Group Treatment Manual

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Research is conducted on critical and emerging issues surrounding the funding, delivery, and outcomes of public behavioral healthcare and the civil and criminal justice systems. Faculty conducts research to validate best practices and to encourage their implementation in community settings.

Consultation is provided to a variety of state agencies, including the Department of Children and Families, the Office of Court Administration, the Department of Juvenile Justice, the Department of Health, and the Department of Corrections. The Department's focus is on those areas where law and public policy intersect with behavioral health services and spans a wide range of topics and specialties.

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Training programs are offered by the Department's faculty and staff throughout Florida in the areas of forensics, substance abuse, treatment planning, co-occurring disorders, homelessness, informed consent, civil commitment, and treatment and policy issues in trauma and gender-specific issues.

For copies of this manual or for further information on the Triad Women's Project please contact:

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INTRODUCTION

Women who have survived violence and abuse may also have substance use and mental health disorders. The Triad Women's Group was developed as a healing response to the wounds of women's lives. The group is a collaboration of clinicians, consumer/survivor/recovering women, researchers and behavioral healthcare administrators. Each person also brought experience and expertise in various areas to the table including substance use disorders, psychiatric disorders, trauma-related issues and the intersections of these fields.

The result is a unique, practical and effective manual for a group treatment that works with women recovering from substance use disorders, to empower them to improved mental health, and to support their survival from violence and trauma. This violence may have been physical or sexual, may have occurred at any age including recent victimization, and may be by strangers or people known by the women.

With nearly three years experience providing Triad Women's Groups, we have learned a great deal and are prepared to disseminate the model. Service providers and group facilitators report enjoying using the manual. The group fits easily within their framework of community mental health centers and substance abuse treatment facilities. Triad groups are successfully being offered in outpatient and residential settings. The group is being offered in jails with modifications.

DEVELOPING THE TRIAD GROUP

The Triad Women's Project grew under the auspices of the Substance Abuse and Mental Health Services Administration's (SAMHSA's) "Women with Co-occurring Disorders and Violence Study". The project involves integrative strategies and integrated interventions including a targeted case management team, a peer support group, and a group therapy – the Triad Women's Group.

Dr. Arthur Cox and his staff at the Florida Center Florida Center for Addictions and Dual Disorders in Avon Park, Florida had developed a mixed gender trauma treatment group for people with co-occurring mental health and substance use disorders. To enhance and refine the group a committee met for one year, creating group sessions, piloting them with clients, and then revising them based on feedback from the group facilitators and the women themselves. We established an inclusive and collaborative method of developing the group. In order for groups to be respectful, sensitive, and empowering for group participants, we sought input from consumers

The committee began its work by developing a consensus on treatment principles (Appendix A) and further articulated its understanding in a statement on the development and course of co-occurring disorders and the impact of violence on the lives of these women (Appendix B). The principles and statement underlie the interventions of this project.

In an unusual and productive process the committee heard strong opinions, thoughts and feelings from the fields of substance abuse, mental health and trauma recovery, consumer empowerment and co-occurring disorders. By fully discussing and reviewing seemingly contradictory issues

such as, “power” and “powerlessness” the committee reached consensus on principles. In this case it was accomplished by respecting both the AA tradition of admitting powerlessness over a substance and trauma recovery principles of developing ones own sense of personal power.

The services researchers on the committee carefully reviewed the literature. They and the clinicians had been influenced in their work especially by the work of John Briere (1996) and his thoughts on group work with adults molested as children; Maxine Harris (1998) and her colleagues at Community Connections and their work in dealing with trauma issues for women with severe mental illnesses; Evans and Sullivan (1995) and their compassionate work combining their experience with addictions and trauma; and finally for the clinically effective and well demonstrated work of Marsha Linehan (1993) on training people with borderline personality disorder in cognitive behavioral skills.

One of the primary hypotheses underlying this project is that integrated treatment for mental health disorders, substance abuse, and trauma will be more effective than treatment that addresses these problems separately.

Existing integrated group interventions described in the literature have focused on trauma and addiction, or trauma and mental health; but our committee did not uncover group interventions that addressed all three issues simultaneously.

TARGET POPULATION

The Triad Women’s Group was developed for women who have experienced violence and have both substance abuse and mental health problems. The group might not be appropriate for women that have never been the victims of violence or abuse either as children or adults.

In terms of the timing of participation in the group, once the most immediate issues for women in treatment have been met, this group has been shown to be appropriate. Issues that may need to be addressed first include an acute psychotic episode, medical detoxification or stabilization from an acute psychotic episode. The group then addresses all issues in an integrated fashion, so it is not necessary to “treat the substance abuse first” or for women to be completely stabilized psychiatrically before beginning group.

The groups are designed to be effective for women with a wide range of problems including thought disorders, mood disorders, personality disorders, substance-related disorders, post traumatic stress disorder, and other anxiety disorders.

Understanding the role of psychotropic medications, the nature of symptoms, and possible reactions to medications are important goals for the group. Facilitators will need to accurately identify all types of mental health symptoms including positive (hallucinations, delusions) and negative (apathy, social withdrawal) symptoms and have the skills to respond effectively. Women who have been severely abused in childhood may have PTSD or dissociative disorders. This may not have been diagnosed previously.

Women in the groups may or may not have substance dependence. For women who abuse substances, but are not substance dependent as defined by the *DSM-IV* (see Appendix C), discussion may focus on the exacerbating effect of some drugs on mental health symptoms or the members' ability to stay safe. In many settings women are required by the program to remain abstinent. In some outpatient settings abstinence is a goal but not a requirement for participation.

DIVERSE NEEDS

Many group members are mothers, and many of them have lost custody of their children. For many women keeping or regaining custody of their children is the primary motivation for participation in substance abuse treatment. Many of the skills learned in group such as emotional management and effective communication also increase parenting skills. Knowledge such as the difference between abuse and discipline is also helpful. This is not, however, a parenting class and cannot substitute for a course specifically designed for that purpose.

Also, women come from a variety of cultural backgrounds that have different beliefs and attitudes about women's roles, the use and abuse of substances, mental illness, violence, and childcare. Important cultural differences exist in how violence, substance abuse, and mental illness impact women, how women accept help, and how women recover. Facilitators of groups must be sensitive to differences in culture, parental status, sexual orientation, physical ability, age, trauma history, and marital status. Recognizing and appreciating their diverse needs helps each member appreciate her own uniqueness and strengths.

The diversity among group members is a strength, however special attention may need to be given to assure that minority members feel comfortable. Several facilitators have expressed concern that women from racial, ethnic, and sexual orientation minorities do not fully participate when they are overwhelmingly "outnumbered". Facilitators report more involvement when there was at least one similar minority group member. This is not always possible to arrange however and attention may be needed to create a secure, accepting atmosphere for minority members by supplementing the group material to meet their needs.

GOALS OF THE TRIAD WOMEN'S GROUP

The group is designed to achieve several major behavioral healthcare goals; specific outcomes may vary for different women or groups of women.

The goals of treatment include:

- Maintain personal safety
- Reduce psychiatric symptoms
- Increase abstinence for those with substance dependence
- Reduce use by those with substance abuse disorder
- Reduce trauma-related symptoms associated with histories of violence/abuse

The group is designed to accomplish this by the processes of:

- Building problem-solving skills
- Maintaining recovery and preventing relapse

- Assisting women to build on their strengths
- Building social supports and interpersonal effectiveness
- Enhancing members' capacities to cope with distress
- Building emotional regulation skills
- Addressing triggers for substance use
- Increasing awareness of abusive relationships

To facilitate short-term treatment planning, each group includes specific goals and objectives for that session.

GROUP FORMAT

The group is designed to meet once a week for two hours. Two hours allows group members time to explore and process emotionally difficult material. Having this amount of time also helps create a safe and secure environment. In outpatient settings, especially, some women will be in non-supportive living environments and their only opportunity to explore this material will be in the group setting.

The group is structured into four phases with four sessions per phase, for a total of sixteen sessions or chapters. Members may continue to attend the group even when they have completed the 16 chapters. Our experience is that many members are motivated to review the material again and this proves very helpful to them. They can contribute their recovery experiences to new members. Due to a limited number of group openings, priority is given to new members before agreeing to let a member repeat sessions.

There is a great deal of material in each session. The facilitator may decide to spread one Chapter over 2 or 3 sessions if the group appears to be very important for this set of members. Another option is to review some of the discussion questions in each Chapter and choose those that are most relevant to this particular group of members.

GROUP SIZE

The ideal size for the group is 5 to 10 members. Fewer members reduces the opportunities for members to learn from each other, and more does not give members enough "air time" (Briere, 1996, p. 175). All members need the opportunity to speak or not to speak, as they choose.

OPEN VS. CLOSED GROUPS

This group is intended for use in both inpatient and outpatient settings. The committee recommends that inpatient groups could be open, that is, new members can join each week, and that outpatient groups use a modified open format. Pragmatic issues often dictate whether the group is open or closed (Linehan, 1993, p. 11). Inpatient settings usually require open groups because women join the group as they enter treatment. As one might expect, women with Triad issues often have difficulty with change and trust (Linehan, p. 11). Therefore, an open group format can present both challenges and opportunities.

For outpatient settings the committee recommends an in-between system for new-member entry. New members may join only at the beginning of a four-week phase, and we recommend that new members meet with the group facilitator before their first group. This allows for both the building of cohesion seen in closed groups and the flexibility to respond to agency contingencies.

SESSION DESCRIPTIONS

The chapters for each session begin with a Session Outline that includes the following:

- Rationale—the reason the particular topic is considered important
- Goals—desired outcomes stated in behavioral terms
- Questions—queries, often including typical responses, that can be used in group to create a dialogue about specific issues
- Exercises—interactive activities that enhance the session topic
- Supplies—a list of handouts, etc. used that week.

Following the Session Outline is a step-by-step group format including instructions and notes for facilitators, typical responses to the session questions, and descriptions of the exercises, closure statements, and session handouts. (For a complete list of handouts see Appendix D.)

GROUP RULES

The "welcome session" introduces members and establishes group rules. These should be reviewed at the beginning of each phase and when new members join. Rules are presented as a way to develop and maintain a safe and secure environment, critical for the success of a Triad Women's Group.

Our experience is that this requires an accepting atmosphere in which members feel free to be themselves and to trust others. These rules are deliberately brief to foster a sense that the group is collaborative rather than authoritative.

The groups' have a high degree of tolerance for the symptoms of mental illness and for substance intoxication and withdrawal. Attending the group is interpreted as a sign of motivation to address the issues and an opportunity to engage the person. Individuals do hallucinate and say bizarre things during group. These statements might be redirected to the topic or responded to as an indication of increased group conflict or fear.

One of the rules is that members may leave the room if they are upset and want to calm down, but we ask them to return to the group afterwards. One facilitator said, "Permissiveness in substance abuse settings is unique. Substance abuse treatment is traditionally very much abiding by the rules." The group promotes a flexible approach out of the belief that members can take care of themselves and that traumatized women can better calm their emotions when they feel in control in a situation.

This "permissiveness" gives control to women who may otherwise feel out of control. We focus on creating a welcoming, friendly, caring place in which members can experience non-judgmental acceptance. Facilitators say that this approach has led to retention in treatment.

While the group is "permissive" the facilitator must enforce group rules such as starting and ending on time, scheduling group breaks, and directing the group discussion. For example, bringing children to the group is not permitted even if most group members express their approval. The facilitator brings necessary structure that supports a sense of safety for members.

QUESTIONS AND RESPONSES

The questions throughout this manual are intended to create a dialogue about recovery, empowerment, and survival so that members can learn from each other what works. The great variety of responses seen reinforces the notion that there are many roads to recovery. Each woman has a personal road to travel based on her own circumstances and experiences. The discussions are intended to help women examine their personal values and to create an environment in which women are empowered to make choices.

The facilitator should use the typical responses in this manual to prompt for ideas and bring up discussion topics, but the typical responses are *not* intended to be written on the board instead of the group's responses. They come from a variety of sources, some from our pilot groups, some from referenced material, and some from the authors of this manual. *All responses from members*, however, should be written on a board so that the importance of the contributions of all members is reinforced. *When possible, a member volunteer should write the responses on the board.* There are no correct answers to these questions. Members may not understand the question and may need more explanation, but all responses should be considered important contributions.

CLOSURES

We suggest that at the end of each session the facilitator thank members for participating. Members tell us that this is always helpful to hear. Genuineness is best here. There are reminders to the facilitators to do this in the section closures. If there is homework always remind members that it will be reviewed at the beginning of the next session. In addition, tell members what the topic of the next session will be so they can begin thinking about the subject ahead of time.

SHARING TRAUMA EXPERIENCES

A repeated concern expressed by group facilitators has been the sharing of trauma experiences by group members. Experienced facilitators on the committee report that when a member relates the details of a traumatizing event other members can be re-traumatized. This refers only to details of the event and not to the event in general. When details are shared with the group, facilitators are concerned that members may experience flashbacks and other dissociative symptoms. In a compassionate and respectful manner, members should be asked to limit the sharing of *details* of a trauma experience. At the same time, we must recognize that keeping a trauma experience secret is counter-therapeutic, and some women may need another forum to relate details of their experiences.

CONCURRENT TREATMENT AND SERVICE NEEDS

Women with more acute needs may also need case management. In the fully implemented Triad model this is provided by a Triad Specialist cross-trained in mental health, substance abuse and

trauma-related treatment and most group members have access to this individual case manager. This recognizes that members may have needs that cross agency boundaries such as mental health, substance abuse, protective services, welfare, primary health, and housing services. Case managers also provide emotional support. The group facilitator consults with the case manager on a regular basis, can refer group members to the case manager on the practical issues of living that arise during the group, and use the case manager as a resource.

Service systems present barriers when they require women with these problems to seek services from various agencies and individuals. These barriers can be particularly difficult for women living in poverty, lacking affordable housing, raising children, and lacking transportation. The often-unrecognized traumatizing effects of violence on the lives of women, such as low self-esteem, impaired trust, shame, and anxiety, raise the height of these barriers.

Even with case management it is not unusual for women to miss group because of a lack of community resources for childcare and transportation. Facilitators are encouraged to make contact with members who fail to attend sessions.

The optimal treatment regimen for a woman dealing with these issues combines individual psychotherapy by a therapist cross-trained in all three issues, case management to assist her to access community supports and resources across agencies, psychiatric care to manage medications, a peer support group, and group treatment that teaches skills and provides emotional support. Other potential service needs include vocational/educational services, parenting and childcare services, legal services, and day treatment services.

The Triad Women's Group was developed with private non-profit mental health and substance abuse treatment agencies largely reliant on public funds. While women affected by these problems told us that they wanted individual therapy, we recognized that this was not always feasible. The Triad Women's Group can have positive therapeutic affects for many women as a stand-alone intervention by teaching problem solving and relationship skills and providing emotional support. The group fulfills a critical treatment need for many women.

HANDLING PROBLEM SITUATIONS IN GROUP

Creating a calm, structured, and controlled environment limits acting out behaviors. Occasionally, members will come to the group intoxicated or actively psychotic (actively hallucinating, acting bizarrely) and not respond to redirection creating an unsafe environment for the group. If members are actively psychotic, avoid abstraction and become concrete and repetitive, seek to reduce their anxiety and fear. On occasion a well-timed break can be used to help calm the person and the situation or to seek staff assistance.

Members who are not verbal in-group can be easily overlooked. For some participants any sign of interest or participation such as a head nod, smile, or frown might be used to pull them into the discussion. On the other hand some members may need to be given many sessions before they experience sufficient safety to speak up. The key is to know the needs of each participant.

The general philosophy is to try to keep members in group. Members with depression and negative symptoms of schizophrenia may have difficulty participating and need patience from all

members to listen for their input. If a member cannot stay in a group due to symptoms, try the person at another time when they may be more stabilized on medications. On occasion, however, facilitators have discontinued participation by some members. For instance, one member continually kept talking over other members and despite repeated redirection, kept disrupting the group. The facilitator later learned through a positive urine screen that she had been using methamphetamine.

An important threat to the group is loss of confidentiality. Some of the groups meet in rural communities where there is greater potential for the inadvertent loss of confidentiality. For example, a woman might be seen entering the mental health center by her perpetrator. Loss of confidentiality is a significant threat for women who attend, especially for women in domestic violence situations. If there is a violation of confidentiality, a discussion of it should occur within the group. This gives all members access to the same information allowing them to judge for themselves what is safe to disclose in the group. Members should be told explicitly that the identity of other members is confidential and that personal discussions in group should not be talked about outside the group. Members can be involved in deciding on the best way to proceed and enforce group rules about confidentiality.

The group model supports members using each other as sources of strength in and out of group. The group's attitude about outside contact is similar to that of a support group like AA. The friendships that form among members are supported. While a traditional therapy group recognizes the potential risks of outside contact and prohibits them, this model recognizes the potential risk of outside contact and seeks to deal with them within the group. Some of the potential risks are threats to confidentiality, boundary violations, the bringing of external conflicts into the group, and the creation of sub-groups that undermine group trust.

Facilitators should bring up outside contact in the group by discussing how it may affect member's trust in the group's ability to protect confidential information, how it may affect the group's interpersonal dynamics, and encourage members to talk about their feelings concerning their emotional comfort, safety, and empowerment.

Facilitators report that group members experience flashbacks and other dissociative experiences during group sessions. Facilitators need to be prepared to respond to a woman's individualized needs when this occurs. The sharing of the details about trauma is discouraged to try to avoid these experiences but flashbacks can be triggered in unexpected ways. Early sessions focus on creating safety and session 2 has a grounding exercise. Facilitators should be familiar with grounding techniques and other strategies to reorient them. It is helpful to ask women individually what helps when they experience flashbacks. Some have found techniques that work well for them, and it is helpful to support their control over flashbacks. For example, one woman may respond well to handholding whereas another would react negatively to any physical contact.

One facilitator reports a recent case in which a woman experienced frequent flashbacks/dissociations. She self-diagnoses as having Dissociative Identity Disorder (DID). The facilitators attended to this and used it to educate the group about DID. At times it became too much the focus of the group and other members were not getting their needs met, so they learned to balance her needs with that of other members.

For example, a member announced at the start of one of her first sessions that she had been thinking about killing herself and had spent the entire previous night awake and thinking about this. Rather than diverting all the group's attention to her, the facilitator asked the group members to notice if they felt differently after hearing this than they did before and then used group materials on mindfulness, identifying feelings and developing self-soothing strategies. It also became an opportunity for everyone to talk about those times when the fear of dying was much less overwhelming than the fear of trying to deal with the world. This response increased group cohesion.

As the sessions progressed these discussions also helped this particular member to broaden her trust from just one facilitator to the group as a whole. Sessions on understanding the difference between being a victim and being a survivor helped her begin to identify with others thus increasing her capacity for empathy and ultimately friendship. This particular member had had a particularly horrible childhood filled with unpredictable cycles of violence and neglect. However, she was currently married to a very caring, gentle man. Another member describes her childhood as basically normal, but was coming out of a brutally violent marriage. One felt alienated from group because no one had had it as "bad" as she, another felt she didn't belong because her life had been too "normal". In the sessions defining abuse and violence the members began to understand the many faces of violence and they could begin to see identify a little with each other. Discussions on interpersonal relationships help them see how the defenses they had built, while necessary in the past to protect them from the trauma of their lives, were interfering with some opportunities to build trusting intimate relations.

One facilitator describes the groups as creating "healing communities." "The art is to weave together their similarities to create cohesiveness without losing individuality."

Facilitators must carefully assess each member's mental status in order to monitor the group's capacity for difficult emotional material. Initially, there was a concern that these groups could lead members, especially those with psychotic disorders, to decompensate. However, the groups have been well tolerated by members with psychosis and our pilot data indicated no worsening of psychotic thinking.

Women that have difficulty reading can still benefit from group. It is strongly recommended that the facilitator meet with these women individually to discuss how to respectfully and effectively handle this issue in group.

As the group progresses women may demonstrate either active substance use or psychiatric decompensation. Such crisis situations will require more intensive treatment than a weekly outpatient therapy group.

CRISIS AND EMERGENCY PROCEDURES

Facilitators report that women are often in crisis, especially those who remain in abusive relationships or who are still using substances. These crises can threaten the group's psychoeducational goals but also present learning opportunities. There is a danger that the group can become crises oriented and thereby give inadequate attention to skill building. Some sessions

will invariably be consumed by crises, such as a when a member with bruises reports an urgent concern for her physical safety if she returns to her home. However, a balance is sought between addressing these legitimate crises and the teaching of skills that will give member better tools to manage their lives. The group's structure is flexible, in part, to give facilitators the ability to negotiate this balance. The most common way of achieving this balance is by segueing from the crisis to the session topic because there is often a connection between the crises and the skills being taught.

Women with co-occurring mental health and substance use disorders with a history of violence are at high risk for emergencies and problems that require priority attention. They are at risk for suicidal behavior, self-injurious acts, domestic violence, child abuse and neglect, drug overdoses, mental health crises, and other emergencies. Crises such as eviction, loss of transportation, childcare problems, loss of employment, or lack of food, need priority attention. Not only will a woman's focus be on those immediate needs, they threaten her recovery.

The setting may determine the parameters of response of any particular group and group facilitator. It is highly recommended that thought be given to these parameters before the group and the limits discussed thoroughly with the group. As an example, is there anyone available for emergency calls? If so, the number, available hours, and types of appropriate calls can be discussed. If not, alternative supports such as crisis hotlines and resources should be explored.

