difficult, what are you feeling now?

Attachment Styles

Fearful-avoidant individuals: those high on both dimensions of avoidance and anxiety, experience attachment-related anxiety yet avoid intimate contact with others. In essence, they alternate between deactivation (because of fears of rejection) and hyper-activation(because of fears of abandonment). Some theorists have referred to this style as disorganized because people with this style engage in both activating and deactivating strategies. Indeed, these individuals are uniquely conflicted because they may withdraw from therapy and avoid intimacy with others in relationships while simultaneously longing for closeness and connection. Their inconsistent behaviors make it particularly hard for them to maintain healthy relationships and regulate emotions under duress (Mikulincer & Shaver, 2007b as cite in Marmarosh et. al., 2013).

Dismissing-avoidant individuals: those high on avoidance but low on anxiety, often keep to themselves and can appear self-reliant. They deny fears of being alone or abandoned and do not generally seek out emotional support from others. They tend to use deactivating strategies—that is, they push others away—to deflect intimate contact, such as making a joke or changing the subject after someone shares something vulnerable. These individuals withdraw and minimize attachment-based needs, and they deny anxiety about rejection and abandonment (Mikulincer & Shaver, 2007b as cited in Marmarosh et. al., 2013).

Preoccupied individuals: those low on avoidance but high on anxiety, are often described as clingy or needy. They report more anxiety about relationships and are hypersensitive to signs of rejection or abandonment. These individuals engage in hyper-activation strategies—that is, they exert intense efforts to achieve and maintain intimate contact—and they are preoccupied with fears of being alone. These individuals tend to seek out others for comfort but are often dissatisfied with the support they receive (Mikulincer & Shaver, 2007b, as cited in Marmarosh et. al., 2013).

Secure individuals: those low on both dimensions of avoidance and anxiety, neither avoid intimacy with others nor fear rejection or abandonment. They feel capable of seeking out support and trusting others, and they tend to report caring connections with attachment figures and compassion and empathy for romantic partners and family members. Even when there are challenges within a relationship, these individuals tend to forgive others (Mikulincer & Shaver, 2007b as cited in Marmarosh et. al., 2013).

Appdendix V: Johari Window

Johari Window Questionnaire

Instructions:
• Carefully read each numbered item and its statements marked "A" and "B."
• Assign a point value to the A and B statements as follows:
> • The total point value for A and B added together is **five (5).**
> • If statement A is most similar to what you would do, mark **5** for A and **0** for B (**0**, very unlikely, **5** very likely).
> • If A is not wholly satisfactory, but in your judgment better than B, mark **4** or **3** for A and **1** or **2** for B.
> • The converse is true: if B is best, mark **5** for B and **0** for A and so on (choose best fit/true for you between 0-5).

1) If a friend of mine had a personality conflict with a mutual acquaintance of our and I thought it was important for them to get along, I would:
_____ A. Tell my friend I felt s/he was partially responsible for any problem with this other person and try to let him/her know how the person was being affected by him/her.
_____ B. Not get involved because I wouldn't be able to continue to get along with both of them once I had entered in any way.

2) If one of my friends and I had a heated argument in the past and I realized that s/he was ill at ease around me from that time on, I would:
_____ A. Avoid making things worse by discussing his/her behavior and just let the whole thing drop.
_____ B. Bring up his/her behavior and ask him/her how s/he felt the argument had affected our relationship.

3) If a friend began to avoid me and act in an aloof and withdrawn manner, I would:
_____ A. Tell him/her about his/her behavior and suggest that s/he tell me what was on his/her mind.
_____ B. Follow his/her lead and keep our contact brief and aloof since that seems to be what s/he wants.

4) If two of my friends and I were talking and one of my friends slipped and brought up a personal problem of mine that involved the other friend, of which s/he was not yet aware, I would:
_____ A. Change the subject and signal my friend to do the same.
_____ B. Fill in my uniformed friend on what the other friend was talking about and suggest that we go into it later.

5) If a friend of mine were to tell me that, in his/her opinion, I was doing things that made me less effective than I might be in social situations, I would:
_____ A. Ask him/her to spell out or describe what s/he has observed and suggest changes I might make.