The group can be facilitated in a freestanding setting, but attention needs to be paid to adequate emergency procedures. Safety is a central concern and members are helped when assurances are given about a safe environment for the group. The first group session focuses on safety and members write down a personalized list of crisis numbers and a safety plan for domestic violence. Facilitators may want to repeat this exercise, as needed, or check if members have kept it in case of an emergency.

Facilitators may need to supplement the group material with additional information about community resources and how best to access them. Group members can often help each other by sharing such information with each other.

Our experience with the groups is that, especially when this is the primary treatment service women are receiving, it is important to deal with pressing issues or crises in the women's lives. Most facilitators briefly elicit this discussion at the beginning of the group. This material can often be incorporated into the session materials and the basic principles applied to the problem or issue.

FACILITATOR STYLE

One of the most important tasks of the facilitator is to foster an environment that is healing. This can be accomplished by establishing clear boundaries between staff and members; a collaborative attitude that communicates respect, empathy, and compassion; respecting uniqueness while affirming similarities; conveying optimism for recovery; and focusing on positive steps toward recovery, empowerment, and survival. The facilitator needs to believe that members are doing the best they can with their unique circumstances and skills. Women need to be encouraged to see their strengths rather than focus on deficits. One aspect of working with this population is understanding how a woman's lack of confidence may lead her to respond to

the facilitator in overly compliant ways. For example, one danger is that members may reveal information before they are ready. For this reason, the manual emphasizes the obvious option for a member of not sharing in the group. It is important that members are empowered to participate or not, as they wish.

FACILITATOR GENDER

Women who have been traumatized by violence often find it difficult to trust staff members who are the same sex as the perpetrators, who are overwhelmingly male. Therefore, female facilitators are recommended unless this is impractical. (Briere, 1996, p. 175).

FACILITATOR EXPERIENCE AND TRAINING

Experienced clinicians with either mental health or substance abuse training and knowledgeable of group process are capable of running Triad Women's Groups. It is highly recommended, however, that the group facilitator receive special training in treating co-occurring disorders and in working with people that have trauma-related disorders. Further, ongoing supervision by a trauma specialist is recommended.

The groups are intended to be very interactive with emphasis on members learning from each other. The role of facilitators as experts is not emphasized. The Triad Project has used co-facilitation along with cross training in trauma, mental illness, and substance abuse in-services to train new facilitators. We have employed licensed clinicians with at least 5 years of experience providing direct clinical services to women with Triad issues to act as mentors to less experienced staff. Due to a lack of such experienced clinicians at some sites, we have employed outside consultants to assist with the training of new facilitators.

Clinicians with a strong background in treating survivors of trauma are particularly desirable as mentors. These mentors then co-facilitate the group until they are confident that the person being trained has adequate skills to run the group independently. The length of co-facilitation has varied significantly but 16 is the minimum number of sessions. By co-facilitating the groups, the clinician becomes Triad trained and can train others. Agencies have been responsible for choosing staff to be mentored as Triad Women's Group facilitators. This has generally been based on factors such as interest, years of experience, and training. We recommend at least 2 years of direct clinical experience.

When staff members plan to facilitate groups like this, they need to weigh carefully how their own experiences can influence their work in this arena. The issues of mental health, substance abuse, and violence are widespread in our society. Many staff members who work in this field have been directly impacted in some way, either through personal experience, in their families, or in their personal relationships. In one national study almost one-third of male therapists and over two-thirds of female therapists had experienced at least one type of abuse in their lifetimes (Pope & Vasquez, 1998, p. 65). The value of having "been there" has long been recognized in the substance abuse treatment field as an asset if staff members have long-term sobriety. More recently, community mental health centers have sought to employ consumers as staff to support other consumers in recovery.

Briere (1996, p. 101) suggests that a facilitator who is a survivor of violence is likely to have a basic and sympathetic understanding of a client's responses to trauma and be better able to instill hope for positive outcomes. However, clinician survivors who have not integrated the experience and continue to use denial, dissociation, and avoidance are ill prepared to assist others; and the group material may trigger unwanted emotions in the facilitator.

CONSULTATION AND SUPERVISION

Facilitators need clinical supervision to consult about group dynamics, dealing with difficult trauma-related responses in-group, members triggering flashbacks with each other, and acting out in groups. One area often raised in supervision by Triad Women's Group facilitators is how best to deal with the dynamic tension between attending to immediate crisis situations of members and covering the group material. Supervision through direct observation and frequent consultation is recommended for non-licensed staff. The use of non-licensed staff is supported by the straightforward, easy to follow manual. Prudent practice requires regular clinical supervision of all facilitators with more intense supervision for unlicensed staff working with women with such complex problems.

Agencies can help assure the quality of group facilitation by helping staff members explore their professional and emotional competence to facilitate this type of group. This work can be very difficult and significant support for group facilitators is encouraged.

Before initiating a Triad Women's Group, facilitators should have adequate supervision and consultation arranged. Even experienced group clinicians, who are preferred to facilitate the groups, need access to supervisory support and consultation. Many clinicians have gained their experiences primarily in one field so that even when cross-trained in mental health, substance abuse, and trauma they need access to consultation across disciplines. For example, a facilitator with substance abuse experience may need consultation available on medications and their side effects. They may otherwise attribute extreme tiredness to drug withdrawal rather than as a side effect of an anti-depressant. A facilitator with mental health experience may need consultation to accurately identify signs of substance use and withdrawal. Consultation and supervision by a trauma specialist is critical. Such supervision is needed to process group dynamics, understand members' reactions to the material, and to deal with the facilitator's emotional reactions. Trauma-related work is often emotionally stressful for facilitators and they are vulnerable to this stress if not prepared for it or inadequately supported.

ADDITIONAL RESOURCES

The list of books and Web addresses in Appendix E can be helpful to both providers and consumers.

Note: Instructions for facilitators are bulleted, and material to be read aloud or paraphrased is *italicized.*

WELCOME

INTRODUCTIONS AND WELCOME

Creating Safety

The first session is critical in the process of creating a welcoming and safe environment for members. Facilitators must give priority attention to the safety of members within and outside the group. Location of the group may be a matter of safety for some members as members in violent relationships may feel unsafe going to a building where they may be identified. Others may fear loss of confidentiality or stigma.

Members must feel safe in-group to feel sufficiently empowered to make changes in their lives. With this in mind, the first session focuses on members dealing with generally non-threatening material as they get to know each other and the facilitator and on personal safety. The rules in the group are intended to create a safe environment for members to share and learn from each other.

- Welcome members to the session and check on their physical and emotional comfort.
- Introduce yourself and briefly explain your clinical experience.

  Please introduce yourselves and share with the group what you hope to get out of attending this group. Let's go around the room.
- Tell members when the break will come, if members can smoke during the break, and the location of the restrooms.

GROUP RULES

Groups start and end on time every week.

In order for you to feel safe and secure in-group, please respect each other's experiences and listen while others speak. Aggression and disrespect are not acceptable.

Clarify that aggression includes verbal hostility and confrontations. Members are expected to use respectful language in disagreements with the facilitator or other members.

One of the challenges in any group is to have members share group time. Some members will be unfamiliar with a treatment group. Some members are reticent to speak-up and need to be prompted by the facilitator. Some may take a while to warm-up and feel safe in the group. On the other hand members may dominate the group due to their more extroverted nature or because they are friends outside of group. All of these present challenges to group cohesion that must be continually assessed. Mostly subtle interventions are effective at redirecting members. Only occasionally is a directive approach needed such as when a member insists on talking when others clearly need to speak.

Absences. Call ahead if you're going to miss group. (Have a phone number or a business card with a number ready to give out.)

Excused absences include personal and family illnesses, unsolvable childcare problems, family emergencies, vacations, and funerals.

Unexcused absences include being tired, being in a bad mood, and having solvable childcare problems. It may also include psychiatric hospitalization if there is a repeated pattern of hospitalizations with little evidence that the woman is working a recovery program.

What is said in this group is confidential.

- Ask a group member to explain what confidentiality means. Some simple slogans are useful: "What is said here stays here," and "I can talk about my being here, but not about *your* being here." Reinforce the importance of confidentiality often to communicate that this is to be taken seriously.

  Disclosing personal information is always voluntary. You don't have to say anything if you don't want to.

  You may leave the room if you are upset and want to calm down or you want to use the restroom. However, we ask that you return to the group afterwards.

- Encourage members to ask questions about the rules.

GROUP FORMAT AND AGENDA

Each group will last two hours with a ten- to fifteen-minute break in the middle. There will be four phases, each lasting four weeks, for a total of sixteen weeks.

- Distribute and read the themes for each phase and topic areas for each session (**Handout 1a).**

Phase I: Mindfulness
Getting Comfortable with Yourself

INTRODUCTION TO PHASE I: MINDFULNESS

Phase I focuses on getting comfortable with ourselves. We will discuss how the concepts of recovery, empowerment, and survival apply to Triad issues. We will talk about making choices for personal safety; learn how the mind, body and emotions work together; and explore ideas about what it means to be female.

Chapter 1: EMPOWERMENT—BUILDING SAFETY

Fred Fearday

SESSION OUTLINE

RATIONALE

The first group should be non-threatening for members so that they can start to share their experiences with mental illness, substance abuse, and violence. The overriding agenda in this group is for members to begin a process of feeling safe, secure, and empowered in the group. This session focuses on positive change and the sharing of experiences about safe people and places in the community. Safety and security are key concerns, because most women with Triad problems are distressed by the emotional consequences of violence as well as by coping with mental health and substance abuse problems.

GOALS

1. Members will understand how recovery, empowerment, and survival can become part of their lives.
2. Each member will understand what is meant by a personal plan for safety and learn how to create an environment that is physically and emotionally safer for herself and her family.

QUESTIONS

1. *What does recovery mean to you?*
2. *What are some feelings of being empowered and feelings of being powerless?*
3. *What is the difference between a victim and a survivor?*
4. *When you feel down or tense, what do you do to soothe or calm yourself?*
5. *Who are some safe (or safer) people in your lives?*
6. *What are some safe (or safer) places in your lives?*

(Continued on next page.)

EXERCISES

1. *Crisis Numbers*. Members write on index cards examples of Triad-related emergencies and phone numbers that they can call for help.
2. *Safe Responses*. Members are given Handout 1b (Self-Soothing), on which they will complete a practice situation in-group and then list safe ways they will respond to 3 situations during the next week. They track what they did, how effective it was, and then report the results during the next session.

SUPPLIES

Chalkboard or equivalent, index cards, pencils or pens, Handouts 1a (Triad Women's Group Curriculum), 1b (Self-Soothing) and 1c (Personalized Safety Plan)

RECOVERY

Question 1: ***What does recovery mean to you?***

- List the responses on a chalkboard or equivalent. Write down *all* of the responses without judging them. If necessary, use the Typical Responses list to prompt the women for more answers.

Typical Responses	
Change lifestyle	*Peace of mind*
Stop using	*Honesty*
Build self-esteem	*Ignore peer pressure*
Learn more about myself	*Working 12 steps*
No relapsing	*Make better choices*
Take medications	*Go to support group*

- Read the Triad Women's Project's definition of recovery:

  TRIAD DEFINITION OF RECOVERY: *A personal journey in pursuit of wholeness: living in harmony with others, assuming personal responsibility, achieving a sense of purpose, hope for the future, and peace of mind. Recovery is a lifelong process of discovery that involves a potential for relapse.*

  Can anyone add anything to this definition?

EMPOWERMENT

- Read the Triad Women's Project's definition of empowerment:

  TRIAD DEFINITION OF EMPOWERMENT: To understand options in an environment that promotes choice and the means to pursue those choices. In addition, you must perceive that you have the ability to make genuine choices. This requires that you have sufficient confidence in yourself to make such choices.

  Can anyone add anything to this definition?

Question 2: ***What are some feelings of being empowered and feelings of being powerless?***

- Make two columns on the board: "Feelings when empowered" and "Feelings when helpless or powerless." Ask members to contribute a feeling to each column.

Typical Responses			
Feelings when empowered		**Feelings when helpless or powerless**	
Strong	*Confident*	*Fear*	*Weak*
Hope	*Joy*	*Anger**	*Worthless*
Powerful	*Happy*	*Afraid*	*Resentment*

*Anger can be in either category. For example, when used to create change, anger can be empowering.

SURVIVAL

- Read the Triad Women's Project's definition of survival:

TRIAD DEFINITION OF SURVIVAL: To take responsibility for dealing with the personal consequences of trauma while understanding that you do not bear responsibility for being a victim of trauma. To value those coping strategies that allowed you to survive violence and to understand that new strategies are needed to deal with the emotional consequences of past violence and create safe environments for yourself and your family. To shift your identity from that of a "victim" to that of a "survivor" who can thrive in the present.

Can anyone add anything to this definition?

Question 3: ***What is the difference between a victim and a survivor?***

- Make two columns on the board: "Victim" and "Survivor."

Typical Responses			
Victim		**Survivor**	
Is weak	*Is a casualty*	*Is strong*	*Lives one day at a time*
Is suffering	*Has no one*	*Endures*	*Lives to tell the tale*
Is injured	*Gives up*	*Stays alive*	*Takes care of herself*
Is helpless	*Is wounded*	*Has hope*	*Outlasts others*
		Is determined	

Discussion Question:

What are some of the reasons victims of violence are sometimes blamed for their own mistreatment?

SELF-SOOTHING SKILLS: Strengthening the Ability to Care for Yourself

Question 4: *When you feel down or tense what do you do to soothe or calm yourself?*

Typical Responses		
Keep busy	*Get to a support group*	*Think of suicide*
Socialize	*Listen to music*	*Eat*
Go to a bar	*Go to AA or NA*	*Stay away from bars*
Go shopping	*Use a relaxation tape*	*Take medication*
Bite my nails	*Call my sponsor*	*Hurt myself*
Pray	*Smoke a cigarette*	*Withdraw from others*
Exercise	*Yell at the kids*	*Go to a beauty salon*
Watch TV	*Find a place to be alone*	*Garden*
Read a book	*Hide*	

Discussion Questions:

Which of these activities have been most useful to you?

Which have not been helpful?

Which can be effective right away but cause long-term harm? (What about getting high, smoking cigarettes, shopping, and yelling at the kids?)

Which can cause harm if overdone?

Which are learned in violent situations? (In violent situations we often have few choices, no power, and little self-confidence.)

Drinking, drugging, and self-injury are sometimes things women do when they are distressed. What kinds of situations prompt thoughts of drinking, using drugs, or hurting yourself?

What are some safe alternatives to the activities that cause harm?

SAFETY

Question 5*: Who are some safe (or safer) people in your lives?*

Typical Responses	
Friend	*Family member*
Partner	*Clergy*
Crisis line	*Case manager*
AA or NA sponsor	*Neighbor*

Question 6: *What are some safe (or safer) places in your lives?*

Typical Responses	
Relative's house	*Support groups*
Churches, synagogues, etc.	*Coffee shops*
Libraries	*Drop-in centers*
Stores or malls	*A safe room or spot in my house*
Parks	*Domestic violence shelters*
Driving around in the car	*Workplaces*
AA or NA meeting	*A safe place in my mind*

Some of you may be in unsafe situations now and may need to prepare a safety plan in case further violence happens. I will hand out a safety plan at the end of the group. Look it over. It can give you some ideas for your own safety plan. You can ask your counselor questions about the plan or bring questions to our next group.

EXERCISE 1: Crisis Numbers

- Pass out index cards and pencils. Ask members what they think would be a mental health or substance use emergency. Write their answers on the board.
- Ask members to write on their cards the names and phone numbers of people and places they can call in mental-health, domestic violence, or substance-use emergencies.
- Tell members that if they don't know the phone numbers to write down the names and look up the phone numbers by next week.
- Copy your own list of local emergency numbers on the board and ask the members to copy those they think they might need.
- Ask if any members want to tell the others about a good place to call.

BUILDING EMOTIONAL AND PHYSICAL SAFETY

Yes, we can find new ways to deal with difficult situations. We can also develop habits that keep us emotionally and physically safe. We'll talk more about these in later sessions, but think about routines that promote health and well-being. Some of these are

Eating nutritiously,
Getting enough rest,
Structuring time,
Taking prescribed medications,
Always getting help for physical and mental health problems.

EXERCISE 2: Safe Responses

- Pass out **Handout 1b** (Self-Soothing**).**

  Imagine a difficult situation and how you would feel during it. What would you do to calm or soothe yourself? How effective would it be? What would be some good or bad consequences? Write all this in the Practice Situation column.

- Look at each member's handout and make sure the members understand what is expected. *Over the next week, please fill in the next three columns for 3 situations that actually occur.*

CLOSURE

- Thank members for attending. Express a hope that members will begin to feel more comfortable as you continue to meet. Pass out **Handout 1c** (Personalized Safety Plan).

Today we talked about building safety and the concepts of recovery, empowerment, and survival. Next week, please remember to bring in the Self-Soothing Handout so we can go over it together. Next week's topic is Mind, Emotions, and Body. We will talk about how to improve our awareness of our thoughts and feelings.

Everyone should review Handout 1C (Personalized Safety Plan). Those of you that are currently living in dangerous or possibly violent situations should complete these handouts. Every group session we will discuss and review the safety of each member's living situation. We can also assist each other in updating these plans as needed.

HANDOUT 1a:
TRIAD WOMEN'S GROUP CURRICULUM

PHASE I: Mindfulness
Getting Comfortable With Yourself

	Welcome
	Handout 1a: Triad Women's Group Curriculum
Chapter 1	**Empowerment—Building Safety**
	Handout 1b: Self-Soothing
	Handout 1c: Personalized Safety Plan
Chapter 2	**Mind, Body, and Emotions**
	Handout 2: Event-Thought-Feeling Worksheet
Chapter 3	**How Mind and Emotions Work Together**
Chapter 4	**What It Means to Be a Female**

PHASE II: Interpersonal Effectiveness Skills
Having Healthy Relationships with Yourself and Others

Chapter 5	**Assertive Communication**
	Handout 5a: Goals in Situations
	Handout 5b: Communications Worksheet
Chapter 6	**Trust and Intimacy**
	Handout 6a: Interpersonal Mastery and Self-Respect
	Handout 6b: Rational and Irrational Thoughts about Relationships
Chapter 7	**Boundaries**
Chapter 8	**Social Support**
	Handout 8: Social Support Diagram

HANDOUT 1a (cont.)

PHASE III: Emotional Regulation
Feeling Good

Chapter 9:	**Controlling Cravings and Urges**
Chapter 10:	**Self-Esteem**
	Handout 10: The Self-Esteem Game
Chapter 11:	**Self-Soothing**
Chapter 12	**Acceptance and Healing**
	Handout 12: "Serenity Prayer"

PHASE IV: Distress Tolerance
Staying Healthy in a Stressful World

Chapter 13	**Problem Solving**
Chapter 14	**Dealing with Violence**
	Handout 14a: Kinds of Violence and Abuse
	Handout 14b: Relationship Wheels
	Handout 14c: Why Do Victims Stay with Abusers?
Chapter 15	**Crisis Management and Recovery**
Chapter 16:	**Relapse and Recovery**

HANDOUT 1b: SELF-SOOTHING

	Practice Situation	Situation 1	Situation 2	Situation 3
Situation Examples: a difficult relationship, a trigger for using, a flashback, feeling depressed, being in an unsafe place, seeing violence, getting mad at kids				
My feelings and thoughts during the situation				
My efforts to calm or soothe myself (what I did to manage my thoughts and feelings)				
Rating from 1–10 how well it helped me calm down 1 = not effective at all 10 = very effective				
What were the good and bad consequences of what I did to soothe myself?				

HANDOUT 1c: PERSONALIZED SAFETY PLAN

The following steps represent my plan for increasing my safety and preparing in advance for the possibility of further violence. Although I do not have control over my partner's violence, I have a choice about how to get my children and myself to safety.

STEP 1: SAFETY DURING A VIOLENT INCIDENT

I can use some of the following strategies:

- I can keep my purse and car keys ready and put them _____ in order to leave quickly.
- I can tell _____ about the violence and ask them to call the police if they hear suspicious noises coming from my house.
- I can teach my children how to use the telephone to call the police and the fire department. (Be careful about placing responsibility on the children.)
- If I have to leave my home I will go _____. (Decide this even if you don't think there will be a next time.)
- When I think we are going to have an argument I will try to move to a room (_____ _____) that has fewer risks (avoid the bathroom, garage, kitchens, rooms with weapons, or rooms with no access to an outside door).

STEP 2: SAFETY WHEN PREPARING TO LEAVE

I can use the following strategies:

- I will leave money and extra set of keys with _____ so I can leave quickly.
- I will keep copies of important documents at _____.
- I will open an individual savings account by (date) _____ to increase my independence, or I will find a safe place to hide cash.
- Other things I can do are
  _____
  _____
  _____

- I can call the national or statewide hotlines to talk about my options for safety.
- I can call my local domestic violence shelter to talk about my options for safety.
- I can seek shelter by calling any of these hotlines. They will refer me to the closest shelter. I will call ahead of time to find out the procedure for admission.
- I can keep a roll of change or a pre-paid calling card _____ so that if I leave I can make confidential calls that can't be traced on the phone bill.
- I will check with _____ and _____ to see who would be able to let me stay with them or lend me some money. I can also leave extra clothes with him/her.
- I will sit down and review my safety plan with a friend _____every _____.
- I will rehearse my escape plan and parts of it with my children if I think it is appropriate.

STEP 3: SAFETY IN MY OWN HOME

Safety measures I can use if he leaves, is forced to leave, or if I am in a new home include

- I can change the locks on my doors and windows as soon as possible.
- I can install a security system (including extra locks, poles to wedge against doors, an electronic system, etc.).
- I can install an outside motion detector/lighting system that lights up when a person is in the yard.
- I will teach my children how to use the telephone to make a collect call to me and to _____ in case my partner takes the children.
- I will notify the caretakers of my children who have permission to pick them up and that my partner is not permitted to do so. Some will require a court order. The people I will inform about who has pick-up permission include
  _____(Teachers/school)
  _____(Day care/After school staff)
  _____ (Babysitter)
  _____(Family/Friends)
  _____(Neighbors) _____(Others)
- I can notify _____ and _____ that my partner no longer lives with me and they should call the police if my partner is seen near my home.

STEP 4: SAFETY WITH A PROTECTIVE ORDER

I can do the following to help with the enforcement of my Protective Order/Injunction for Protection:

- I will always keep my Protective Order/IFP/other probation orders on or near my person in/at _____ (location).
- I will give my Protective Order/IFP to the police/sheriff's departments in the community where I work, where I visit family or friends, and where I live. I will make sure it is filed properly with the District Clerk.
- I can call the local domestic violence shelter if I have any questions about or problems with my Protective Order/IFP.
- I will inform my employer, my minister, my closest friend, and _____that I have a Protective Order/IFP in effect.
- If my partner destroys my Protective Order/IFP I can get another certified copy from the courthouse by going to the District Clerk's office located at
  _____
  _____.
- If my partner violates the Protective Order/IFP I can call the police and report the violation, contact my attorney, call my advocate, and advise the court of the violation. (Make sure it gets documented!)
- If the police do not help, I can call my advocate or attorney and file a complaint with the chief of the police department.

STEP 5: SAFETY ON THE JOB AND IN PUBLIC

I will consider carefully which people I will ask to help secure my and my children's safety. I might use the following strategies:

- I can inform my boss, the security supervisor, my co-workers, and _____at work about my situation.
- I can ask _____ to help screen my calls at work.
- When leaving work I can _____.
- When driving home, if problems occur, I can _____.
- If I use public transportation I can _____.
- I can use a different bank and different grocery stores, convenience stores, malls, and department stores and shop at different hours so that my batterer will not be able to find me so easily.
- I will be careful and watchful. I must always look over my shoulder and be cautious of any person or car that might be following me.

STEP 6: SAFETY AND DRUG OR ALCOHOL USE

If drug or alcohol use has occurred in my relationship with the battering partner, I can increase my safety by some or all of the following strategies:

- If my partner is using I can _____.
- If I am experiencing cravings and urges, I might try _____ before I decide to use.
- I might also _____.
- If I am going to use drugs or drink I can do it in a safe place with people who understand the risk of violence and are committed to my safety.
- If I relapse, I can safeguard my children and myself by not driving, by getting a babysitter in advance, and by _____.

STEP 7: SAFETY AND MY EMOTIONAL/MENTAL HEALTH

To take care of myself and build up my courage and self-esteem I can do some or all of the following:

- If I feel down and ready to return to a potentially abusive situation I can _____ _____.
- When I have to communicate with my partner in person or by telephone I can _____ _____.
- I can try to use "I can" statements with myself and to be assertive with others.
- I can tell myself "_____" whenever I feel others are trying to control or abuse me.
- I can read _____ to help me feel stronger.

- I can call my counselor at _____ and I can call _____.
- I can make sure I don't run out of my medications and that I don't miss any of my doctor appointments.
- I can take my medications as prescribed.
- If I am having unsafe thoughts, I can _____.
- I can attend support groups at _____ or _____, I can also attend support groups at the domestic violence shelter or outreach program, or I can _____ to gain support and strengthen my relationships with other people.

STEP 8: ITEMS TO TAKE WHEN LEAVING

When I leave I should take:

- My personal identification
- My birth certificate
- The children's birth certificates
- My social security card
- The children's social security cards
- School and vaccination records
- Driver's license, car registration, and proof of automobile insurance
- Money
- Financial documents (income tax records, bank account records, IRA's, etc.)
- Checkbook, ATM card
- Credit cards
- Keys: house, car, office
- Lease/rental agreement/house deed/mortgage payment book
- Medication (mine and children's)
- Work permits
- Green card
- Passport(s)
- Medical records (for all family members)
- Medical insurance papers
- Marriage/divorce certificates
- Address book
- Pictures
- Jewelry
- Clothes
- Small items to sell if necessary
- Children's favorite toys/blankets
- Items of special, sentimental value
- My Protective Order/Injunction for Protection
- Any other important items or documents

STEP 9: TELEPHONE NUMBERS I WILL HAVE WITH ME

I will keep this personal safety plan at home, at work, and wherever else is handy along with the following numbers:

Police Department _____
National Coalition Against Domestic Violence National Hotline:
1-800-799-SAFE (7233)
Florida Coalition Against Domestic Violence State Hotline: 1-800-500-1119
Local Domestic Violence Shelter Hotline: _____
Local Domestic Violence Outreach/Support Groups: _____
District Clerk (for registry of Protective Orders/IFP's: _____
Work Number: _____
Supervisor's Number: _____
Minister: _____

HANDOUT 1c (cont.)

Attorney: _____
Schools: _____
Daycares: _____
Doctor: _____
Mental Health Center/Counselor:
_____
Detox/Outpatient Substance Abuse Center/Counselor:
_____
Friend(s):
_____
Family member(s):
_____
Other: _____
_____
_____

Adapted from: National Domestic Violence Hotline. (2000). *Personalized safety plan.* Austin, TX: Author.

Phase I: Mindfulness
Getting Comfortable With Yourself

Chapter 2: MIND, BODY, AND EMOTIONS

Margo Fleisher-Bond

SESSION OUTLINE

RATIONALE

Through building self-awareness women learn to identify core parts of themselves: moods, emotions, thoughts, physical sensations, and behaviors. They learn how chemical dependency, trauma, and mental illness affect self-awareness and how current and past behaviors may be ingenious adaptations to trauma. There are opportunities to think of mood, cognitive, emotional, and sensory experiences as tools to use in recovery. The development of self-awareness contributes to a woman's strong and natural tendency to heal herself.

GOALS

1. Members will improve self-awareness of their moods, emotions, thoughts, physical sensations, and behaviors.
2. Members will understand how chemical dependency, trauma, and mental illness affect their self-awareness and how their current ways of coping are often ingenious techniques of survival.

QUESTIONS

1. *What is a mood?*
2. *What is a thought?*
3. *What is an emotion?*
4. *How do we know what we are feeling?*
5. *How did you come to know what you know about yourself?*

EXERCISES

1. *FLASH Feelings*. Each member identifies experiences of fear, love, anger, sadness, and happiness (FLASH) that she has either enjoyed or valued, and the group discusses how all feelings are part of being human and how all feelings have value.
2. *Deep Breathing*. Members become aware of the various body movements involved in breathing as well as the ability of deep breathing to help us relax, that is, how we can use our bodies to affect our emotions.

SUPPLIES

Chalkboard or equivalent

INTRODUCTION

- Spend a little time going over the completed Self-Soothing handouts (Handout 1b). Ask if any members are willing to share one of the situations they used on the worksheet.

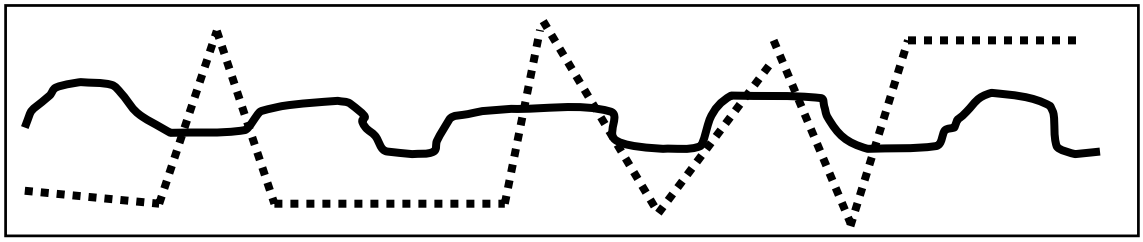
Start each group session with a brief review of the members' current issues. Specifically focus on women with safety and/or emergency issues. Review members' emergency crisis numbers and members' Personalized Safety Plans.

Last week we discussed the goals of recovery, survival, and empowerment and began to discuss how to achieve personal safety. One of the most important ways to do this is to increase our self-understanding and self-awareness. We can look at our feelings, our thoughts, our physical sensations, and the things we do. And we can understand how these work together.

Question 1: ***What is a mood?***

Typical Responses	
A mood is a state of mind.	*I have good moods and bad moods.*
My overall feeling	*My emotional state*
What I feel most of the time	*My outlook on things*

- Draw a graph like the one below on the blackboard showing normal moods (comfortable, with mild fluctuations) and moods that are affected by depression or manic episodes (extreme fluctuations in mood).



Look at the board. It shows how two different people's moods change over time. Why would one person's mood go up and down so dramatically? (substance abuse, mood disorders, violence, etc.)

Question 2: ***What is a thought?***

Typical Responses	
Something that happens in my head	*Something I know*
An idea	*A plan to do something*

Question 3: ***What is an emotion?***

Typical Responses
An emotion is a feeling.
It's how I feel.
Sometimes I have good feelings, and I have a lot of bad feelings.
Depression is a feeling.
I don't know what an emotion is.

When we talk about emotions or feelings we mean exactly the same thing. These are just different words for the same thing.

Question 4: ***How do we know what we are feeling?***

Typical Responses
Sometimes I don't know what I am feeling.
I feel like I can't sit still.
My heart races.
My stomach gets upset.
I smile
I tear up.
I don't have any emotions.
I know what I am feeling from my gut.
I know what I am feeling from my behavior.
I don't know what I feel because I get high before I can think about it too long.

Everyone has emotions. Sometimes we like them and sometimes we don't, but they're all there for a reason. I'm going to write a list of five feelings on the board, called the FLASH feelings (Naster & Hinrichs, 1988). *I think these pretty much cover all the emotions human beings have.*

- Write the five FLASH feelings on the board:

Fear	(apprehension, worry, dread, horror, unease, anxiety)
Love	(appreciation, caring, admiration, gratitude, serenity)
Anger	(annoyance, rage, resentment, indignation)
Sadness	(regret, loss, weariness, grief, resignation, hurt
Happiness	(joy, contentment, exuberance, satisfaction)

*Part of understanding ourselves is understanding how our thoughts, our emotions, and our bodies work together. Our bodies also express emotions. Lets start with **fear**. What are some things your body does when you are afraid?*

- Either write the following FLASH sensations on the board or not depending on time constraints. Quite a bit remains to be covered after this.

- **Discussion Questions:**

  What does fear feel like?

Typical Responses: FEAR	
My heart beats rapidly.	*I feel butterflies in my stomach.*
My breathing gets shallow and fast.	*My hands and feet get cold.*
I shake.	*I feel like I have to go to the bathroom.*
My teeth chatter.	*My color turns pale/white/gray.*
I break into a cold sweat.	*My pupils dilate*

  A threat, or a situation that is perceived as a threat, causes a rush of adrenaline and a strong "fight or flight" sensation. When a person is unable to do either, the fear can feel overwhelming.

  What are some things you do to deal with fear?

  Why is alcohol called liquid courage?

  What other drugs take away fear?

  What does love feel like?

Typical Responses: LOVE	
Pleasurable sensations associated with a sensory event.	*My heart jumps or tightens.*
General sense of physical well-being.	*I feel like hugging him.*
I admire her.	*I care about what happens to that person.*
I am grateful to know that person.	*I enjoy our talks and the time we spend together.*

  Women whose attention must be on survival may have few opportunities to experience rewarding relationships and not have a clear understanding of what love is.

What does anger feel like?

Typical Responses: ANGER	
My heart beats heavily and rapidly.	*I sweat.*
My breathing is deep and fast.	*My face, eyes, ears, or neck turn red.*
I feel a hot burning in my chest.	*I grit my teeth.*
The muscles in my jaw, arms, hands, and shoulders tighten.	*I make fists.*
I feel like I want to pace or strike out.	*Blood vessels in my forehead bulge.*

Physically, anger is very much like fear, based on our need to fight to protect ourselves against a threat or what we think is a threat. Women are sometimes frightened by anger in themselves or in others because they believe it means violence is coming. They often come to regard all anger as destructive and "bad."

Can anyone give an example of when anger is good?

What does sadness feel like?

***Typical Responses:* SADNESS**	
My movements slow down.	*I turn blue.*
I cry.	*I feel sick, like the flu.*
I feel emptiness inside.	

Do we use stimulants such as coffee, chocolate, cocaine, or amphetamines to help feel emotions other than sadness or to stop being depressed?

What does happiness feel like?

Typical Responses: HAPPINESS	
My skin glows.	*I smile.*
My eyes are bright.	*I feel like I can accomplish anything.*
I feel good.	*I feel like the world is a safe and interesting place*
I laugh.	
I have energy.	

Question 5: ***How did you come to know what you know about yourself?***

Typical Responses:
I don't know how I know; I just do. *My grandmother taught me some things about feelings.* *My mother said that I was crazy. Sometimes that seems true.* *I am learning about insanity in NA.*

EXERCISE 1: FLASH Feelings

- Ask the women to use the FLASH feelings model to give examples of times they experienced each of the emotions and it felt good. If time permits, write their responses on the board.
- Help the women focus on the naturalness of feeling any of these emotions and the fact that it is O.K. to have any of these feelings.

	Typical Responses
Fear	*I love roller coasters!* *I pay good money to see slasher and horror films!* *I don't like anything scary. I feel too much fear as it is.* *I like parachuting/parasailing/bungee jumping.* *I like the excitement of gambling—I never know how things will turn out.* *I use thrill seeking to avoid other feelings.*
Love	*When I listen to beautiful music I feel love.* *I feel love when I am with my fiancé.* *I don't know what love is or when I've ever felt it.* *When I see a sunset or beautiful art I feel love.* *Chocolate!* *The world is perfect to me when I am with my children.* *I like to play with puppies and kittens.* *I feel love when I can give to others.* *I feel love when I am at the beach.*
Anger	*One time I got so pissed at my ex I told him off, and it felt good!* *I wasn't able to truly recover until I got mad at my disease.* *When I get a "mad on" I feel pumped!* *My anger gives me the courage I need to advocate for my children.*
Sadness	*When someone I love is away and I miss him or her, it is a bittersweet feeling.* *I am a sucker for dramas and tear-jerker movies.* *After I have a good cry, I feel better.* *I like to listen to sad and sentimental songs. I get into it.*
Happiness	*I don't know what that feels like.* *I was happy when I got my 90-day recovery medallion!* *I feel happy when I think about the day my children were born.* *I feel happy when I think about the good things in my future.*

Optional Discussion Question:

Do you ever avoid doing things you really need to do in order to avoid feelings you don't like such as fear or anger?

EXERCISE 2: Deep Breathing

- The following closing exercise involves teaching women an important skill—learning self-awareness grounded in their physical reality. Although the statements sound similar to progressive relaxation or even a hypnotic induction, it has a very different function. It is *not* designed to place women in an altered state of consciousness. This can be risky for women with thought disorders or trauma survivors with dissociative tendencies. Therefore it is important that the facilitator speaks throughout the exercise, keeps it brief, and uses frequent reality reminders such as "You are probably aware of the temperature in the room…the feeling of the chair you are sitting on…the noises we can hear from the traffic outside."

The exercise we're going to do now shows how we can use our bodies to affect our emotions.

- ~ *Sit as comfortably as you can.*
- ~ *You can keep your eyes either closed or open.*
- ~ *Rest your hands on your stomach and notice how the stomach rises gently as you inhale and drops as you exhale.*
- ~ *Practice this a moment.*
- ~ *Place your hands on your ribs and notice that as you inhale your stomach rises and your ribs expand as your lungs fill your body.*
- ~ *Notice that as you exhale your ribs close together gently and your stomach gently pushes the air out.*
- ~ *Notice, after you exhale, how naturally the air flows into your body.*
- ~ *Feel your chest rise as you inhale and drop as you exhale.*
- ~ *Experience for a moment the sensation of your chest dropping, your ribs pulling together, and your stomach pushing out the air when you exhale. Notice how naturally the stomach rises, the ribs separate, and the chest rises when you inhale.*

CLOSURE

(After the exercise) *Notice how you may feel a little calmer, that you may have a light feeling of relaxation or a deep restful feeling. However you feel is fine for this moment. Notice that something you have done—the deep breathing—has an effect on your emotions, your body, and maybe even your thoughts.*

Thanks for coming everyone. See you next week. We will talk about how our mind and emotions work together.

Phase I: Mindfulness
Getting Comfortable with Yourself

Chapter 3: HOW MIND AND EMOTIONS WORK TOGETHER

Margo Fleisher-Bond

SESSION OUTLINE

RATIONALE

In this session it is shown how feelings are caused by thoughts and how current negative thinking stems from past experiences of trauma, drug-related problems, and mental illness. Women learn to manage their emotions by attending to their thoughts and selecting new, rational perceptions to replace old, erroneous thoughts based on negative events.

GOALS

1. Members will understand the connection between events, their perceptions and thoughts about the events, and their resulting feelings.
2. Members will begin to see how managing emotions is an internal process that is within their control.

QUESTIONS

1. *Where do your feelings come from?*
2. *How do you manage your feelings?*

EXERCISE

Event-Thought-Feeling Worksheet. Members fill out handouts showing the connection between events, thoughts, and feelings.

SUPPLIES

Chalkboard or equivalent, Handout 3

INTRODUCTION

Start each group session with a brief review of the members' current issues. Specifically focus on women with safety and/or emergency issues. Review members' emergency crisis numbers and members' Personalized Safety Plans.

In our last session we talked about different emotions and about accepting how natural it is to feel all of these emotions. We ended with a breathing exercise to learn more about how our actions and physical sensations affect our emotions. Today we are going to learn how our thoughts cause our feelings.

Question 1*: Where do your feelings come from?*

- Ask members to contribute and write the responses on the board.

Typical Responses
I really don't know where my feelings come from; I think they just happen.
My feelings come from other people. If they feel good, I feel good. If they feel bad, I feel bad.
I feel good when I get what I want and bad when I don't get what I want.
I create my own feelings; they are based on my expectations.

- Write the following event-thought-feeling diagram (adapted from Ellis, 1975) on the board.

Event → **Thought** → **Feeling**

Our feelings are caused by how we think about events—things that happen around us or to us.

1. *Something happens* **(Event)**.
2. *We understand it based on past experiences or current attitude* **(Thought)**.
3. *This thought affects how we feel as a result of the event* **(Feeling)**.

This is important: feelings are natural and logical consequences of thoughts, and feelings are never wrong or crazy.

- On the board, write an example, either the one below or one based on a current situation.

Event	Thought	Feeling
I passed my counselor in the hall, and she didn't say hello to me.	She's abandoning me, just like everyone else I've ever cared for.	Intense anger, fear, sadness
	I must be in trouble with her.	Fear
	Who the hell does she think she is?	Anger
	Nobody likes me!	Loneliness

Feelings are hard to control, and most events and situations are out of our control. We <u>can</u> take a look at how we think and try to think more rationally or logically. We can change our feelings. Let's look at our example again.

Event	Thought	Feeling
The scenario is the same since events are not within our control.	She must be preoccupied. I know she thinks I am important in the group.	Happy/Love
	I guess she didn't see me.	A little sad
	I am important.	Love
	Oh, well.	No feeling

EXERCISE: Event-Thought-Feeling Worksheet

- Group members complete only the **Event, Thought, and Feeling** sections of number 1 of Handout 3 regarding an event that happened recently. As members share their work, assist them in identifying the event, the thought, and the feeling. This will take some time.

Discussion Questions:

<u>Is it live, or is it Memorex</u>? Past experiences influence our thinking—in fact, all our thoughts are based on the past. Events that are really neutral may be colored by memories of similar experiences in the past. Can anyone give an example?

One example might be the experience of being alone. In the past that may have meant that after you were alone for a while something bad would happen. How else could we think about being alone?

<u>Stinkin' Thinkin</u>'. For people with addictions, craving for substances may heavily influence thoughts. Can you give some examples?

<u>"Having a bad day"</u> may lead to "I deserve to use" or " No one could blame me for drinking after that." Accomplishments or victories may be followed by "I think I'll reward myself." What are some different thoughts we might have? (Examples: "One day at a time" and "This too shall pass.")

<u>Irrational Thinking</u>. Sometimes our problems may lead to irrational perceptions or a worldview not grounded in reality. Examples include thoughts such as "Everybody hates me" and "Everybody is out to get me." Is it realistic to think the whole world is spending time and attention focused on us? Can anyone give some other examples?

Sometimes our irrational thinking is caused by our mental illness, our past trauma, or our addiction. For example, schizophrenia can cause us to hear things that are not there, trauma can make us feel that we could have acted to stop something we had no control over, and addiction can make us think that we can control our use of substances-even though we know if we pick up we will binge.

How can we test the reality of these thoughts? For example, if a sales clerk is rude to you, notice how he or she treats the person before you and after you in line. Another powerful way to test reality is to check with others—get other opinions. Can you think of any more ways?
Now go back and look at the thoughts you wrote on the handout. Do any of them seem irrational?