_____ B. Resent his/her criticism and let him/her know why I behave the way I do.

6) If one of my friends aspired to an office in our organization for which I felt s/he was unqualified, and if s/he had been tentatively assigned to that position by the leader of our group, I would:

_____ A. Not mention my misgivings to either my friend or the leader of our group and let them handle it in their own way.

_____ B. Tell my friend and the leader of our group of my misgivings and then leave the final decision up to them.

7) If I felt that one of my friends was being unfair to me and his/her other friends, but none of them had mentioned anything about it, I would:

_____ A. Ask several of these people how they perceived the situation to see if they felt s/he was being unfair.

_____ B. Not ask the others how they perceived our friend, but wait for them to bring it up with me.

8) If I were preoccupied with some personal matters and a friend told me that I had become irritated with him/her and others and that I was jumping on him/her for unimportant things, I would:

_____ A. Tell him/her I was preoccupied and would probably be on edge for a while and would prefer not to be bothered.

_____ B. Listen to his/her complaints but not try to explain my actions to him/her.

9) If I had heard some friends discussing an ugly rumor about a friend of mine which I knew could hurt him/her and s/he asked me what I knew about it, if anything, I would:

_____ A. Say I didn't know anything about it and tell him/her no one would believe a rumor like that anyway.

_____ B. Tell him/her exactly what I had heard, when I had heard it, and from whom I had heard it.

10) If a friend pointed out the fact that I had a personality conflict with another friend with whom it was important for me to get along, I would:

_____ A. Consider his/her comments out of line and tell him/her I didn't want to discuss the matter any further.

_____ B. Talk about it openly with him/her to find out how my behavior was being affected by this.

11) If my relationship with a friend has been damaged by repeated arguments on an issue of importance to us both, I would:

_____ A. Be cautious in my conversations with him/her so the issue would not come up again to worsen our relationship.

_____ B. Point to the problems the controversy was causing in our relationship and suggest that we discuss it until we get it resolved.

12) If in a personal discussion with a friend about his/her problems and behavior s/he suddenly suggested we discuss my problems and behavior as well as his/her own, I would:

_____ A. Try to keep the discussion away from me by suggesting that other, closer friends often talked to me about such matters.

_____ B. Welcome the opportunity to hear what s/he felt about me and encourage his/her comments.

13) If a friend of mine began to tell me about his/her hostile feelings about another friend whom s/he felt was being unkind to others (and I agreed wholeheartedly), I would:

_____ A. Listen and also express my own feelings to me/her so s/he would know where I stood.

_____ B. Listen, but not express my own negative views and opinion because s/he might repeat what I said to him/her in confidence.

14) If I thought an ugly rumor was being spread about me and suspected that one of my friends had quite likely heard it, I would:

_____ A. Avoid mentioning the issue and leave it to him/her to tell me about it if s/he wanted to.

_____ B. Risk putting him/her on the spot by asking him/her directly what s/he knew about the whole thing.

15) If I had observed a friend in social situations and thought that s/he was doing a number of things which hurt his/her relationships, I would:

_____ A. Risk being seen as a busy body and tell him/her what I had observed and my reactions to it.

_____ B. Keep my opinion to myself rather than be seen as interfering in things that are none of my business.

16) If two friends and I were talking and one of them inadvertently mentioned a personal problem which involved me, but of which I knew nothing, I would:

_____ A. Press them for information about the problem and their opinions about it.

_____ B. Leave it up to my friends to tell me or not tell me, letting them change the subject if they wished.

17) If a friend seemed to be preoccupied and began to jump on me for seemingly unimportant things, and became irritated with me and others without real cause, I would:

_____ A. Treat him/her with kid gloves for awhile on the assumption that s/he was having some temporary personal problems which were none of my business.

_____ B. Try to talk to him/her about it and point out to him/her how his/her behavior was affecting people.

18) If I had begun to dislike certain habits of a friend to the point that it was interfering with my enjoying his/her company, I would:

_____ A. Say nothing to him/her directly, but let him/her know my feelings by ignoring him/her whenever his/her annoying habits were obvious.
_____ B. Get my feelings out in the open and clear the air so that we could continue our friendship comfortably and enjoyably.