Question 2: ***How do you manage your feelings?***

Typical Responses
I try to make the right things happen.
I stuff my feelings.
I ignore my feelings.
I use drugs and alcohol.
I find someone to comfort me.
I think my experiences through, and see where I might be distorting my understanding about what has just happened.
I try not to feel – taking my medications as prescribed helps me manage my feelings.

Discussion Questions:

How do mental health and substance use disorders affect our judgment?

How do mental health and substance use disorders affect our ability to deal with problems?

What role does denial play in dealing with mental illness, substance abuse, and trauma?

What skills are needed to cope with mental health symptoms?

Typical Responses
Accepting that I need help.
Understand that I am not to blame for my mental illness, but that I must deal with it.
Reporting and tracking changes in symptoms accurately.
Recognize symptoms such as irrational thinking and depression.
Taking medications as prescribed.
Speaking up when I meet with my psychiatrist.
Accepting that mental health problems are a part of my life.
Not getting down on myself because I have mental health problems.
Not using drugs and alcohol that mess up my thinking.

How does it happen that you take or do not take your medications?

Typical Responses
I forget.
I won't take it if I think it will lower my high.
I know I won't be able to sleep without it.
I know I will become paranoid if I don't take it.
I don't like that it makes me jittery.
It has made me put on weight which my boyfriend does not like.
It makes me not want to have sex.
It helps me not use drugs or alcohol.
It makes me so tired I can hardly get anything done during the day.
I am pregnant and I was told not to take it.
When I take it I can be around people easier.

EXERCISE (Continued)

As we explore new ways to manage our feelings, we should honor the ways we have coped in the past as doing the best we could. We have talked about how our thinking causes our feelings, and some of the reasons we think as we do. Now let's look at ways to change our opinions and our thoughts about an event and notice if that changes our feelings about that event.

- Ask the group members to now fill in the **New Thought/Feeling** column on their **Event-Thought-Feeling Worksheets (Handout 3)**. Make suggestions for alternate thoughts, and ask other group members for feedback. A useful way to come up with alternate thoughts is to ask if they have been in a similar situation and felt O.K. afterwards. Help members explore what they were thinking when this happened.

CLOSURE

- Thank members for attending. Give special thanks to those who shared their experiences in the group. Ask members to complete the Event-Thought-Feeling Worksheet (Handout 3) and bring it to the next group. Suggest that members continue to practice deep breathing.

Next week we'll talk about what it means to be a female.

HANDOUT 3: EVENT-THOUGHT-FEELING WORKSHEET

1	**EVENT** *Describe an event that happened in the last 24 hours.*	**THOUGHT** *Describe your thought(s) about that event.*	**FEELING** *Describe your feeling(s) after your thoughts about the event.*	**NEW THOUGHT/ FEELING** *Give an example of some different thought(s) and the feeling(s) that would follow.*
2	**EVENT** *Describe an event that happened in the last 24 hours.*	**THOUGHT** *Describe your thought(s) about that event.*	**FEELING** *Describe your feeling(s) after your thoughts about the event.*	**NEW THOUGHT/ FEELING** *Give an example of some different thought(s) and the feeling(s) that would follow.*
3	**EVENT** *Describe an event that happened in the last 24 hours.*	**THOUGHT** *Describe your thought(s) about that event.*	**FEELING** *Describe your feeling(s) after your thoughts about the event.*	**NEW THOUGHT/ FEELING** *Give an example of some different thought(s) and the feeling(s) that would follow.*

Phase I: Mindfulness
Getting Comfortable With Yourself

Chapter 4: WHAT IT MEANS TO BE A FEMALE

Gigi Cabrera

SESSION OUTLINE

RATIONALE

This group will help members create greater awareness of their bodies and their sexuality. The group will explore how cultural expectations, trauma, substance abuse, and mental illness have affected the images women have of themselves.

GOALS

1. Group members will gain a new sense of awareness of themselves and a personal meaning of what it means to be a female.
2. Group members will understand how their beliefs about being female can change if they are drug and alcohol-free and mentally stable.

QUESTIONS

1. *When you think about being a female, what are the first things that come to mind?*
2. *What do people think about females and males in your culture?*
3. *What thoughts do you have about your body?*

EXERCISE

Deep Breathing with a Positive Thought. Members practice the deep-breathing exercise learned in Chapter 2 while holding a positive thought about being a woman or about their bodies.

SUPPLIES

Chalkboard or equivalent, extra copies of Handout 3

INTRODUCTION

Start each group session with a brief review of the members' current issues. Specifically focus on women with safety and/or emergency issues. Review members' emergency crisis numbers and members' Personalized Safety Plans.

Last week we continued looking at how our minds, emotions, and bodies work together to heal and recover. One tool we used was the Event-Thought-Feeling Worksheets. Let's look at the ones you filled in since our last group.

- Review their worksheets with them. Ask those who did not complete a worksheet to think of an event that happened in the last week and to complete one now. Offer additional blank copies of the worksheets (Handout 3) in case group members want to continue to practice.

An important part of discovering who "we are" is understanding what it means to be a woman, and that's what we'll be exploring this week.

Question 1: ***When you think about being a female, what are the first things that come to mind?***

Typical Responses			
Negatives		**Positives**	
Hormone swings	*PMS*	*More sensitive*	*Caring*
Big thighs/butt	*Gain weight*	*Soft-spoken*	*Mothering*
Labor pains	*Talk too much*	*Care-giving*	*Nurturing*
Menstrual period/cramps	*Losing your shape*	*Compassionate*	*Strong*
		Giving birth	*Wise*
Difficulties with body image	*Not taken seriously*	*More socially responsive*	*Competitive*
			Beautiful
Vulnerable emotionally	*Vulnerable physically*	*Spiritual*	*Conscious about bodies*
		Able to relate well	
Uncomfortable undergarments	*Expected to be a maid*	*Able to compromise*	*Sexy*

Question 2: ***What do people think about females and males in your culture?***

Typical Responses	
Female	**Male**
Women are unable to take care of themselves even though they are supposed to take care of the children.	*Men are the strong protectors and should make all of the decisions.*
Girls should be gentle and sweet.	*Boys can be aggressive and mean.*
Women are men's sexual toys.	*Men need a lot of sex.*
Girls are more verbal and like to talk.	*Boys are better at math and science.*
Girls and women are supposed to act and look a certain way.	*Men are supposed to act and look a certain way but not as much as girls and women.*
A woman lives her life to please others.	*A man lives his life to work and improve society through his efforts.*
It's okay for a woman to work, but she still has to keep the house clean and take care of the needs of her family.	*A man should bring home the bacon and when he is at home he should be treated like a king.*
Women should stay home with the children.	*Men have more freedom to do what they want.*
If a woman sleeps around she is a slut.	*If a man sleeps around he is a stud or his wife is not giving him what he needs.*
Women are very emotional but that is expected.	*A man should always be in control of himself and his life.*

Discussion Questions:

Are there differences between ethnic and racial groups in their roles for females and males?

Are women often taught to please others and to put others' needs first?

What do you think is the difference between selfishness and caring for yourself?

Do you agree with the statement "One of the best ways to care for your children is to care for their mother"?

Are men and women who abuse alcohol or drugs judged differently in your culture?

How do abuse and violence reinforce the traditional roles of women in your culture?

Question 3*: What thoughts do you have about your body?*

Typical Responses			
Positive		***Negative***	
Attractive	*Strong*	*Shame*	*Betrayed*
Healthy	*Sexy*	*Dirty*	*Guilt*
Nice hair	*Life-giving*	*Overweight*	*Disgusted*

Discussion Questions:

Does your culture overvalue a woman's attractiveness and undervalue her personality and abilities? (Walker, 1994, p. 434; Mangweth, Pope & Hudson, 1995)

Do you think that women who have been sexually abused often make themselves unattractive in order to avoid sex—for example, gain too much weight and lose too much weight?

What are some things women do when they have a poor body image? (munching on unhealthy foods, binge eating, not eating nutritiously, etc.)

*The stress of a violent childhood may have long-term physical effects (*American Medical Association, 1992). *Can you think of some examples?* (irritable bowel syndrome, excess gas, tension headaches, back pain, etc.)

Can mental illness contribute to a distorted body image? (American Psychiatric Association, 1994*)*

Can substances cause health problems? (American Psychiatric Association, 1994).

Did you know that some psychiatric medications cause weight gain?

Do you think that sexual functioning can be affected in women who have been sexually abused? (McClelland, Mynors-Wallace, Fahy & Treasure, 1991)

Do you think exercise is important to recovery?

What keeps us from taking better care of our bodies?

EXERCISE: Deep Breathing with a Positive Thought

Let's do the breathing exercise again, and this time identify something you feel very good about in terms of being a woman or something good about your body. Then hold this thought as you do the breathing.

CLOSURE

During the last four sessions (Phase I) we talked about making choices for our personal safety, we looked at how our thoughts affect our feelings, and we talked about what it is to be a female. I hope this has been a useful experience for you and that you will continue with us as we begin Phase II next week. Phase II focuses on Interpersonal Skills and next week's topic is Assertive Communication.

Phase II: Interpersonal Skills
Healthy Relationships

INTRODUCTION TO PHASE II: HEALTHY RELATIONSHIPS

Phase I was about learning about ourselves. Our focus was on taking care of our minds, our bodies, and our emotions. Now we will learn new skills in relating to others and building healthy relationships.

If new members are joining for Phase II, review the safety rules of Chapter 1 and reinforce the need for confidentiality.

Start each group session with a brief review of the members' current issues. Specifically focus on women with safety and/or emergency issues. Review members' emergency crisis numbers and members' Personalized Safety Plans.

Chapter 5: ASSERTIVE COMMUNICATION

Margo Fleisher-Bond

SESSION OUTLINE

RATIONALE

Communication both impacts and is impacted by mental illness, substance abuse, and the experience of violence. Individuals with all three Triad issues have often not developed the skills required to communicate their needs well to others. It is important for Triad women to understand the difference between messages they send to others and the messages they intend to send.

GOALS

1. Members will learn how to express and meet their needs using both verbal and nonverbal *forms* of communication and passive, aggressive, and assertive *styles* of communication.
2. Members will understand how violence/trauma, mental illness, and substance abuse affect communication.

QUESTIONS

1. *What is verbal communication?*
2. *What is nonverbal communication?*
3. *What is passive communication?*
4. *What is aggressive communication?*
5. *What is assertive communication?*

EXERCISE

Role-Playing Communication Styles. Group members role-play passive, assertive, and aggressive communication styles, with coaching from the facilitators and other group members.

SUPPLIES

Chalkboard, Handouts 5a and 5b

FORMS OF COMMUNICATION

There are 2 forms of communication: verbal and nonverbal.

Question 1: ***What is verbal communication?***
Verbal communication is spoken, written, or symbolic language (such as sign language).

Question 2: ***What is nonverbal communication?***
Nonverbal communication is everything else used to express a want, need, idea, or emotion.

Typical Responses	
Non-vocal sounds (whistles, yawns)	*Use of space*
Facial expressions	*Volume of voice*
Body positioning	*Tone of voice*
Gestures	*Posture*
Touching	*Ways of dressing*
Hairstyle	*Eye contact*
Way of walking	*"Attitude"*

Discussion Questions:

Do we send messages we don't want to because of nonverbal habits we're not aware of?

Are there common nonverbal ways of communicating in the drug culture?

We communicate <u>verbally</u> off and on when we're with people. How often do we communicate <u>nonverbally</u>? (all the time)

STYLES OF COMMUNICATION

There are 3 styles of communication: passive, aggressive, and assertive. Each style can be useful depending on circumstances.

Question 3: ***What is passive communication?***

Typical Responses	
Being indirect	*Being manipulative*
Not saying anything	*Hunched posture*
Beating around the bush	*Deferring to others' wishes and desires*
Being vague	*Trying to get others to guess your needs*
Trying to blend into the surroundings	*Putting the rights of others before my own*
Trying to look smaller than you are	*Little or no eye contact*
Having something important to say but not wanting to say it	*Talking softly*

Discussion Questions:

Is the passive style used more by women than by men?

Is this different for different cultures?

Passive communication is best used when someone has a lot more power than you have or is likely to hurt you. Sometimes it is in our best interest to respond passively. Can anyone give an example? (in court, when someone has a weapon, etc.)

Passive communication may be a primary style in an abusive family or relationship. Why is that?

Overuse of passive communication can be a problem because others have to guess what you want. Can someone give an example?

Question 4: ***What is aggressive communication?***

Typical Responses	
Making threats	*Being intimidating*
Staring at people	*Raising my voice*
Yelling at my kids	*Invading others' space*
Putting my rights before others' rights	*Giving ultimatums*
Waving a weapon around or making a fist	*Hovering over people*

Discussion Questions:

Is the aggressive style used more by men than by women?

Is this different for different cultures?

Aggressive communication causes problems (fights with roommates or loved ones, arrests for domestic violence or assault, problems with disciplining children, etc.). Would aggressive communication ever be the best style to use (screaming or grabbing the arm of a child who is about to step in front of car, etc.)?

Aggressive communication is often used in abusive families and on the street. Why?

Aggression tends to close off channels of communication more than being assertive or passive, because the receiver has few choices other than to comply or become aggressive too. What might be more effective?

Question 5: ***What is assertive communication?***

Typical Responses	
Being to-the-point	*Respecting boundaries*
Being honest	*Regular and direct eye contact*
Asking direct questions about what another person means or needs	*Asking for what I want and being open to negotiation*
Respecting my rights	*Talking loud enough for others to hear*
Respecting others' rights	*Having confidence in what you say*
Respecting the process of trying to understand each other	*Standing or sitting up straight in a relaxed position*
Being direct and clear about what I want	*Being willing to back up what you say*

Discussion Questions:

Can any of you share about how assertiveness was effective for you in the past and how it felt when you used it?

Assertiveness is useful in almost all situations, and if it doesn't work, it leaves communication open to try again with other styles. It is called a win-win method. What does that mean?

Do you think these 3 communication styles (passive, aggressive, and assertive) are based more on learning or on personality?

How can a mental illness affect how we communicate with others? For instance, does depression affect how we communicate? Does taking medication change how we communicate with other people?

EXERCISE: Role-Playing Communication Styles (passive, aggressive, and assertive)

- Group members role-play verbal and nonverbal forms of passive, aggressive, and assertive communication in front of the group, with coaching and support by the facilitator and other group members. Some examples of communication scenarios are
  - ~ Asking a family member for a small loan;
  - ~ Telling a son or daughter to clean his or her room;
  - ~ Declining an offer from a salesperson;
  - ~ Refusing drugs or alcohol;
  - ~ Turning down an unwanted sexual proposition;
  - ~ Asking for help with a writing assignment;
  - ~ Reporting medication side-effects to a counselor, nurse, or physician;
  - ~ Inviting someone to go out.

GOALS IN SITUATIONS

- Pass out **Handout 5a** (Goals in Situations).

To get what we want it is necessary to know what we want—that is, to understand our goals. In terms of dealing with others there are at least three kinds of goals (Linehan, 1993):

1. ***Objective goals****—what concrete results you want from an interaction*
2. ***Relationship goals—****getting or keeping a good relationship*
3. ***Self-respect goals****—keeping or improving self-respect and liking yourself*

- Read the following examples:

Your landlord unfairly keeps your security deposit.

1. ***Objective goal****—get your deposit back (most important).*
2. ***Relationship goal****—keep the landlord's goodwill to get a reference for another apartment.*
3. ***Self-respect goal****—don't give in or get overly emotional.*

Your best friend wants to come over to talk about a problem, but you want to go to bed.

1. ***Objective goal****—go to bed.*
2. ***Relationship goal****—keep your good relationship with your friend.*
3. ***Self-respect goal****—balance caring for your friend with caring for yourself.*

A friend may ask you on a date, and you think your friend may expect sex.

1. ***Objective goal****—to have a pleasant evening.*
2. ***Relationship goal****—to keep our friendship.*
3. ***Self-respect goal****—to keep my values by not having sex before I want to.*

- Have group members think of additional situations and identify the objective, relationship, and self-respect goals.

CLOSURE

- Handout Communication Worksheet (**Handout 5b**).

Before we leave today I would like us all to do #1 from the worksheet together.
During the next week I would like you to take some time and finish the rest of the worksheet so we can go over it at the beginning of group next week.

Today we talked about the ways we communicate with others and what types of goals we have when we communicate. Next week we will talk about what happens in relationships when there is trust and respect.

HANDOUT 5a: GOALS IN SITUATIONS

OBJECTIVE GOALS
(What results you want from an interaction)

- Obtain your legitimate rights.
- Get someone to do something.
- Refuse a request.
- Resolve a conflict.
- Get your opinion taken seriously.

Questions to ask yourself:

1. *What results or changes do I want from this interaction?*
2. *What do I have to do to get the results I want? What will work?*

RELATIONSHIP GOALS
(Getting or keeping a good relationship)

- Act in a way such that the other person keeps liking and respecting you.
- Balance immediate goals with what's good for the long-term relationship.

Questions to ask yourself:

1. *How do I want the other person to feel about me after the interaction?*
2. *What do I have to do to keep this relationship?*

Sometimes the main goal of the interaction is getting the other person to approve of you, stop criticizing you or rejecting you, or to stay with you. Sacrificing your own needs and wants for the relationship may cause the relationship to be out of balance.

SELF-RESPECT GOALS
(Keeping or improving self-respect and liking yourself)

- Respect your own values and beliefs.
- Act in a way that makes you feel moral.
- Act in a way that makes you feel capable and effective.

Questions to ask yourself:

1. *How do I want to feel about myself after the interaction is over?*
2. *What do I have to do to feel the way I want to about myself?*
3. *What will work to keep my self-respect?*

*****ALL THREE TYPES OF GOALS MUST BE CONSIDERED IN EVERY INTERPERSONAL OR PROBLEM SITUATION*****

Adapted from: Linehan, M. (1993). *Skills training manual for treating borderline personality disorder* (p. 116). New York: The Guilford Press.

HANDOUT 5b: COMMUNICATIONS WORKSHEET

1	**SITUATION** Describe an **event** in the last 24 hours, what you **thought** about it, and how you **felt** about it.	**COMMUNICATION** Describe what you communicated and how you did so (verbal, nonverbal, assertive, aggressive, passive, etc.)	**RESULT** Did you get what you wanted? How did you **feel**?
2	**SITUATION** Describe an **event** in the last 24 hours, what you **thought** about it, and how you **felt** about it.	**COMMUNICATION** Describe what you communicated and how you did so (verbal, nonverbal, assertive, aggressive, passive, etc.)	**RESULT** Did you get what you wanted? How did you **feel**
3	**SITUATION** Describe an **event** in the last 24 hours, what you **thought** about it, and how you **felt** about it.	**COMMUNICATION** Describe what you communicated and how you did so (verbal, nonverbal, assertive, aggressive, passive, etc.)	**RESULT** Did you get what you wanted? How did you **feel**

Phase II Interpersonal Skills
Healthy Relationships

Chapter 6: TRUST AND INTIMACY

Fred Fearday

SESSION OUTLINE

RATIONALE

Women who were raised in abusive situations often have not learned vital lessons about relationships. It's difficult to learn about trust when the people you depend on act in harmful ways toward you. Sex may be confused with intimacy. Substance abuse further impairs judgment about safe relationships, and women with mental illnesses may isolate themselves.

This session talks about what actions promote trust, violate trust, or lead to mutual respect and give-and-take. Members will learn how to balance their needs and wants with the needs and wants of others and be able to identify the stages of a relationship and what it means to be emotionally close to another person.

GOALS

1. Members will be able to state what conditions create trust and safety.
2. Members will learn what conditions violate trust and safety.
3. Members will learn how healthy and unhealthy relationships differ.

QUESTIONS

1. *What kinds of behaviors create trust, mutual give-and-take, and safety?*
2. *What behaviors violate trust, mutual give-and-take, and safety?*
3. *How have substance abuse and other harmful behaviors interfered with trust?*
4. *What happens if hurts and problems build up in a relationship?*
5. *What is intimacy?*
6. *What is necessary for closeness (intimacy) to occur?*
7. *What are the key elements of an intimate relationship?*
8. *What is emotional safety in a relationship?*
9. *What won't I tolerate in a relationship?*

EXERCISES

1. *Keeping Relationships in Balance.* Members contrast *demands* and *shoulds* versus *priorities* and *wants* on the board.
2. *Myths about Relationships*. Members discuss rational versus irrational thoughts concerning relationships.

SUPPLIES

Chalkboard or equivalent, Handouts 6a and 6b, extra copies of Handout 5b (Communications Worksheets)

INTRODUCTION

Start each group session with a brief review of the members' current issues. Specifically focus on women with safety and/or emergency issues. Review members' emergency crisis numbers and members' Personalized Safety Plans.

Last week we talked about communicating our wants and needs assertively. (Review the **Communications Worksheets**. **(Handout 5b**). Ask if any members are willing to share a situation they worked on during the week or a situation from the last 24 hours they would be willing to work on.

This week we'll talk about intimate relationships and when and when not to trust. Some people are able to use the assertiveness skills we talked about last week with strangers but not with friends. We will also talk about balancing objective, relationship, and self-respect and how to keep relationships in balance.

TRUST

Question 1: ***What kinds of behaviors create trust, mutual give-and-take, and safety?***

Typical Responses*
When someone doesn't give other people private information about you
When someone accepts me the way I am
When I am there for them and they are there for me
When boundaries are respected
When someone does not try to hurt me or take advantage of me
When someone really listens to me
When people make a real commitment to one another
Mutual respect
**Adapted from Harris, 1998, p.62.*

- Ask for specific behaviors that show constancy, predictability, knowing someone, and sharing, as shown below (adapted from Harris, 1998, p. 64).