19) In discussing social behavior with one of my more sensitive friends, I would:
_____ A. Avoid mentioning his/her flaws and weaknesses so as not to hurt his/her feelings.
_____ B. Focus on his/her flaws and weaknesses so s/he could improve his/her interpersonal skills.

20) If I knew I might be assigned to an important position in our group and my friends' attitudes toward me had become rather negative, I would:
_____ A. Discuss my shortcomings with my friends so I could see where to improve.
_____ B. Try to figure out my own shortcomings by myself so I could improve.

Calculating Your Scores:
Copy your point values from the questionnaire to the appropriate spaces below. Add up the total points for each column.

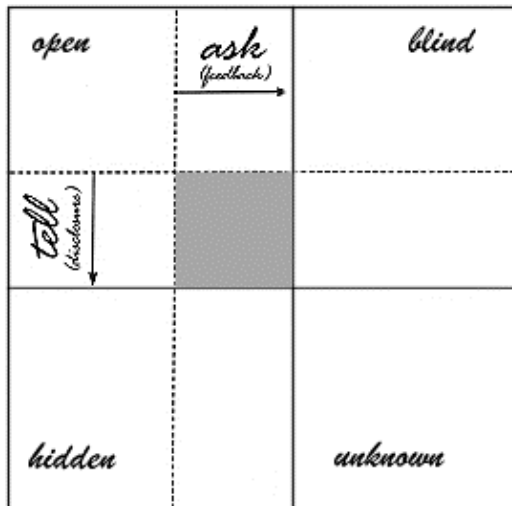| **Solicits Feedback:**	**Willing to Give Feedback:**
2B_____	1A_____
3A_____	4B_____
5A _____	6B _____
7A _____	9B _____
8B _____	11B_____
10B_____	13A_____
12B_____	15A_____
14B_____	17B_____
16A_____	18B_____
20A_____	19B_____
Total _____	Total _____

Charting Your Scores:
• On the top line of the graph below, mark your score for Solicits Feedback, then draw a vertical line downward.
• On the left line of the graph below, mark your score for Willingness to Self-Disclose/Gives Feedback, then draw a line across horizontally (left to right).

In pairs or as a small group please discuss the following:

1) What did you learn about yourself today? Were you surprised by anything?

2) Describe your experiences with disclosure and feedback.

3) How are others impacted by your blind spots?

4) How will you use what you learned today in your professional practice?

Appendix W: TIP Preparation for Facilitators

In preparation for [work] meeting with someone coming for mental health and/or substance use support, I will ground myself by…

_____
_____
_____

I will remind myself that…

_____
_____
_____

Steps I will take to understand cultural context and diversity…

_____
_____
_____

I will know the work is starting to have a negative effect on me when…

_____
_____
_____

If that starts to happen, I will ground myself by…

_____
_____
_____

Someone who can offer me support
1) At work: _____
2) Outside of work: _____

Two self-care strategies that help me manage are…
1._____
_____
_____
2._____
_____
_____

~adapted from TIP Guide, BC Mental Health and Substance Use Planning Council, May 2013

Appendix X: Addressing Countertransference Self-Assessment

Countertransference is often defined as what takes place when a practitioner/clinician acts out in some way in response to a patient/client's behavior as a result of the practitioner's own unresolved personal issues, biases, or exaggerated reactions. These inappropriate reactions can be either negative, as with patients whom the clinician dislikes, or positive, as with the clients the practitioner finds attractive or pleasing. Read over and answer following worksheets. With a partner, discuss the questions you had difficulty answering. Share what you learned about yourself in the process? (Refer to Appendix A: 33 Quick Ways to Ground)

Personal Examples. Each of the following signs and symptoms may be the result of a clinician having a very strong personal reaction to a client, one that is compromising the work. Supply a personal example for each one (you will not be asked to share this with anyone).

- You find it difficult to feel caring and respectful toward a client.
  -

- You are bored much of the time when with a particular patient and can't seem to concentrate on the session.
  -

- You make a series of inaccurate interpretations/assumptions of a client's feelings due to your own over-identification with the issues.
  -

- You feel generally blocked, helpless and frustrated when with a particular patient.
  -

- You have a tendency to speak or think about a client in derogatory terms.
  -

- You are aware that you are working harder than the patient.
  -

- You find yourself more than a little attracted (or repulsed) to a particular client or to certain kinds of individuals who share certain characteristics (such as those who are wealthy, or rebellious, personalities, addictions).
  - ○

Consistently throughout your career, no doubt there have been particular clients who have been able to get under your skin with relative ease. These may include those you find especially appealing. You may make allowances for them that you never would make for others. There are also clients who provoke in you rather strong feelings of anger, frustration, envy, pit or impatience. Further evidence that these *countertransference* reactions are the result of your own unresolved issues/memories is that not all clinicians react as you to these same individuals.

Processing Countertransference Reactions. Before pilots begin takeoff procedures on the runway, they first go through a checklist to ensure that everything is in order. Flaps down (or up)? All engines functioning? And so on. In a similar manner, it is often useful when you encounter difficulty with a patient to begin solving it by asking yourself a series of questions that assess both your professional dimensions and your personal reactions.

Bring to mind a difficult patient who challenges your sense of competence. Picture the person as clearly as you can, focusing in particular on the specific behaviors that trigger your most extreme reactions. Now, answer the following questions about the interaction:

- What specifically lets you know for sure that your relationship with this patient is *not* working?

- How are you overreacting to what is taking place between the two of you?

- What might you be expecting from this person that he or she is unwilling or unable to do?

- How might you alter your working relationship in a way that seems more useful in this case?

- Who does this client remind you of, and how might you be distorting the way he or she appears to you?

- What buttons in you are being pushed by this client?

- In what ways are you making things more difficult than they need to be?

Avoid Blaming. Start with the assumption that conflicts are the result of two people contributing to the problem. Rather than blaming your difficult clients for being resistant or obstructive, assume that *they are doing the best they can with what they have to work with at the time*. In other words, they are trying to cooperate with you, but in ways that are different from what you expect or prefer. If this is the case, then you are an equal partner in the impasse that has emerged. In any case that has become problematic, stop concentrating on the patient's resistant behavior, their defensives and fames; look instead at your own contributions to what has transpired. Furthermore, assume that whatever has happened in this difficult relationship is part of an ongoing pattern, not just in the patient's life but in your own.

Identify Triggers

- What type of client has most consistently "gotten to you" in your career?

- In what ways is your competence challenged by these individuals?

- How have you colluded with a client because of a countertransference attraction or over-identification with his or her issue?

- What do you expect of all your patients that they sometimes seem unwilling or unable to deliver?

Explore the origin of conflict

- What is the disagreement between you and your client *really* about?

- How is this conflict familiar in your life experience? What does it remind you of?

- How are you experiencing a loss of control?

Commit yourself to act differently

- How would you like things to be different?

- How can you strengthen your resolve?

- What are you prepared to commit yourself to doing differently?

Experiment with alternative strategies

- What have you tried over and over again that *hasn't* worked?

- Which of these strategies are you willing to discontinue?

- What are three things you might do instead?

1)

2)

3)

~adapted from *The Therapist's Workbook: Addressing Countertransference and Other Personal Reactions* (Kottler, 2012)

Appendix Y: Hazards Self-Assessment

Rate these hazards on a scale of 1 to 3, being as honest as you can with yourself about the extent to which each of them is or may be a problem for you. If you sense that you may be denying or disowning some of these issues, discuss them with others you know well and trust to be truthful later.

Hazard Rating Scale
 Not a problem: 1
 Could be a problem: 2
 Definitely a problem: 3

Common Hazardous Attitudes
_____ Arrogance: I am perceived by others as a know-it-all.
_____ Omnipotence: I inflate my sense of power and control.
_____ Cynicism: I act as though I've seen it all, and I appear skeptical.
_____ Narcissism: I take myself too seriously, and/or inflate my self-importance.
_____ Hypocrisy: I don't practice in my own life what I expect of others.

Comments/insights:

Self-Defeating Work Habits
_____ Work-a-holism: I work too many hours and/or over-structure my life.
_____ Negligence: I act out by failing to complete paperwork/charting in a timely manner.
_____ Boredom: I feel bored and stale sitting with patients, like I'm going through the motions.
_____ Isolation: I spend too much time alone.
_____ Unidimensionality: I hang around only with other practitioners and talk about work-related stuff.