Constancy *(steadiness, reliability, and dependability) over time—having someone do what they say they will; knowing that you are getting the real story.*

Typical Responses
She always returns everything she has borrowed.
My mother always calls once a week.
My sister always calls when she is going to be late.

Predictability*—being able to count on someone to behave in a certain way; someone not becoming suddenly or unexpectedly angry.*

Typical Responses
My roommate never wants me to talk until she takes a shower in the morning.
She is never verbally abusive even when she is very angry with me.
My friend Kathy is always late.
The secretary here is always friendly when I call.

Knowing someone *over a reasonable period of time*

Typical Responses
I talked to Jason at work for a month before I gave him my home phone number.
I met Mary at the library; I agreed to meet her at the bookstore for coffee but did not give her my home number.

Sharing *the same values with someone*

Typical Responses
I feel safe talking to Stan about my urges to use crack because he has been there and knows what it is like to want to use. I see him in NA every week. He has been clean for two years and he supports my staying clean. Some of my other friends seem to want me to use.

Question 2: ***What behaviors violate trust, mutual give-and-take, and safety?***

Typical Responses	
Cheating	*Private information being shared*
Being abused	*Putting me down*
Being taken advantage of	*Not respecting me or my feelings*
Judging me	*Being forced to have sex*
Covering up the truth	*Bringing up things from my past*
Offering me drugs	*Using around me*
Trying to control me	*Telling me not to take medication*
Not doing what they say	*Lying*
Taking money	

Question 3: ***How have substance abuse and other harmful behaviors interfered with trust?***

Typical Responses
When people are using they are not dependable. *When people use drugs or alcohol, their judgment is off.* *When people are using you cannot tell what they will do.* *When people are using they take and don't give back.* *When people are craving they will do anything for drugs.* *When I use I act differently around my friends.* *When I use I do things sexually that I later regret.* *When I use I get depressed and sometimes want to hurt myself.* *When I use I stop taking my medications for my voices.*

Question 4: ***How have mental illnesses interfered with our relationships with other people?***

Typical Responses
With my mental illness I get paranoid of people and do not trust them. *When I have been manic I used bad judgment and spent a lot of money my family needed.* *People feel they cannot rely on me.* *I don't think I have much to offer someone in a relationship.* *I act pretty inconsistently. Sometimes I am friendly and the next day I don't want to talk to anyone.*

EXERCISE 1: Keeping Relationships in Balance

It is difficult to achieve balance in relationships. Let's review the Handout 5a from last week on ***Goals in Situations****. What happens when there is a conflict between your self-respect goals and your relationship goals?*

- Ask for examples and give some if needed. Examples:
  ~ Someone says, "You must prove you are my friend by using with me."
  ~ Your friend really wants to talk about herself and you are tired and want to get home.
  ~ Your best friend expresses political ideas that you strongly disagree.
  ~ A friend from AA tells you that taking psychiatric medications of any kind is just wrong.

Some women may be quite good at saying no to strangers but not to friends; others may be able to ask for help from their friends but not from their bosses.

- Pass out **Handout 6a** (Interpersonal Mastery and Self-Respect).
- Draw a line down the middle of the board. Ask members to list **others' demands and shoulds** on one-side and **their own priorities and wants** on the other side (Linehan, 1993).

Demands *are those things other people insist you do.*

Shoulds *are those things you think you ought to do for other people.*

Priorities *are those things important to you that need to get done soon.*

Wants *are those things you really want to do because they give you pleasure, or because you simply feel like doing them.*

Typical Responses	
Others' Demands and Shoulds	**My Priorities and Wants**
Get someone a beer	*Get some rest*
Cook dinner for someone	*Read a favorite book*
Clean house	*Go to an AA meeting*
Have sex	*Have sex*
Get to work on time	*Look for a job*

Question 5: ***What happens if hurts and problems build up in a relationship?*** (adapted from Linehan, 1993, p. 75)

Typical Responses	
I don't get what I want from the relationship.	*I feel drained.*
I am often angry and feel resentful toward the other person.	*I start feeling physical symptoms like headaches or stomachaches.*
I feel under a lot of stress in the relationship.	*I begin to feel afraid or in danger.*
I feel unhappy in the relationship.	*I feel that I am always criticized and don't feel supported.*
	I feel worthless.

INTIMACY

Question 6: ***What is intimacy?***

Typical Responses*	
Sex	*Emotional connection*
Passion	*Relationship with sex partner*
Closeness	*Understanding*
Trust	

*Adapted from Harris, 1998, p. 63

Question 7: ***What is necessary for closeness (intimacy) to occur?***

Typical Responses	
Trust	*Rapport*
Listening and being heard	*Confidentiality*
Understanding	*Accepting people as they are*
Honesty	*Familiarity*

- Ask members to use examples to show what they mean.

Question 8: ***What are the key elements of an intimate relationship?***

Typical Responses	
Having things in common	*Communicating well*
Give and take	*Feeling close*
Bonding	*Honesty*
Feeling mutual respect	*Feeling safe*

Discussion Questions:

Do you think survivors of sexual abuse often mistake sex for intimacy and emotional closeness? (Harris, 1998, p. 62)

Have you ever had sex when what you really wanted was emotional closeness?

Have you ever felt disappointed and betrayed when a sex partner failed to treat you with the concern and care you would expect from an emotional intimate?

EXERCISE 2: Myths about Relationships

Sometimes unrealistic and irrational thoughts about what relationships should be like get in the way of understanding their real nature. Fantasies about relationships can interfere with having a real and trusting relationship with someone. They can lead us to make bad decisions.

- Write two columns on the board labeled **Rational** and **Irrational.** Ask the members to think of a few rational and irrational opinions that they or people they know have about relationships and write them down.

- Pass out **Handout 6b (Rational and Irrational Thoughts about Relationships).** Ask that each member pick one of the irrational thoughts and tell why it is irrational.

EMOTIONAL SAFETY

Question 9: ***What is emotional safety in a relationship?***

Typical Responses	
Feeling safe	*Always telling the truth*
Knowing I'm being told the truth	*Feeling understood*
Trust	*Being listened to*
Knowing my feelings are important	*Having my sobriety supported*
Being respected	

Question 10: ***What won't I tolerate in a relationship?***

Typical Responses	
Abuse	*Stealing*
Lying	*Cheating*
Deliberately hurting me	*Child abuse*

CLOSURE

- Thank members for speaking up and being willing to share.

This week we talked about the importance of trust and balance in relationships. Another skill for communicating with others is setting boundaries. We will talk about how to set and maintain personal boundaries next week.

- Encourage the members to keep coming back.

HANDOUT 6a: INTERPERSONAL MASTERY AND SELF-RESPECT

Attending to Relationships

- Don't let hurts and problems build up.
- Use relationship skills to head off problems.
- End hopeless relationships.
- Resolve conflicts before they get overwhelming.

Balancing Your Priorities with Others' Demands

- If overwhelmed, reduce or put off low-priority demands.
- Ask others for help; say no when necessary.
- If you don't have enough to do, try to create structure and responsibilities; offer to do things.

Balancing Your Wants with Others' Shoulds

Look at what you do because you enjoy doing it and *want* to do it versus how much you do because others say it has to be done and you *should* do it. Try to keep the number of each in balance, even if you have to

- Get your opinions taken seriously,
- Get others to do things,
- Say no to unwanted requests.

Building Mastery and Self-Respect

- Interact in a way that makes you feel competent and effective, not helpless and overly dependent.
- Stand up for yourself, your beliefs and opinions. Follow your own wise mind.

Adapted from: Linehan, M. (1993). *Skills training manual for treating borderline personality disorder* (p. 115). New York: The Guilford Press.

HANDOUT 6b:

RATIONAL AND IRRATIONAL THOUGHTS ABOUT RELATIONSHIPS

Irrational **Thoughts about Relationships**	***Rational*** **Thoughts about Relationships**
1. I can't stand it if someone gets upset with me. 2. If they say no, it will kill me. 3. I don't deserve to get what I want or need. 4. If I make a request, this will show that I am a weak person. 5. I have to know whether the person is going to say yes before I make a request. 6. Making requests is really a pushy (bad, self-centered, selfish, unchristian) thing to do. 7. It doesn't make any difference; I don't care really. 8. Obviously, the problem is just in my head. If I would just think differently I wouldn't have to bother everybody else. 9. This is a catastrophe (is really bad, is terrible, is driving me crazy, will destroy me, is a disaster). 10. Saying no to a request is always a selfish thing to do. 11. I should be willing to sacrifice my own needs to others. 12. The other person must be perfect. 13. I will always be hurt if I am open with my feelings. 14. People who love each other should not argue. 15. A good relationship will always be intense.	1. It is OK to want or need something from someone else. 2. I have a choice to ask someone for what I want or need. 3. I can stand it if I don't get what I want or need. 4. The fact that someone says no to my request doesn't mean I should not have asked in the first place. 5. If I didn't get my objectives, that doesn't mean that I didn't go about it in a skillful way. 6. Standing up for myself over "small" things can be just as important as "big" things are to others. 7. I can insist on my rights and still be a good person. 8. I sometimes have a right to assert myself, even though I may inconvenience others. 9. The fact that other people might not be assertive doesn't mean that I shouldn't be. 10. I can understand and validate another person and still ask for what I want. 11. There is no law that says other people's opinions are more valid than mine. 12. I may want to please people I care about, but I don't have to please them all the time. 13. Giving, giving, giving is not the be-all in life. I am an important person in this world too. 14. If I refuse to do a favor for people, that doesn't mean I don't like them. They will probably understand that, too. 15. I am under no obligation to say yes to people simply because they ask a favor of me. 16. The fact that I say no to someone does not make me a selfish person. 17. If I say no to people and they get angry, that does not mean that I should have said yes. 18. I can still feel good about myself, even though someone else is annoyed with me.

Adapted from: Linehan, M. (1993). *Skills training manual for treating borderline personality disorder* (p.118). New York: The Guilford Press.

Phase II Interpersonal Skills
Healthy Relationships

Chapter 7: BOUNDARIES
Carol Parker

SESSION OUTLINE

RATIONALE

This session identifies emotional and physical boundaries used to protect personal space. Members may not have developed skills for dealing with intrusive or disrespectful contact. This session establishes the need and right a woman has to set boundaries with others and have them respected. The group will explore the meaning of personal space and how it changes according to the level of comfort, intimacy, or safety with the other person.

GOALS

1. Members will learn about personal boundaries and how to set them based on their own needs rather than the needs of others.
2. Members will understand the importance of setting boundaries and learn which behaviors maintain or violate boundaries.

QUESTIONS

1. *What is personal space?*
2. *How do you feel when people touch you or stand too close to you when you don't want them to?*
3. *What kinds of signals (body language or other nonverbal communication) tell others that a boundary has been crossed?*
4. *Does anyone you know violate the boundaries you make for yourself?*

EXERCISES

1. *Closeness and Nonverbal Communication.* Members observe nonverbal communications as they stand closer and closer to each other. The distance at which they still feel comfortable is measured with a measuring tape.
2. *Setting Emotional Boundaries.* The facilitator reads aloud examples of behavior and the group members categorize each behavior as either "setting emotional boundaries" or "not setting emotional boundaries."

SUPPLIES

Chalkboard or equivalent, measuring tape, extra copies of Handout 5a

INTRODUCTION

Start each group session with a brief review of the members' current issues. Specifically focus on women with safety and/or emergency issues. Review members' emergency crisis numbers and members' Personalized Safety Plans.

Last week we talked about trust and intimacy. This week we're going to talk about an important part of relationships that is often overlooked: personal boundaries.

Question 1: ***What is personal space?***

Typical Responses

It's where I go to be alone where no one can mess with me.
It's the space I need so I don't feel crowded or unsafe.
It's like a bubble around me. I only let in people I trust.
What space? I don't get any personal space.
It's my bedroom or the bathroom.

How much space would you need in order to feel comfortable or safe in the following situations?

- ~ *riding a bus;*
- ~ *having a neighbor give you a ride in her car? (What if the driver is a male?);*
- ~ *having someone sit next to you in a movie theater;*
- ~ *a stranger walking up to you and asking for a cigarette;*
- ~ *someone you don't trust passing you on the street.*

EXERCISE 1: Closeness and Nonverbal Communication

- Ask participants to make groups of three. Two of the members will stand 5 to 6 feet away from each other and then gradually step closer together. The third person remains stationary and watches for nonverbal clues that one or both of the other members are becoming uncomfortable with the closeness. Everyone will switch places until each member gets a turn at being the evaluator.

Can you think of any cultural differences in personal boundaries? For example, in some cultures it's comfortable for people to stand only a foot away from each other when having a casual conversation. Americans, on the other hand, usually feel comfortable when they are at least two feet apart.

Discussion Questions:

Can you think of any <u>other</u> cultural differences in personal boundaries?

How does your comfort level change when you are angry or depressed?

How about when you have had an argument with your boyfriend or girlfriend?

Does he or she respect your need for less intimacy and more space when you are angry?

Is it difficult to set new boundaries of personal space when someone is used to your old boundaries?

Have you ever noticed that when you are using drugs or alcohol you let people get closer to you than you would if you were sober?

How much personal space do you need when you are feeling anxious, depressed, or paranoid?

Question 2*: How do you feel when people touch you or stand too close to you when you don't want them to?*

Typical Responses

I feel fearful and frozen to the spot wondering what will happen.
I get angry and I want to strike out.
I panic and my first thought is to run away.
I get embarrassed and want to disappear.
I feel excitement and intimidation at the same time.
I feel shame because I think I did something wrong.

Discussion Questions:

When unwanted contact occurs, what do you do? How do you react?

Can you think of any boundary violations that occurred in your childhood that affect you now?

How have boundary violations affected your use of substances or your mental health?

Question 3: ***What kinds of signals (body language, verbal communication or nonverbal communication) tell others that a boundary has been crossed?***

Here are some examples. What signals would you use?

~ Someone asks you for a hug and you don't want to give one.
~ Someone is talking in a loud voice.
~ Someone keeps staring at you.
~ Someone stands too close to you at a bus stop**.**

SETTING EMOTIONAL BOUNDARIES

*We have been talking about setting and maintaining physical boundaries. Now let's talk about psychological or **emotional boundaries**. In the **Goals in Situations** handout from Chapter 5 we went over objective goals, relationship goals, and self-respect goals. Our self-respect goals can be maintained by setting emotional boundaries.*

- ~ *Emotional boundaries help you respect and like yourself.*
- ~ *Emotional boundaries help you and others respect your values and beliefs.*
- ~ *Emotional boundaries help you act openly and honestly.*
- ~ *Emotional boundaries help you feel more capable and effective.*

Sometimes there are conflicts between our self-respect goals and our relationship goals. We talked about them before. For example, what do you do when you think a new boyfriend won't go out with you again unless you have sex with him? Or someone says, "You must prove you are my friend by using with me"? Or your friend really wants to talk about herself and you are tired and want to get home? Or maybe your best friend expresses political ideas that you strongly disagree? Or a friend from AA tells you that taking psychiatric medications of any kind is just wrong?

EXERCISE 2: *Setting Emotional Boundaries*

- Make two columns on the board: ***setting emotional boundaries*** and ***not setting emotional boundaries***. Read the following examples to the group, which will decide what column the example belongs in. The volunteer may abbreviate the examples to save time and writing.

> Ask the women to categorize the behaviors as ***maintaining*** or ***violating*** objective (O), relationship (R), and/or self-respect (S) goals (refer to **Handout 5a**). Discuss why the behaviors maintain or violate these goals. Note that the violations are equivalent to **not setting emotional boundaries.**

- ~ *I wait until I know someone better before I give out my phone number* (R).
- ~ *I don't lie* (S).
- ~ *I give out personal information a little too soon* (violation of R).
- ~ *I give in to my kids most of the time* (violation of R, S).
- ~ *I tell people what I need* (O, R, S).
- ~ *I usually do what my partner wants to do* (violation of R, S).
- ~ *I don't say yes when I really want to say no* (R, S).
- ~ *I lie about things* (violation of S).
- ~ *I ask, "would it be okay if I hug you" before I hug someone* (O, R, S).
- ~ *I wait until I know someone better before I agree to a date* (R, S).
- ~ *I use drugs to show that I am a friend to someone* (violation of R, S).

- ~ *I tell my children no when they demand things from me* (R, S).
- ~ *I tell someone, "I want to think about that first."* (O, S)
- ~ *I have sex with someone because I'm afraid he'll leave if I don't* (violation of R, S).
- ~ *I talk about my history of abuse to people I don't know that I can trust* (violation of R, S).
- ~ *I tell others when I need time for myself* (O, R, S).
- ~ *I let someone talk me into using drugs when I am trying to stay sober* (violation of R, S).
- ~ *I say what I feel and think about things* (O, R, S).
- ~ *I tell my family or partner that I need time alone* (O, R, S).
- ~ *I don't have sex with someone just because I'm lonely* (R, S).
- ~ *I hide my feelings when someone hurts me* (violation of R, S).
- ~ *I tell someone "I feel uncomfortable with that question" or "that request"* (R, S).

Question 4: ***Does anyone you know violate the boundaries you make for yourself?***

- ■ Ask if anyone feels she needs to make a plan to deal with this issue, and if so, ask the group to problem-solve with her. As women brainstorm possible reactions to the boundary violation(s), refer back to sections on assertiveness (Chapter 5) and safety (Chapter 1). Explore with members their right to set clear and comfortable boundaries for themselves and how to use assertiveness skills to set these boundaries.

CLOSURE

During the coming week think about one relationship you have. This can be someone you are close to or simply a clerk in a grocery store. Notice how you behave in the relationship. Notice how you communicate. Observe his or her body language. Notice if there are things he or she does that make you more or less comfortable. Notice where you set your boundaries. Notice if you respect yourself after the interaction. Notice if you act in a way that makes you feel honest, capable, and effective.

We've explored a lot of material in these last few sessions, some of it very difficult. Next week we will discuss the support we get from other people and how to build support in our lives.

- ■ Thank members for showing their commitment to recovery by coming to this group every week. If you know of other things the women are doing that are helpful in their recovery mention those as well.

Phase II Interpersonal Skills
Healthy Relationships

Chapter 8: SOCIAL SUPPORT
Fred Fearday

SESSION OUTLINE

RATIONALE

Social support is a powerful predictor of improved health and recovery for people with a wide range of problems. Healthy social support can offer emotional encouragement; sharing of material resources; and support for a woman's roles as mother, employee, and partner. Supportive people in our lives can help us tolerate or decrease the impact of stress and prevent many symptoms from getting worse.

Women in domestic violence situations are often isolated from their support systems and may be struggling to make new friends or reestablish ties with their families. Women in recovery may be struggling to connect with people who support abstinence. Women with mental illnesses are often stigmatized and struggle to find supportive people. Our social support can give us confidence to tackle everyday stress and cope with the problems related to substance abuse, mental health, and trauma.

GOALS

1. Members will be able to identify their social support network.
2. Members will see how their social support network helps or worsens how they cope with substance abuse, mental illnesses, and the consequences of violence.
3. Members will be able to identify community resources that might offer them additional assistance.

QUESTIONS

1. *Who are members of your support network?*
2. *How do people make recovery hard for you?*
3. *How do people help in your recovery?*
4. *What are some things people do for you?*
5. *What people and programs have helped in your recovery?*

EXERCISE

Social Support Diagram. Group members will make a diagram of support and share names of resources with other members.

SUPPLIES

Chalkboard or equivalent, Handout 8

INTRODUCTION

Start each group session with a brief review of the members' current issues. Specifically focus on women with safety and/or emergency issues. Review members' emergency crisis numbers and members' Personalized Safety Plans.

In the past few weeks, you have been working on understanding yourself better and understanding your relationships with others. Last week we asked you to think about one particular relationship and notice where you set your boundaries. Does anyone want to tell us what you discovered?

Now we are going to look at <u>all</u> of the relationships you have—everyone you have contact with. Anyone who gives you any kind of support is part of your <u>social support network</u>.

Question 1: ***Who are members of your support network?***

Typical Responses	
Sister	*People at church, synagogue, etc.*
Mother	*Members of this group*
My friend	*AA or NA*
Neighbor	*Counselor*
My sponsor	*Daycare center*
Parents	*Drop-in center friends*
My partner	*Doctor*
My boss	*People at work*

- Some group members who are new to recovery may have *constricted* social networks. Those members who have more time in recovery have probably been able to expand their social supports. At first, we want to identify *all* current social supports without judging if those persons support recovery. Probe for informal support systems by asking whom members spend their time with.

Question 2: ***How do people make recovery hard for you?***

Typical Responses
People talk about using in front of me.
My mother always criticizes me.
My partner keeps putting me down.
I have no one to watch the kids when I need to go to AA.
I don't have a car and have to ask others to take me places.
My boss doesn't understand when I get emotional.
I have no insurance to cover my medications.

Sometimes people in our lives are not giving us what we need for recovery and we may need to find more supportive people.

Question 3: ***How do people help in your recovery?***

Typical Responses
My sponsor is there when I need her.
My partner, who still drinks, agreed to keep alcohol out of the house.
My parents watch my kids when I come to this group.
My counselor found me a job and someone to watch my kids while I am at work.
I get medicine for my depression from the mental health center.
AA is a lot of help for me.
I can talk to my friends about my mental health problems.
My kids inspire me to recover.

Question 4: ***What are some things people do for you?***

Typical Responses	
Give me advice	*Just listen to me*
Trade off babysitting	*Loan me money*
Share rides to save on gas	*Help me work the 12 steps*
Give me good advice	

Question 5: ***What people and programs have helped in your recovery?***

Typical Responses	
My partner	*My counselor*
AA, NA, Double Trouble, DMDA	*My job*
My parents	*My grandparents*
My pastor, minister, rabbi	*Our group*
My doctor	*The crisis line*
The drop-in center	*My friends*
Being in school	*The daycare center*
The group home, halfway house	*My child's counselor*
My sister	*Other women in recovery*

Discussion Questions:

What does the AA saying "People, places and things" mean?

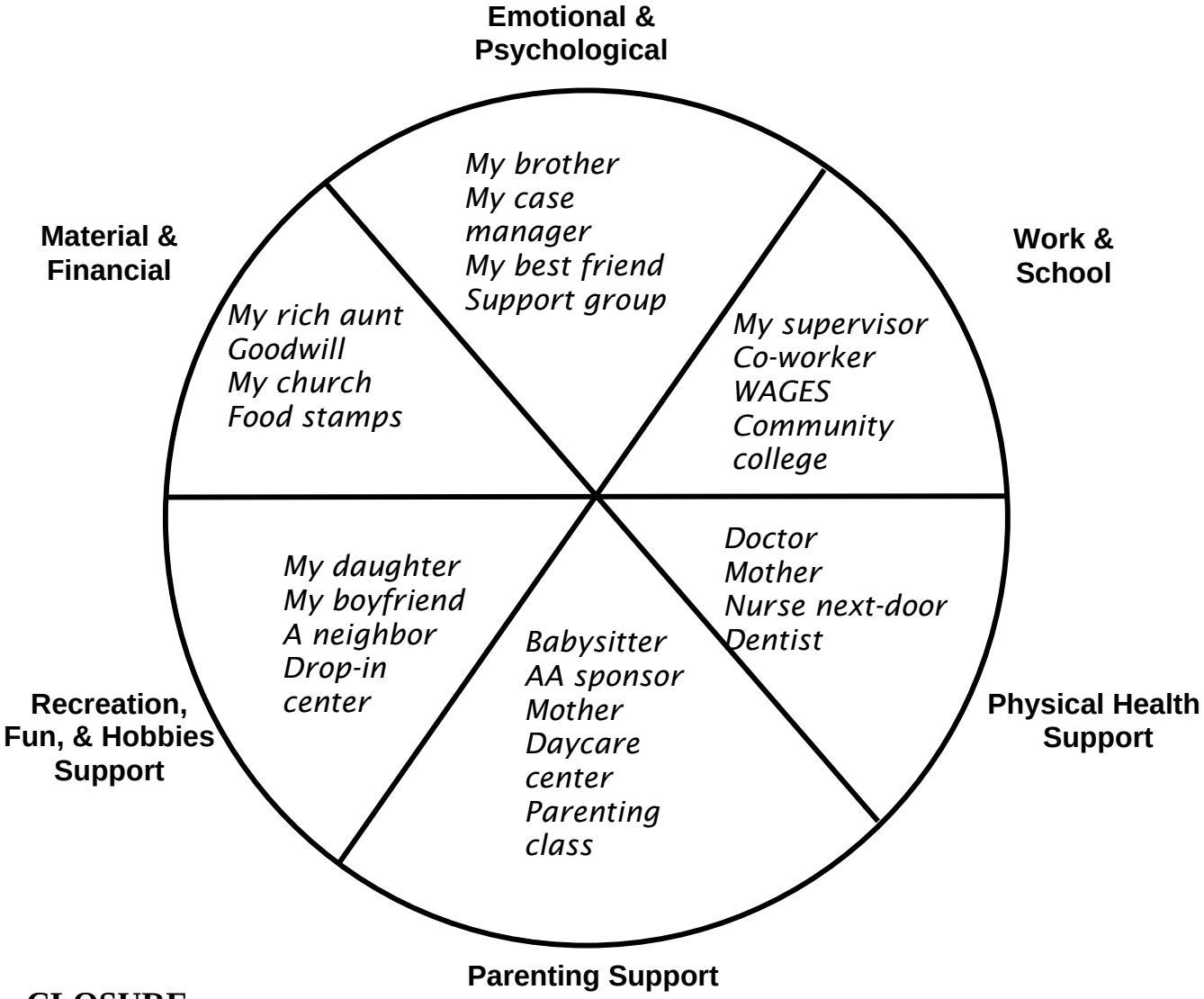
What role has abuse or trauma played in your ability to develop support?

Has hospitalization for mental or emotional problems ever strained your social supports?

When you are in crisis do some of your friends avoid you?

EXERCISE: Social Support Diagram

- Pass out **Handout 8** and then draw a large copy of it on the board. You can simplify your drawing to look like the one below, which also shows some typical responses.
- Ask each member to go to the board and write the name of a support in the slice for at least one of these headings and share how the resource has helped them in recovery. Point out that some people, such as a parent, can easily belong to more than one category.

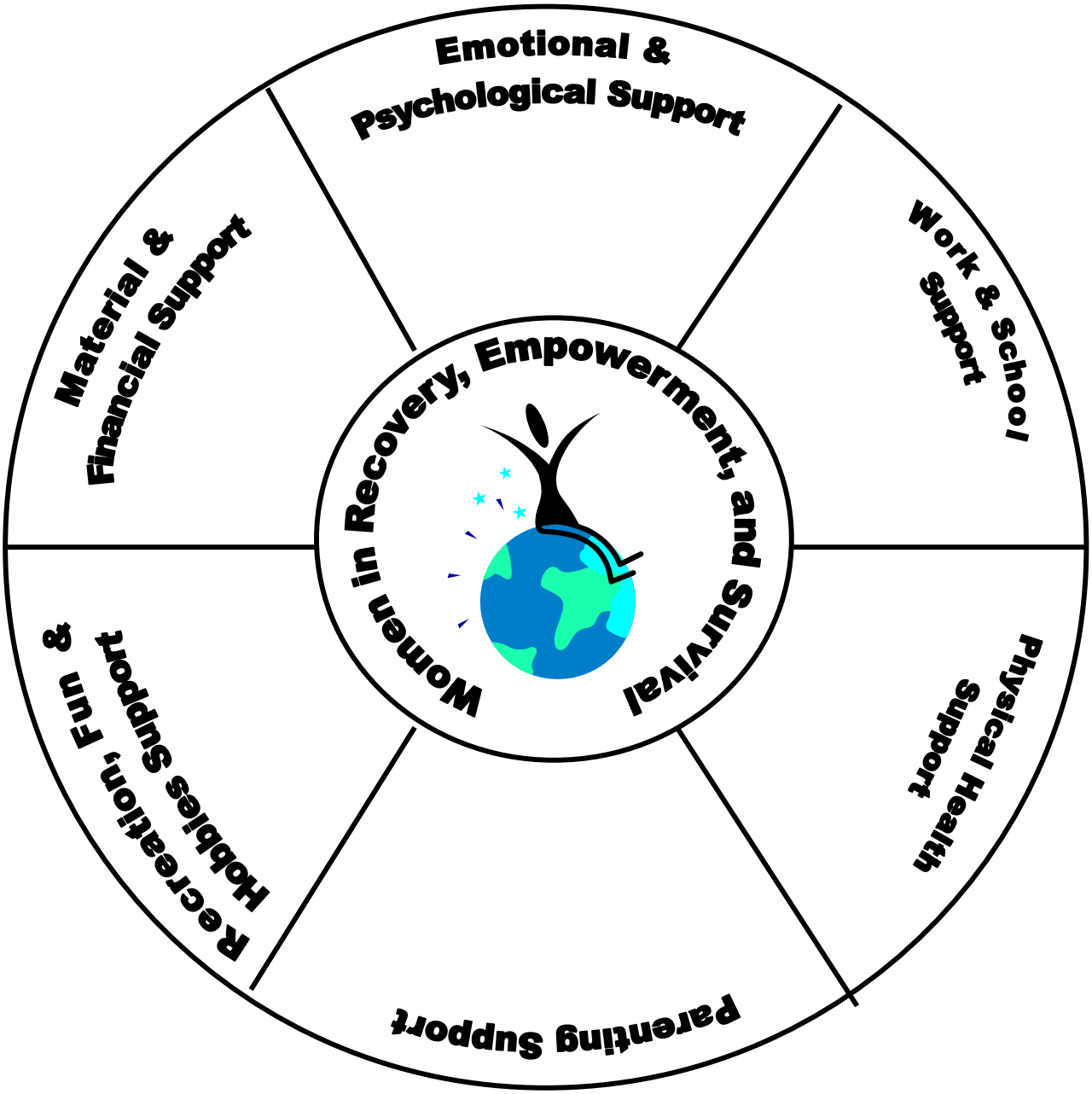


CLOSURE

Before we leave today, I suggest that you share some details with each other about some of the support you have found. You might be able to help each other build more supportive relationships. In Phase II we have learned a lot about our goals and barriers to communicating our wants and needs, and we learned how important trust and boundaries are. In Phase III we will talk about taking care of ourselves. Next week we will learn safe ways to manage our cravings and urges.

- Thank members for coming to group every week. If you know of other things the women are doing that are helpful in their recovery, mention those as well.

HANDOUT 8
SOCIAL SUPPORT DIAGRAM



Phase III: Emotional Regulation
Feeling Good

INTRODUCTION TO PHASE III: EMOTIONAL REGULATION

In the first two phases of this group we increased our understanding of ourselves and our relationships with others. We are now ready to put this understanding to work to help us feel better and meet our personal goals of survival, empowerment, and recovery.

If new people are joining for Phase III, review the safety rules of Chapter 1 and reinforce the need for confidentiality.

Start each group session with a brief review of the members' current issues. Specifically focus on women with safety and/or emergency issues. Review members' emergency crisis numbers and members' Personalized Safety Plans.

Chapter 9: CONTROLLING CRAVINGS AND URGES

Margo Fleisher-Bond and Sharon Slavin

SESSION OUTLINE

RATIONALE

Women with Triad problems often must cope with memories of trauma, cravings for alcohol/drugs, and symptoms of mental illness. These include negative methods of coping such as drinking, using drugs, self-injury, high-risk behavior, unhealthy eating, and sexual impulsivity, all of which can have severe consequences. In recovery cravings and urges are natural and expected. However, giving into them can cause legal and financial problems as well as involvement of child protective services. Triad women need personal inventories of strategies for coping with cravings and urges that are compatible with their journeys of recovery.

GOALS

1. Members will distinguish between basic human needs and cravings/urges that need to be controlled.
2. Members will identify cravings and urges they have experienced and where they come from.
3. Members will learn safe methods of managing cravings and urges.

QUESTIONS

1. *What are some basic needs and desires that all humans have?*
2. *What are some positive and negative effects of drinking or using drugs?*
3. *What kinds of cravings and urges have you experienced?*
4. *What triggers cravings and urges for you?*

5. *What are some of the ineffective methods you have used to cope with cravings and urges?*
6. *What are some safe ways available to you now to manage cravings and urges?*

EXERCISE

Strategies to Manage Cravings. Each member creates a personal list of strategies she believes have been or will be helpful to her. If a member is feeling a craving *right now*, it is discussed.

SUPPLIES

Chalkboard or equivalent, paper, and pens or pencils

Question 1*: What are some basic needs and desires that all humans have?*

Typical Responses		
Relief from pain	*Pleasure*	*Food and water*
Sleep	*Self-esteem*	*Safety*
Friendship	*Happiness*	*Love*
Sex	*Oxygen*	*Money*

Cravings and urges can be strong and uncomfortable physical and emotional feelings. An example of a craving is when an addicted cigarette smoker goes for a time without a cigarette and feels physical withdrawal symptoms. The same pattern of cravings and urges can hold true for problem habits such as binge eating, excessive washing, sexual impulsivity, or cutting oneself. While they can be difficult to tolerate, the cravings and urges of addiction will diminish over time. As women in recovery deal with stress and painful emotions in new ways the urge to return to old habits lessens. However, there may always be an urge to return to old habits in the belief that one can get the pleasurable benefits of a drug or a behavior without its negative consequences.

Question 2: ***What are some positive and negative effects of drinking or using drugs?***

Typical Responses	
Positive	**Negative**
Euphoria	*Hangovers*
Don't feel afraid	*Get arrested*
Can socialize better	*Spend too much money*
Feel like a million dollars	*Vomit*
Lowered inhibitions	*Depression*
Fit in	*Confusion*
Problems go away	*Suicide*
Don't feel depressed	*Bad reaction with medications*
Sex is better	*Paranoia*
Can sleep	*Embarrassing behavior*
Feel relaxed	*Get in fights*
Feel happy	*Brain and organ damage*

Question 3: ***What kinds of cravings and urges have you experienced?***

Typical Responses

Cravings for crack; I feel really agitated until I get high.

I have dreams where I am chasing a drink.

Whenever I think about what my grandfather did to me, I want to cut or burn myself.

I imagine hurting my abusive boyfriend, and I'm afraid someday I really will.

I sometimes want to do what my voices tell me to do so they'll stop.

I'm constantly eating now, and I'm gaining too much weight.

If I'm feeling sorry for myself, I want to do something that makes me feel better—like get high on something.

A trigger is something that makes you want to drink, use drugs, or do some other compulsive behavior. Many triggers are common among people, such as overhearing drug talk. In fact, during a discussion like we're having today, most of us have probably felt at least an urge to drink or use. On the other hand, some triggers can be unique to one woman's experience, like the scent of a cologne causing flashbacks of an assault by a man who wore that cologne. Some triggers can be avoided, and some cannot. We can avoid watching people drink in a bar by not going into bars. But we cannot always avoid smelling a particular cologne that causes flashbacks.

Question 4: ***What triggers cravings and urges for you?***

Typical Responses

Someone offers me a hit and all of a sudden I want it more than anything.

When I see a man who looks like the guy who molested me, I want to get high so I don't have to think about him.

Rock music makes me think about partying and drinking.

Seeing beer commercials on TV.

When I get flashbacks, I feel like I have to do something or I'll lose my mind—so I cut myself.

Whenever I get angry about anything I want a drink.

Seeing any kind of violence.

When someone is mean to me I eat a lot of junk food.

Question 5*: What are some of the ineffective methods you have used to cope with cravings and urges?*

Typical Responses

When I felt lonely, I went to a bar and drank Coke. I felt uncomfortable and started drinking rum and Cokes.

I tried to be a "social drinker" but always lost control.

I tried to quit cold turkey many times, but there was always "just one last line."

I'd pick a fight with my boyfriend, but that just made things worse.

I cut myself to change my feelings.

I smoked a lot of cigarettes but ended up using anyway.

I switched from crack to pot—but always went back.

Eating helps a little, but I feel terrible about my weight.

Having cravings and urges doesn't mean you're doing something wrong. Thinking about doing something is not the same as doing it. All of us have cravings or urges from time to time that we don't necessarily act on.

You may have acted on cravings and urges in the past to temporarily relieve your misery. Now you have probably realized that the negative consequences outweighed the temporary relief. Losing your kids, losing your job, financial problems, loss of self-esteem, and losing your health, for example, are high costs to pay for addiction.

Question 6: ***What are some safe ways to manage your cravings and urges?***

Typical Responses

I go to lots of AA meetings.

I use the AA slogan "THINK, THINK, THINK" and remember what it was <u>really</u> like at the end of my using.

I get away from trigger situations and do something that distracts me.

I pray to my Higher Power.

I pamper myself—take a long bath, watch a good movie, or read a book.

I eat something sweet to take care of the physical craving.

I carry my AA chip with me all the time.

I call my sponsor or call my best friend.

I know now that the voices are not real and come from schizophrenia, and it helps me to ignore them when I tell my counselor about them.

I wrap myself up in a blanket when I feel unsafe.

Talk to people about it. Don't keep it to myself.

At times when in the past I would have cut my arm, I go for a walk.

I call a crisis line.

I find something stimulating to distract me—like loud music or a puzzle.

As you come to feel empowered by new choices when you have cravings or intense urges, you will gain a sense of power over your behavior and well-being.

Don't forget: cravings and urges are short-lived ("This too shall pass"). You—especially more experienced group members—can comfort each other that although uncomfortable cravings seem like they will never end, they will. For example, once you are over with the physical withdrawal from alcohol or a drug, the physical craving will cease. As you practice your personal coping techniques, you will soon be more comfortable riding out the cravings.

More good news is that cravings and urges for substances happen less often and seem less intense the longer you are in recovery.

EXERCISE: *Strategies to Manage Cravings*

- Ask each member to prepare a personal list of strategies she believes have been or will be helpful to her. Suggest they keep their lists with them at all times, such as in a wallet or purse.

- Ask if anyone is experiencing a craving or urge *right now*. If anyone says yes, ask which coping techniques from her list would work best. Then ask if anyone else has any suggestions.

CLOSURE

Today we discussed that cravings and urges are to be expected when we try to give up using, drinking, and other problem habits. We know that the uncomfortable cravings and urges can be relieved temporarily by returning to old behavior. However, we have learned that this will result in all sorts of negative consequences for ourselves, and with this in mind we have made lists of methods we can use to deal with cravings and urges. Using the list will require us to have confidence in ourselves along with courage, determination, and hope for a better future.

Phase III: Emotional Regulation
Feeling Good

Chapter 10: SELF-ESTEEM
George Thomas

SESSION OUTLINE

RATIONALE
Self-esteem is one of the most important building blocks of psychological health. The purpose of this session is to increase members' self-esteem and at the same time demonstrate a simple strategy to continue this process. The session will help members get to where they want to be in terms of self-esteem and stay there.

GOALS
1. Members will learn ways to bolster their self-esteem.
2. Members will learn to protect their self-esteem from events that might lower it.

QUESTIONS
1. *What does it mean to have healthy self-esteem?*
2. *What have people said or done to you that helped you feel good about yourself?*
3. *What have <u>you</u> done that helped you feel good about yourself?*
4. *Have there been times in your life when you felt better about yourself than other times? What made the difference?*
5. *Are there areas in your life where you feel better about yourself than others?*
6. *What can you do or think about to improve your self-esteem?*
7. *What have people said or done to you that threatened your self-esteem*?
8. *What have <u>you</u> done that made you feel worse about yourself?*
9. *Have there been times in your life when you felt worse about yourself than other times? What made the difference?*

EXERCISE
The Self-Esteem Game. Members answer the above questions and use these answers in a game format.

SUPPLIES
Chalkboard or equivalent, index cards, pens or pencils, Handout 10

INTRODUCTION

Start each group session with a brief review of the members' current issues. Specifically focus on women with safety and/or emergency issues. Review members' emergency crisis numbers and members' Personalized Safety Plans.

Last week we talked about controlling cravings and urges and thought of new ways to cope with life as we continue to feel good. Did anyone come up with some new ideas for taking care of yourself since last week? If you used any of the new ways to cope, you can pat yourself on the back. Patting yourself on the back for trying new ways to cope will help build your self-esteem, which is what we will talk about this week.

Question 1: ***What does it mean to have healthy self-esteem?***

- Important concepts that the facilitator should introduce into the discussion, if the members don't, include
  1. A feeling of accomplishment for the things you've done;
  2. Confidence in your ability to meet challenges successfully;
  3. Fewer feelings of guilt or shame;
  4. Willingness to stand up for your rights and speak your mind without ignoring the rights or opinions of others;
  5. Willingness to consider both negative and positive feedback.

EXERCISE 1: The Self-Esteem Game

- **STEP 1**: **Getting started**. Give everyone a pile of small index cards, a pen or pencil, and **Handout 10** (The Self-Esteem Game).

We are going to design and play a self-esteem game. The purpose of this game is to understand what affects our self-esteem and how we can increase it. In this game we will make ***plus cards*** *(cards describing things that increase our self-esteem),* ***minus cards*** *(cards describing things that reduce our self-esteem), and* ***blocks*** *(cards describing ways of decreasing the effect of things that reduce our self-esteem). If the plus card that you create is something that increases your self-esteem <u>and</u> you have control over it, you will get to put two pluses on the card—which makes it a* ***double plus card****.*

The object of the game is to increase your self-esteem. You get to decide how many of each card there will be. You can even decide how many points you want to have. The only requirement is that you be honest. Do not say, for example, that being insulted by a friend would not lower your self-esteem if it really would. First we're going to talk about some things that effect how we feel about ourselves.

Question 2: ***What have people said or done to you that helped you feel good about yourself?***

Typical Responses	
They loved or cared for me.	*They said something nice to me.*
They respected me.	*I was recognized for something I've done.*
They did me a favor.	*They got me the gift that I asked for.*

Question 3: ***What have <u>you</u> done that helped you feel good about yourself?***

Question 4: ***Have there been times in your life when you felt better about yourself than other times? What made the difference?***

Question 5: ***Are there areas in your life where you feel better about yourself than others?*** **(skills, talents, roles, abilities, etc.)**

Question 6: ***What can you do or think about to improve your self-esteem?***

Typical Responses	
Accomplish a goal	*Get through a day without a crisis*
Feel in control of myself	*Do something nice for myself*
Think about a fun memory	*Pamper myself because I'm worth it*
Do something new or challenging	*Do something relaxing*
Make new friends	*Go to church*
Do something I've been putting off	*Spend quality time with my kids*
Think about something I do well	

STEP 2: **Making *plus cards*.**

Think about what makes you feel good about yourself. Write each answer on a separate index card. You may use your own ideas or any ideas from our discussion. Next, put a plus in the upper right-hand corner of each of these cards. All of these are your ***plus cards****. Try to make* ***at least 10 plus cards.***

STEP 3: **Making *double plus cards.***

Now think about which ones you have direct control over. If you know that you control the example you put on the index card, put another plus right next to the first plus. The cards with two plusses are now your ***double plus cards****.*

- Suggest they discuss with the group any ones that they have questions about. Other members may have good suggestions about why one does or does not have control over that particular example.