Comments/insights:

Other Side Effects
_____ Futility: I get discouraged and frustrated with progress (or lack thereof) in my work.
_____ Fatigue: I lead a lifestyle that drains me of energy.
_____ Intellectualizing: I restrict my degree of emotional expressiveness.
_____ Mistrust: I find it difficult to experience intimacy in my personal life.
_____ Relationships: I face a number of conflicts with colleagues at work.

Comments/insights:

Formulating a Self-Diagnosis

Now that you have completed the hazard assessment "intake questionnaire," create a kind of

diagnostic impression of yourself based on the date generated. I am not talking about

choosing a label from *DSM,* but rather about writing a summary report describing yourself as

if you were the patient who just sat down.

For example, I might write about myself as follows:
This is an individual with a high level of need for approval, which he can't seem to satisfy. He reports that his ambition and drive to succeed seem out of control, to the point where he is often planning for the future rather than enjoying the present. He appears to struggle with boredom a lot, stirring things up in his life periodically as a way to meet his need for novelty and stimulation. Although he says that he wants more intimate friendships in his life, he reports that he has not been successful in making that happen to the extent that he'd like. Issues of power and control, two main themes in his life, might interfere with this ability and willingness to compromise in relationships.

Write a similar case report and diagnostic impression of your own patterns.

You don't have to share this but if some people are willing to share in pairs or with the group

that would be helpful.

~adapted from *The Therapist's Workbook: Identifying Sources of Stress* (Kottler, 2012).

Appendix Z: Building and Maintaining Support Self-Assessment

This preliminary inventory should represent those current relationships that sustain you most effectively. They are hardly enough to provide all the support you need—and deserve—but they are models for what you care about the most.

Review Appendix C: Teaching Self-Care Strategies.

Pushing People Away

Assume for the moment that one reason you don't have enough support in your life is because of things you do to keep people at a distance. Some of this behavior could be intentional on your part, although unconscious motives may also be operating.

Check the items in this exercise that apply to the way you see yourself functioning in relationship, and supply an example of a recent time when you engaged in this behavior.

- Making yourself inaccessible to others.

    o Example: "If I don't go out much or put myself in situations where I meet new people, it just isn't going to happen. Sometimes I can be a bit of a recluse."

_____
_____
_____

- Being critical and judgmental toward others.
    o Example: "I spend a lot of time acting cynical about the way other people behave. It makes me feel superior, but it also distances me; I don't give others a chance to know me, or me to know them."

_____
_____
_____

- Seeking to control relationships in ways that make others become frustrated.
    o Example: "I like to think I'm pretty flexible, but in actuality I work behind the scenes to get my way. I might win the battle, but at great cost."

_____
_____
_____

- Refusing to initiate contact or take risks with people I perceive as attractive or interesting.
    - Example: "When at social gatherings, I interact with the same familiar people, even though I'd very much like to make new contacts and connections."

_____
_____
_____

- Hiding behind your role as a practitioner to prevent others from getting close to you.
    - Example: "I notice that much of the time I end up being the listener, the one with the answers. Yet even when people try to get to know me better, I deftly switch the focus back to them, because that's where I'm comfortable.

_____
_____

- Being withholding.
    - Example: "I am withholding with my patients/clients as well as with my family. I tend to pout when I don't get my way. I say to myself, 'Okay, you don't want what I'm offering? Fine.' Then I pull away to punish them."

_____
_____

- Refusing to invest sufficient time and energy in relationships; failing to make them a priority.
    - Example: "I say I want more support in my life, more intimate relationships, but I lack the initiative to follow through on my intentions. It's so much easier to remain in my comfortable, flawed little world."

_____
_____

It's likely as a result of reviewing how you might be keeping people at a distance and thus undermining potential for a more solid support system, you have discovered several self-defeating behaviors in yourself. To change this pattern, you are going to have to take decisive action.

What actions are you willing to commit to taking in your efforts to build a more loving and satisfying support system?

-

-

-

What are you willing to commit to doing to move what has been getting in your way?

-

-

-

Based on the commitment you've just made, identify sequential steps you intend to follow to achieve your ultimate goals.

1.

2.

3.

~adapted from The Therapists Workbook: Building and Maintaining a Support System (Kottler, 2012)