Now we're going to talk about things that effect your self-esteem in negative ways.

Question 7: ***What have people said or done to you that threatened your self-esteem?***

Typical Responses	
They abused me.	*They called me names.*
They said I caused all their problems.	*They told me I was crazy.*
They said they didn't believe I was abused.	*They never listened to me.*
They didn't believe I could do something.	*They made fun of me.*
They said I was a bad mother.	*They deliberately picked a fight with me.*
They wouldn't let me make decisions.	

Question 8: ***What have <u>you</u> done that made you feel worse about yourself?***

Question 9: ***Have there been times in your life when you felt worse about yourself than other times? What made the difference?***

STEP 4: **Making *minus cards*.**

Now think about what makes you feel bad about yourself. Write each answer on separate index cards. Again, feel free to use any ideas from our discussion. Try to make ***at least 5 minus cards****. Put a minus sign in the upper right-hand corner. Notice which ones you have control over but don't mark this on the cards.*

STEP 5: Blocks.

Now we're going to help each other think of ways to block the effects of things that lower our self-esteem. Who would like to volunteer first to share a ***minus card****?*

- As each member shares a minus card, ask her to suggest how she could reduce the effect or how she has reduced the effect in the past of that minus card. Then ask her if she would like suggestions from other group members.

Did anyone write about something that was on an ***Event-Thought-Feeling Worksheet*** *you did before? Remember, changing your thoughts and beliefs about a minus can be a successful way to block the minus without changing the event itself.*

Now that you have thought about ways to ***block*** *the minus card and you've heard some other suggestions, please write the blocks on the card. Next, write* ***at least one block*** *on all your other minus cards.*

- As everyone works to write blocks on the minus cards, invite members to give each other feedback and suggestions as needed.

Next look at your ***minus cards*** *again. If the* ***blocks*** *you wrote already worked well for you in the past or you honestly plan to use them in the future,* ***change the minus to a plus****. After all, either this threat to your self-esteem has been diminished or you have a plan that you think will work.*

The threat is not so much a threat as an opportunity for you to try new coping methods and prove to yourself that you can control how much events and people effect your self-esteem.

STEP 6: Adding up your points

*The last thing to do is **count up all of your plusses**—and don't forget that each double plus card equals two plusses. You also have to **subtract the minuses**. This is your final score for today*

.

To play this game every day, just notice the things that threaten and increase your self-esteem. Use the things that increase your self-esteem to add to your pile of plus cards every week. Use the things that threaten your self-esteem to make more minus cards. Every time you identify a block that has worked in the past or you honestly think it will work in the future, write the block down and turn the minus card into a plus card. When you think you have direct control over how the item on the plus card affects your self-esteem, you get to turn the plus card into a double plus card.

Your score will vary a lot at the beginning, but after playing this game for a few weeks, your score should get higher and higher. That is because you will more quickly identify threats and boosts to your self-esteem and you will keep changing minuses into plusses and plusses into double plusses and your plus pile will grow bigger and bigger.

Discussion Questions:

How do your spiritual beliefs affect your self-esteem?

How has being abused affected your self-esteem? Having mental health problems? Having substance abuse problems?

CLOSURE

Recognizing things that affect our self-esteem is an important part of having and maintaining a sense of control over the emotions and events in our lives. Ultimately, we are in charge of how high a score for self-esteem we want to have. You'll find as you play this game that you cope better and that the solutions to your problems are within your reach. Be creative. And most of all, reward yourselves for all of the things that you do or say that help you feel better about yourselves. Rewarding ourselves is one way to build motivation and self-esteem.

Next week we will talk about how to take care of ourselves when life gets us down in ways that do not include harmful behaviors or drugs. Before the next group, try to notice ways that you soothe yourself when you feel angry or depressed and we'll invite you to share some of those strategies next week.

HANDOUT 10: THE SELF-ESTEEM GAME

Plus and Double-Plus Cards

++

When I have a job

++

When I do stuff with my kids

+

When my sweetie says nice things to me or does nice things for me like dinner and a movie

+

*When I don't use drugs**

Minus Cards with Blocks

+

When my boyfriend tells me I'm stupid

<u>Blocks</u>: (1) Ask myself if I'm stupid, or if he's just being mean (2) Tell myself that doing something stupid doesn't make me a stupid person (3) Realize it's sad that he tries to increase his self-esteem by saying mean things.

++

When I start using again

<u>Blocks</u>: (1) Immediately call my sponsor and get help (2) Tell myself that I will learn from this (3) Be honest with myself about why I decided to use.

++

A fight with my mom

<u>Blocks</u>: (1) Finish talking about the problem without saying more mean things (2) Talk about how it feels to argue (3) Walk out! Finish it when my emotions are calmer.

+

When everything seems to go wrong

<u>Blocks</u>: (1) Look harder for things that are going right (2) Tell myself that this too shall pass (3) Do something fun as a reward for a hard day like baking homemade cookies with my kids.

*A person with a Substance Abuse Disorder has control over his/her use; one with a Substance Dependence Disorder (alcoholic or addict) does not have control (Step 1 of AA). Hence, this card can have one plus or two.

Phase III: Emotional Regulation
Feeling Good

Chapter 11: SELF-SOOTHING
Margo Fleisher-Bond and Sharon Slavin

SESSION OUTLINE

RATIONALE

Women with Triad issues tend to be ambivalent about self-care. One of the most damaging effects of abuse, addiction, and mental illness is the tendency to continue patterns of self-care that were learned as basic survival techniques in response to abuse, mental health symptoms, or while using substances. Some of these patterns may have been learned from others, such as an abuser. The abuse survivor may harm herself rather than another person. The addict may revert to picking up drugs or alcohol because it's the most immediate way to change her state of mind. A woman with a mental illness may have difficulty feeling worthwhile enough to provide self-soothing. All tend to experience themselves as not worth the effort that self-soothing takes. Alternative soothing methods that depend on trusting another person may seem dangerous or unavailable without a high cost. In this session the members will be encouraged to learn methods of self-soothing and self-care that increase their potential to improve the quality of their lives.

GOALS

1. Members will understand what self-soothing means.
2. Members will identify their past efforts at self-soothing.
3. Members will identify other methods for self-soothing and discuss how and why specific methods might improve the quality of their lives.
4. Members will make lists of self-soothing strategies to use when distressed.

QUESTIONS

1. *What did you do as a child to relieve emotional pain or to cope with loss or abuse?*
2. *What do you do <u>now</u> that is potentially self-harmful?*
3. *What are some reasons that you avoid self-soothing and self-care?*
4. *What emotions and thoughts do you have when you practice self-soothing?*
5. *What have you done in the past that was self-soothing but not harmful?*
6. *When you fall back into old habits, how do you get back into recovery?*

EXERCISE

Strategy List. The group members write on index cards specific ways to deal with problems and self-destructive behaviors.

SUPPLIES

Chalkboard or equivalent, index cards, pens or pencils

INTRODUCTION

Start each group session with a brief review of the members' current issues. Specifically focus on women with safety and/or emergency issues. Review members' emergency crisis numbers and members' Personalized Safety Plans.

In the last couple of weeks we have been working to move beyond knowing ourselves and interacting well with others towards actually feeling good. For many of us this means tackling some tough issues. We've talked about dealing with cravings and urges by finding other ways to take care of our needs, and last week we talked about building self-esteem. Did anyone notice other things you do or think that help you feel better? Does someone have new cards with items that increase or decrease your self-esteem?

One of the most important things we can do to feel good is to take really good care of ourselves. This week we will talk about how this is sometimes hard to do and how we are used to doing other things when we are filled with pain, and we will share with each other some thoughts and feelings about really treating ourselves well.

Question 1: ***What did you do as a child to relieve emotional pain to cope with loss or abuse?***

Typical Responses	
Bang my head	*Hide*
Bite my nails	*Suck my thumb*
Pinch myself	*Get into trouble a lot*
Cut myself with a plastic knife	*Throw temper tantrums*
Pick fights	*Starve myself*

Question 2: ***What do you do <u>now</u> that is potentially self-harmful?***

Typical Responses	
Hate myself	*Have unprotected, impulsive sex*
Use drugs	*Smoke*
Self-mutilate	*Choose abusive partners*
Attempt suicide	*Sabotage good relationships*
Take chances	*Starve myself*
Throw temper tantrums	*Drive dangerously*
Binge eat	*Refuse to take medication*

Discussion Questions:

Which of these things did you keep secret?

Which are you ashamed of?

Which of these are related to low self-esteem?

Do you think that self-soothing and self-care are important to recovery?

Question 3: ***What are some reasons that you avoid self-soothing and self-care?***

Typical Responses	
People will think I'm selfish.	*It makes me feel weird.*
I don't even think about it.	*I'm too busy taking care of others.*
Old habits are hard to break.	*I don't know how.*
If my own mother won't take care of me, why should I?	*I don't deserve it.*

Question 4: ***What emotions and thoughts do you have when you practice self-soothing?***

Typical Responses:	
I am afraid I will get into trouble.	*I think I am selfish, but I love it.*
I am more grounded.	*I am not so dependent on others.*
I'm awkward, don't know what to do.	*It doesn't feel real.*
It makes me feel more powerful.	*I stop thinking so much.*
I think I don't deserve self-soothing because I think I'm worthless.	*It's okay not to always take care of others.*
I can breathe.	*I feel pretty.*

Discussion Questions

Do you ever feel torn between doing something for yourself or doing something for somebody else?

Is drinking or using drugs a kind of self-soothing?

Question 5: ***What have you done in the past that was self-soothing but not harmful?***

Typical Responses		
Took a walk	*Meditated*	*Stayed home, took a nap*
Exercised	*Danced at home*	*Did a crossword puzzle*
Called a friend	*Wrote in my journal*	*Called my sponsor*
Went to a meeting	*Played with my cat*	*Sat down for my meal*
Straightened up the house	*Gave myself a mental hug*	*Thought about my accomplishments and successes*
Prayed	*Asked for a hug*	

Question 6: ***When you fall back into old habits, how do you get back into recovery?***

Typical Responses	
I say it is not a crisis.	*I forgive myself.*
I get help right away.	*I have a sense of humor.*
I coach myself that slips happen.	*I organize my priorities better.*
I get involved in a good cause.	*I pray for help and forgiveness.*
I try to hang around with people who support my recovery.	*I let myself get so sick that I have to go to the hospital.*
I give myself a pep talk.	*I read something that inspires me.*
I try to be less hard on myself.	

Old habits are hard to break. There is a great temptation to continue our old behaviors once we have slipped. This can mean slips in substance abuse, self-hatred, refusing to take medications, and other harmful things. It is important that we learn to refocus ourselves through self-soothing and self-care so we will be less vulnerable to old habits.

EXERCISE: Strategy List

- Have the members write on index cards specific ways to deal with problems and desires for self-destructive behaviors.

Typical Index Card		
Problem	**Action Solution**	**Thought Solution**
I feel depressed.	*Light candles and take a bath.*	*"This too shall pass."*
I want to get high.	*Call my sponsor and cook dinner for us.*	*"I can have fun without getting high."*
I want to cut myself.	*I walk in the woods and count the birds I can hear.*	*"I don't want any more scars. I want them all to heal."*
I have racing thoughts.	*I lay off the caffeine, meditate, and then clean house.*	*"I need to focus on one thing."*

CLOSURE

Today we identified some ways to take care of ourselves better. The strategy list that you developed today and the strategy list for dealing with cravings that you created two weeks ago will together offer you a lot of choices for feeling better. Thinking ahead of time about ways to handle unpleasant situations or cravings is a very important skill to have in recovery and in life. Another important skill is to be able to accept yourself completely, past and present included, and to start looking to a future in which you are healing from the pain of the past. We will talk about acceptance and healing next week.

Phase III: Emotional Regulation
Feeling Good

Chapter 12: ACCEPTANCE AND HEALING

Carol Parker

SESSION OUTLINE

RATIONALE

Linehan (1993, p. 102) defines suffering as "pain plus non-acceptance of the pain" and believes that our suffering is reduced when we deeply accept the painful reality of past or present events and the impact they have had on our lives. Deep acceptance of our painful past and present does not mean that we approve of what has happened or is happening to us, but that we are letting go of fighting reality. Accepting that we have a mental illness, substance abuse problem, or have been abused does not mean that we accept those events joyfully into our lives. It simply means that they are our reality and that we must understand the pain and its impact so that we can heal. When we are able to turn our energy to understanding what is within and not within our control to change in the present, we have begun the process of healing.

GOALS

1. Members will understand the importance of accepting the realities of their lives, both in the past and in the present.

2. Members will learn how denial of their problems can actually increase their suffering and delay the healing process.

QUESTIONS

1. *What are the pros and cons of avoiding painful emotions* (Linehan, 1993, p. 102)*?*
2. *How has putting the past out of your mind worked for or against you?*
3. *How have you lied or bargained with yourself, with your sponsor, with God, or with your therapist to deny your addiction, mental illness, or abuse?* (Linehan, 1993, p. 102)
4. *What would happen if you stopped lying and bargaining and focused on understanding how painful events have affected your life?*
5. *What are the similarities between the "Serenity Prayer" and acceptance?*
6. *What does the expression "You have to play out the hand that you were dealt" mean to you?*

EXERCISE

The Purple Room. Members imagine they are in a purple room and that they hate purple and must acknowledge the dislike in order to change the color.

(Optional) Diabetes. Members discuss the parallels between diabetes and Triad problems.

SUPPLIES

Chalkboard or equivalent, Handout 12 ("Serenity Prayer")

INTRODUCTION

Start each group session with a brief review of the members' current issues. Specifically focus on women with safety and/or emergency issues. Review members' emergency crisis numbers and members' Personalized Safety Plans.

Last week we talked a great deal about self-soothing and taking care of ourselves. Did you use any of the strategies on your index cards? How did you feel afterwards? Has anyone thought of new ways to take care of yourselves?

This week we are going to talk about a difficult concept: acceptance. How do we make peace with painful things that have happened and at the same time accept that they really happened? We will start with understanding and accepting painful emotions.

Question 1: ***What are the pros and cons of avoiding painful emotions?***

Typical Responses
If you don't feel, you won't be seen as weak.
Painful emotions tell you to stay away from people.
I think that if you never feel pain then you can't feel anything else like pleasure.
If I never feel pain then I can be happy.
Without pain I'd never ask anyone to help me.
If I never had angry pain I might just keep taking it and taking it.
If I never had emotions I'd be a robot.
I wouldn't like to feel blank.

Discussion Question:

What happens when we deny that we are in pain?

Question 2: ***How has putting the past out of your mind worked for or against you?***

Typical Responses
I just fooled myself and had to deal with it anyway.
It just came back in flashbacks and messed with my thinking.
It bought me some time to get high again before I felt it.
I got right back into an unhealthy relationship before I recognized the pattern.
I felt like a failure because I couldn't put it behind me.

Discussion Question:

Using these strategies usually just contributes to the suffering. When we stuff our feelings, they find other ways to show themselves repeatedly. Can you give some examples of how your pain shows or comes out?

Typical Responses	
I have a lot of bad dreams.	*I cry over the silliest things.*
I hit my kids every time so-and-so calls me.	*I take a lot of showers to feel cleaner.*

Question 3: ***How have you lied or bargained with yourself, with your sponsor, with God, or with your therapist to deny your addiction, mental illness, or abuse?*** **(**Linehan, 1993, p. 102)

Typical Responses
I told myself that I wasn't abused.
I told myself it wasn't that bad or that I can't tell family secrets.
I tried to make my therapist prove that I was special before I'd talk to her.
I promised God I'd be good if he would make the hurt and consequences go away.
I lied to my counselor about my drug use.
I don't tell anyone about wanting to hurt myself.
I lied to my sponsor, or I didn't tell her the whole truth.
I pretended that something didn't bother me when I knew it did.
I told myself that the caffeine made my thoughts racy, not my Bipolar Disorder.

Question 4: ***What would happen if you stopped lying and bargaining and focused on understanding how painful events have affected your life?***

Typical Responses
I would have to confront the pain.
I would have to be honest with my therapist.
I would have to deal with myself.
I would have to find ways to cope with the truth.
I would have to look honestly at my past and my present.

Discussion Questions:

There is a psychologist who added to the idea of accepting our pain by saying that the acceptance must be "radical," that is, it must come from deep within and it has to be complete. She also said that radical acceptance transforms suffering into pain and that acceptance is the only way out of hell (Linehan, 1993, p. 102).

What do you think she means by complete acceptance from deep within?

Typical Responses	
Seeing reality	*Finding truth*
Acknowledgement	*Honestly letting go*
Recognition	*Deep understanding*

Dr. Linehan also says that suffering is the combination of pain plus not accepting the pain. What do you think she means by that?

EXERCISE: The Purple Room

Imagine that you are in a purple room and that you hate the color purple (Linehan, 1993, p. 102). *You refuse to acknowledge that you hate purple, or accept that the room is painted purple. Will you ever make the effort to get a different color of paint and paint the room a color that pleases you? Or will you just ignore the purple?*

Can anyone give an example of something that happened in her life like the purple room?

How is being in a purple room like being an addict?

How is it like having a mental illness?

How is it like the consequences of trauma?

- Pass out **Handout 12** ("Serenity Prayer").

Question 5: ***What are the similarities between the "Serenity Prayer" and acceptance?***

Typical Responses
You can't control other people.
They both want you to let go of the things you cannot change.
Nobody likes to think that you can't change someone else if you try hard enough; this tells me to accept them for what they are and work on myself.
Both say to tell yourself the truth and then you can think better.
Both say letting go of the pain is a smart thing to do.

Acceptance and healing don't come all at once. The process of acceptance requires choosing over and over again to see things as they really are. By paying attention to what you have control over and what you do not, you'll understand the difference between the things you can change and the things you can't. Understanding our power over our own lives and our limitations is a good definition of humility.

Question 6: What does the expression "You have to play out the hand that you were dealt" mean to you?

Typical Responses
I can fold or play out the hand. I ain't gonna fold!
Some things are out of my control.
I need to accept my bad luck along with the good luck.
Do the best with what you're given.
Acceptance is the answer to all my problems.

Let's talk about the difference between willingness and willfulness (Linehan, 1993, p. 103, from May, 1982). *<u>Willingness</u> means <u>doing what is needed</u>. It's about trying to be effective. <u>Willfulness</u> is sitting on your hands when action is needed and <u>refusing to make changes</u>. It's about being stubborn. Willfulness is stubbornly repeating the same behavior when you know it won't make things better. Willfulness is waiting for an easy answer and refusing to try new strategies.*

Now, let's think of life like it is a baseball-pitching machine and there is a woman standing at the plate with a bat. The only way she will get better at hitting the ball is by swinging the bat each time a ball comes out (<u>willingness</u>). Sometimes she will be successful, sometimes she will not. She can get angry every time she misses and she can cross her arms and refuse to accept that the ball is coming. She can also stand in the way of the ball and get hit. This is <u>willfulness</u>, but nothing stops the pitching machine; the balls just keep coming, just like things keep happening in

life. Neither willpower, nor refusal to see, nor refusal to hit, nor crying will stop the ball from coming or life from happening. The trick is to accept that the ball is coming and figure out what you can do to hit the ball out into the field. When bad things happen you can't always turn them into a good play. If the ball comes directly at you, hits you and you get hurt, you can accept that it happened, understand what you might do differently next time—if anything—and focus on the next pitch. Life is like that; there is always something to deal with. Winning is learning to step up to the plate and choosing to accept that those balls <u>are</u> coming. Winning is swinging the bat and learning from your mistakes and successes.

CLOSURE

Thinking about the "Serenity Prayer" helps us get closer to understanding the concept of acceptance. Let's read the "Serenity Prayer" together.

Spend just a little time this week noticing how often you think things <u>should</u> be different. Notice how it feels to accept how they <u>are</u>, not how they <u>should</u> be. You may feel a little relief, a little less resentment. You can be correct that things <u>should</u> be differently ("She should be nice to me; "I should have had more mothering;" "The baseball pitching machine shouldn't pitch so hard or fast.") The acceptance comes with understanding how things really are and understanding our strengths and limitations for dealing with them.

*Next week we will start using the **Workbook for Success**. This is a tool to help people write effective plans for achieving their goals. It can help you set goals and deal with the problems that come up as you try to meet your goals.*

In some ways, each of you has been developing your own philosophy of life. Next week we will begin Phase IV, Distress Tolerance: "Staying Healthy in a Stressful World." We will be talking about philosophy and turning it into a way of living.

HANDOUT 12
"SERENITY PRAYER"

God, grant me the serenity
To accept the things I cannot change,
Courage to change the things I can,
And wisdom to know the difference.

Author unknown, sometimes attributed to Reinhold Niebuhr

Phase IV: Distress Tolerance
Staying Healthy in Stressful World

INTRODUCTION TO PHASE IV: STAYING HEALTHY IN A STRESSFUL WORLD

This is the beginning of the fourth phase of groups. So far we've worked on knowing ourselves better, making healthier relationships, and on coping with painful and difficult aspects of ourselves as we make progress in recovery. This phase now takes the knowledge and skills we have learned and talks about applying them to the real world—a world full of joy and pain and often very stressful.

If new people are joining for Phase IV, review the safety rules of Chapter 1 and reinforce the need for confidentiality.

Start each group session with a brief review of the members' current issues. Specifically focus on women with safety and/or emergency issues. Review members' emergency crisis numbers and members' Personalized Safety Plans.

Chapter 13: PROBLEM SOLVING
George Thomas

SESSION OUTLINE

RATIONALE

Trauma, substance abuse, and mental illness often cause complex problems while undermining our confidence that they can be solved. The purpose of this group is to give members the skills and confidence to tackle problems before they become crises. This includes giving members the self-monitoring skills needed to quickly and effectively identify problems and evaluate solutions.

GOALS

1. Members will learn how to identify problems more quickly and accurately.
2. Members will gain confidence in their ability to solve problems.
3. Members will learn how to devise, implement, and evaluate solutions to problems.

QUESTIONS

1. *How can we become more aware of changes in our thoughts, feelings, and behaviors?*
2. *How can being more aware help us solve problems?*
3. *When you have a problem, what steps do you take to find the best solution?*
4. *Can you define the problem you described in the exercise to bring it more under your control?*
5. *How can you change the way you feel about things that are beyond your control?*

EXERCISE

Describing a Problem to Others. Members form pairs, acting as interviewers and interviewees, and take turns describing a problem to the other member.

SUPPLIES

Chalkboard or equivalent, extra copies of the *Workbook for Success*

INTRODUCTION

Problem solving is related to goal-setting because we often set goals of overcoming problems we face, for example, not having custody of our children or not having enough money or friends. Hand out copies of **Workbook for Success** (Appendix G). Give members a few minutes to review the workbook. *The **Workbook for Success** is a tool for helping you write a plan for reaching your goals. Later in this group we will talk about some of the problem-solving skills in the book.*

In earlier groups you have described your thoughts and feelings during a difficult situation, tried a self-soothing strategy, and evaluated how well it worked. We have also talked about being aware of our thoughts, feelings, and behaviors. This self-monitoring can help us recognize problems more quickly.

Question 1: ***How can we become more aware of changes in our thoughts, feelings, and behaviors?***

Here are some ways:

1. *Set aside time to think about how the day or week went (because some people spend too much time thinking about their problems, it is important to set a time limit to this);*

2. *Ask people you trust to tell you if they notice changes in your behavior;*

3. *Keep a journal or diary;*

4. *Keep a detailed record of thoughts, feelings, and behaviors—for example, rate how much anxiety you felt during the day on a scale of 1 to 10, record the frequency of urges to self-harm and note the place and time of day.*

Question 2: ***How can being more aware help us solve problems?***

1. *We'll detect problems before they get worse. We look for warning signs that a problem we have is about to get worse—anxiety, depression, excessive anger; mania; disorganized thinking; cravings for drugs or alcohol; flashbacks of traumatic experiences, etc.*

2. *We'll understand the problems. Self-monitoring can help us learn when, where, and under what circumstances problems occur.*

3. *We'll learn to evaluate different solutions. Self-monitoring can help detect small improvements that indicate a strategy is working.*

Question 3*: When you have a problem, what steps do you take to find the best solution?*

Typical Responses
I think of as many ideas as I can.
I get as much information as I can.
I think about what I've done in similar situations in the past.
I talk to people I know.
I weigh the pros and cons of each solution.

EXERCISE 1: Describing a Problem to Others

- Ask each member to describe one problem she has. Then ask the members to form pairs and interview each other to obtain more detailed descriptions of the problems just described, including what has been tried to solve it, etc. Let each person be both an interviewer and an interviewee. Ask each interviewer to give a description of her partner's problems after the first set of interviews. Repeat after the second set of interviews.

Question 4: ***Can you define the problem you described in the exercise to bring it more under your control?***

EXERCISE 2: Using the Workbook for Success to Achieve a Goal

- Distribute copies of the *Workbook for Success* to group members who have not received the workbook or didn't bring their copies.

Think about the problem that you just talked about. How can you frame it in a way that turns it into a goal? For example, I don't have a babysitter so that I can attend GED classes. This could be restated as "My goal is to find a babysitter so that I can attend GED classes." After you have turned your problem into a goal, write it as a Goal in the ***Goal Planning Chart*** *on page 2 of your Workbook for Success. Next, fill in three steps that you can take to reach this goal. And last, think of a realistic, fun, caring thing to do for yourself that will be your reward for achieving this goal.*

The next step in this process is to write the Goal on the ***Step Questions Chart*** *on page 3 and then write in Step #1 and your answers to the following sections on the chart. Complete a Step Questions Chart for each Step of Goal #1.* (At this point, you may want to walk around the room and assist group members with filling in the chart.)

This is the up-front work in achieving your goals and this is all you need to fill out today. Your next task is to work on each step at home and report the progress in the ***Weekly Goal Progress Chart*** *every week until your goal is accomplished.*

Now let's talk about the ***Reward Step*** *for a moment. Rewarding ourselves for the hard things that we do is almost as important as doing the work itself, because rewards are what motivate us. One of the rewards will be whatever you promised to do for yourself once you accomplished this goal. Often, if you think about it, accomplishing a goal comes with many other rewards. For example, finding a babysitter so that I can attend GED classes means that I am on my way to getting my GED, which will be rewarding too. Eventually it might mean a higher paying job. But most importantly, I will increase my self-esteem and the feeling that I am capable of solving problems in my life. The Workbook for Success also includes a* ***What I Learned Char****t. Filling out that chart may help you avoid some of those same obstacles when you try to reach other goals. I encourage all of you to try to achieve at least one goal by using this workbook.*

Question 5*: How can you change the way you feel about things that are beyond your control?*

- If group members need prompting, you can remind group members of two things:

1. Last week's discussion about acceptance and the "Serenity Prayer" and how it applies to problem solving and goal setting.

2. The connection between events, thoughts, and feelings and how members at least have some control over what they *think* about an event and, therefore, how they feel.

CLOSURE

This week we talked about finding solutions to problems in our lives. Problems often arise when we encounter obstacles to reaching our goals so this group was also about goal-setting. The Workbook for Success *can help us reach old goals and set new goals. All of the skills you have learned during this group, during treatment, and from people that you trust and respect will help you feel better and stronger about the choices you make. Next week we'll try to understand how violence has affected our relationships, our thoughts and feelings, and our behaviors. We will also talk about relationships where there is equality and respect.*

Phase IV: Distress Tolerance
Staying Healthy in Stressful World

Chapter 14: DEALING WITH VIOLENCE

Michelle Levasseur

SESSION OUTLINE

RATIONALE

In this session women will define different types of violence and their effects on current relationships, thoughts, and behaviors. Women may not have considered certain behaviors as violence—for example, when her partner calls her names, controls who she sees, or intimidates her by smashing things. Some effects of violence are obvious, like bruises or broken bones, but the effect on a woman's thoughts about herself and others, as well as the way she copes with the stress from the different kinds of violence, are less evident. When a woman understands the relationship between past or current violence and her current mental health and substance abuse, she can choose safer ways of dealing with the violence and develop healthier relationships.

GOALS

1. Members will define domestic violence, physical abuse, and sexual abuse.
2. Members will understand the impact of past and current violence on mental health and substance abuse, and on current relationships.
3. Members will differentiate between unhealthy and healthy relationships.
4. Members will identify strategies to increase their personal safety.

QUESTIONS

1. *What is physical violence or abuse?*
2. *What is emotional abuse?*
3. *What is adult sexual abuse?*
4. *What is child sexual abuse?*
5. *What is the difference between discipline and physical abuse?*
6. *How do physical violence, sexual abuse, and emotional abuse affect your mental health?*
7. *What do you think violence has to do with your abuse of drugs or alcohol?*
8. *If you are being abused, what can you do to change the situation?*
9. *What kinds of supports are there for victims of domestic violence and rape?*
10. *If you have ever been to a domestic violence shelter, what would you like to tell us about the experience?*

EXERCISE

Relationship Wheels. The Power and Control Wheel and Equality Wheel (Handout 14b) are used to contrast Power and Control with Equality.

SUPPLIES

Chalkboard or equivalent; Handouts 14a (Kinds of Violence and Abuse), 14b (Relationship Wheels), 14c (Why Do Victims Stay with Abusers), and 1c (Personalized Safety Plan)

INTRODUCTION

Start each group session with a brief review of the members' current issues. Specifically focus on women with safety and/or emergency issues. Review members' emergency crisis numbers and members' Personalized Safety Plans.

Who wants to talk about problems they encountered during the last week? What strategies did you use to overcome them? Does anyone want to offer a suggestion or talk about a problem you encountered? Did anyone have a chance to use the ***Workbook for Success****?*

This week we are going to go a little further in looking at power in relationships, especially the use of violence. First let's talk about the different kinds of violence and abuse.

Question 1: ***What is physical violence or abuse?***

Typical Responses	
A pattern of using physical violence for power and control	*Getting disciplined with something like a hanger, brush, or shoe*
Hitting, biting, strangling, stabbing, shooting, etc.	*Giving someone broken bones or bruises*
Having things thrown at me	*Having my mouth washed out with soap*
Being hit with a bat or a belt	*Being hit over and over again*
Being burned	*Being told how he/she is going to hurt me*

Question 2: ***What is emotional abuse?***

Typical Responses	
Being called names or insulted	*My boyfriend threatening me a lot*
Being criticized all the time	*Threatening to take the children away*
Being neglected or ignored all the time by my parents	*Being told that I was ugly and not wanted*
My boyfriend always wanting to control me	*Telling me I can't tell anyone or he'll hurt me*
Threatening to hurt someone or something (pets) that I care about so I'll do what he wants	*Accusing me of being unfaithful all the time so he can abuse me (using jealousy as an excuse)*
Keeping me away from family, friends, and money	*Locking me in a room or out of the house*
Telling me how she's going to hurt me	*Stalking me*
	Harassing me at work

Question 3: ***What is adult sexual abuse?***

Typical Responses	
When someone touches you in a sexual way without your consent	*When someone rapes you (this is considered sexual assault)*
When someone forces you to do sexual things that you don't want to do	*Saying nasty things to you and slapping you on the butt*

Question 4: ***What is child sexual abuse?***

Typical Responses	
Any sexual act with a child by an adult or older child	*Someone showing his/her genitals to a child or rubbing them on the child*
Touching private parts	*Making the child touch private parts*
Making a child do sexual things (like undressing) on film or in person	*Exposing a child to obscene pictures, movies, or adults having sex*
Making crude or sexual comments to a child	*French kissing*

Question 5: ***What is the difference between discipline and physical abuse?***

Typical Responses	
Discipline	**Abuse**
Used to teach a child the difference between right and wrong	*Causing marks, bruises, sores, or broken bones*
Hitting below the waist with open hand only	*Hitting a child on the face, head, or stomach*
Trying to change a bad behavior	*Used to harm and humiliate a child*
Reasonable use of force that does not leave marks, bruises, sores, or broken bones	*Hitting a child with objects like brushes, shoes, rulers, belts, switches, paddles, or bats*
	Using violence when you know it doesn't work and you know there are better ways to discipline the child
	Calling a child names, insulting and humiliating the child

- At this time you may choose to pass out copies of **Handout 14a: Definitions of Abuse.** This decision may be based on your determination of the usefulness of the material for this particular group of women.

- Pass out Handout 14b: Relationship Wheels.

We are going to review ways that others exercise power and control over us, and we'll talk more about what an equal relationship looks like. But first, let's look at the Relationship Wheels.

EXERCISE: Relationship Wheels

- Have one group member read a section from the **Power and Control Wheel** and have another person read from the corresponding section of the **Equality Wheel.** Ask the women to talk about how each method of **Power and Control** versus **Equality** would make them feel and what the abuser accomplishes by using these methods. For example:

Example from Power and Control Wheel:

- Why would your partner control whom you see or talk to and blame you for making him hit you?

Possible responses

- He wants to make sure no one has a chance to tell me that the violence is wrong.
- By blaming me, he makes me feel too guilty to think I have a right to leave him.

Example from Equality Wheel:

- How do you feel when someone shows you he supports your goals in life?

Possible response

- It makes me think my needs are as important as his are.

Question 6: ***How do physical violence, sexual abuse, and emotional abuse affect your mental health?***

Typical Responses	
I feel worthless.	*I want to escape with drugs.*
I feel like my feelings and needs don't matter.	*I feel anger that I am afraid I cannot control.*
I feel used.	*I cry a lot.*
Sometimes I just hate life.	*Sometimes I hate myself.*
I feel like I am going crazy.	*Sometimes I hate others.*
I feel weak and stupid.	*I feel helpless.*
I feel jumpy and scared a lot.	*I just want to die.*
Sometimes I feel paranoid that bad things will happen.	*I have a lot of doubts about myself.*
I space out a lot.	*I can't sleep.*

Question 7: ***What do you think violence has to do with your abuse of drugs or alcohol?***

Typical Responses
I still use drugs as a way to escape from the memories.
My husband used to badger me to use drugs, and then he would threaten to report me if I talked about leaving him—I was afraid I would lose my kids.
I realize now that being drunk put me in some risky situations.
When I got hooked on drugs, I thought that my boyfriend was right that I was stupid and couldn't take care of myself.

Discussion Question:

How does violence affect your relationships with your family and friend?

Typical Responses
I still feel ashamed sometimes that I was in an abusive relationship.
I am angry with my family for not helping me or listening to me.
Sometimes when I feel helpless I scream at my children to make them do what I want them to.
A lot of my friends felt abandoned because my partner wouldn't let me see them, and I was too embarrassed to tell them why.
I feel guilty because my children were abused too and I couldn't stop it.
My mother used this to make me feel like I couldn't make it on my own.
My son treats me just like his father did.
I worry that I am a terrible mother because he used to tell me that I was.

Discussion Question:

How does violence affect your intimate relationships?

Typical Responses
It is hard for me to trust my partner in a relationship.
I feel so needy that I let him walk all over me even more.
I sometimes use verbal and physical violence too in my relationships.
It is difficult to enjoy having sex.
I am afraid that he will take advantage of me.
It is hard for me to share intimate details about myself because I am afraid they will be used against me later.
Sometimes I just don't want to have any more intimate relationships.
I'd rather be alone than get hurt again.
I keep waiting for that first punch.
It is hard for me to be assertive about what I need.

Discussion Question:

Earlier, we talked about healthy relationships in terms of Trust and Intimacy. What makes a healthier relationship in terms of Power and Equality?

Typical Responses	
Mutual respect	*Sharing goals and values*
Solving problems together without putting each other down	*Not being criticized if my values are different*
Feeling good about yourself	*Helping each other reach our goals*
Feeling safe about being honest	*Help with parenting*
Getting and giving emotional support	*Not being called names or criticized*
Trust and intimacy	*Feeling accepted for who I am*
Being able to talk freely	*Feeling safe from violence*
Self-respect	*Feeling close*
Being faithful	*Having fun together*
Being comfortable with the other person	*Having sex when we both want it*
	Making decisions together

A very important part of finding healthier relationships is believing that we deserve them.

Question 8: ***If you are being abused, what can you do to change the situation?***

Typical Responses	
Leave	*Try to get him to stop*
Talk to family or friends	*Call the police*
Talk to my counselor or therapist	*Call a domestic violence hotline*
Stay and fight back	*Do a safety plan*
Nothing	

A battered woman leaves the abuser an average of five times and over a period of eight years before she stays gone (Okun, 1986). *There are many reasons why a woman does not leave her abuser or why she goes back.*

- Pass out **Handout 14c** (Why Do Victims Stay with Abusers?) If time permits, go over one example from each category.

Question 9: ***What kinds of supports are there for victims of domestic violence and rape?***

Typical Responses	
Family and friends	*Churches, synagogues*
Case managers, therapists	*The police*
Support groups	*Rape and domestic violence*
Domestic violence shelters	

- Mention to group members that you will hand out a worksheet at the end of the group that includes a place for phone numbers to important resources in the community.

Question 10: ***If you have ever been to a domestic violence shelter, what would you like to tell us about the experience?***

Typical Experiences
Shelter life is very demanding.
They are unable to provide needed assistance and support.
Shelters offer education about the dynamics of domestic violence.
You can get assistance in getting Injunctions for Protection or other restraining orders.
You can get other legal advice.
They have support groups.
It's better if family and friends can visit.
They offer referral to community programs and services.
You can get food, clothing vouchers, and furniture.
Lots of times people end up going back home.
I finally relaxed and was able to sleep.
I felt safe.

Shelter staff would be the first to admit that shelter life is very difficult. But there are many ways that a shelter can help you even if you don't move into the shelter. For example, shelter hotline staff can provide immediate safety planning; legal advice; and food, clothing, and furniture vouchers. They also provide referral to community programs and services.

Discussion Question:

What are some alternatives to going to a domestic violence shelter?

CLOSURE

Recall what you can from our previous sessions to answer the following questions.

1. *If bad memories or feelings become triggers, what can you do?*
2. *Who can you talk to for support?*
3. *What self-soothing techniques can you use to deal with distressing feelings?*

In the first session we talked about Personalized Safety Plans and have discussed them each session since. We have a Personalized Safety Plan ***(Handout 1c)*** *for you to fill out on your own. Feel free to talk to me afterwards if you have some questions or talk to your counselor. Turn to the last page of Handout 1c and fill in the local numbers.*

- Have the local domestic violence shelter, detoxification unit, and crisis line numbers available. The Florida Coalition Against Domestic Violence Hotline and the National Coalition Against Domestic Violence Hotline are already filled in. Members may be able to share other phone numbers that are helpful in their recovery.

Next week we will discuss how to deal with crises that threaten our recovery.

HANDOUT 14a:
KINDS OF VIOLENCE AND ABUSE

Violence is the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community. Violence either results in or has a high likelihood of resulting in injury, death, emotional harm, a person being deprived (for example, deprived of a job, food, or access to supports), or a negative impact on one's development.

Physical Violence is the non-accidental causing of physical harm to a child or adult for the purpose of controlling, dominating, intimidating, or manipulating another person. Physical violence can include behaviors such as hitting, kicking, punching, pushing, biting, slapping, strangling, burning, raping, restraining, stabbing, or shooting.

Verbal Abuse is a means of controlling, humiliating or intimidating another through the use of insults, put-downs, shouting, or threatening another with sexual or physical violence.

Emotional Abuse is a continual and repeated pattern of behavior that includes verbal abuse and mental mind games intended to destroy one's self-esteem and confidence for the purpose of controlling and causing another to feel powerless. Emotional abuse can result in emotional instability, intimidation, and victimization. Emotional abuse can be done on purpose or unconsciously. It can also be the withholding of emotional support and love or the shifting of blame or responsibility for abuse onto the victim.

Economic Abuse is the control of the use and availability of money by one person over another. This can include preventing the other from getting or keeping a job, requiring them to ask for money, taking their money, not allowing participation in making decisions about the use of money, or knowing about the family's finances.

Social Abuse is a means to control another by limiting the other person's social activities and relationships with family and friends; controlling what the other person does, who they see or talk to, what they read and where they go; or limiting their freedom to go out or to be involved in their community. Jealousy is often used to justify these actions.

Sexual Abuse is any unwanted sexual touching either directly or through clothing without the person's agreement or consent including not being able to give consent due to mental problems or drug impairment. Sexual abuse may also include denying privacy, forcing sex acts that are not comfortable, and sexual assault. Child sexual abuse includes any sexual act with a child that is performed by an adult or an older child.

Sexual Assault is penetration of the vagina or rectum with the penis (rape) or other body part, penetration of the mouth with the penis, or the touching *of* or *with* intimate or sexual parts, against the person's will or without consent.

HANDOUT 14a (cont.)

Date Rape or Acquaintance Rape is a rape committed by someone the person knows. It is the most common type of rape on college campuses and in the military. Rape occurs anytime that sexual intercourse takes place without consent, even in a marriage. This is referred to as marital rape.

Sexual Harassment is a form of gender or sex discrimination that includes unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature. Sexual harassment usually falls in one of two categories. Quid Pro Quo is a form of sexual harassment where hiring or job promotions are made dependent on a relationship with the person who has the hiring and firing power or the person who determines who gets the promotion. Hostile work environment is a form of sexual harassment in which the work environment is allowed to become unpleasant in a way that relates to gender such as explicit sexual language or behavior.

Domestic Violence is a learned pattern of behavior used by one person in an intimate relationship to control and have power over the other person. The partners may be married or not, gay or lesbian, living together, separated or dating. The abuse or threat of abuse can be physical, emotional, verbal, economic, or sexual.

NOTE: All of the above methods are also used by women against men and by women in lesbian relationships. For example, the abuser may threaten to tell the ex-spouse of her partner or the authorities that her partner is lesbian so they will take the children; an abuser may say, "no one will believe you because you are a lesbian;" or may threaten to "out" her partner. Female abusers may say, "women can't abuse women" to justify their tactics (Roe & Jagodinsky, 2000).

Adapted from:

Domestic Abuse Intervention Project. (1986). *Power and control tactics of men who batter educational curriculum.* Duluth, MN: Minnesota Program Development, Author.

Center on Crime, Communities & Culture. (2000). *Discussion of major domestic violence terms* [On-line}. Available Internet: http://www.soros.org/crime/pfdv/contents/preface.html. [2000, July 6].

LeMoyne College. (2000). *Definitions IRL 101 – Public policy.* [On-line]. Available Internet: http://web.lemoyne.edu/~donn/irl101/irl101.htm. [2000, July 11].

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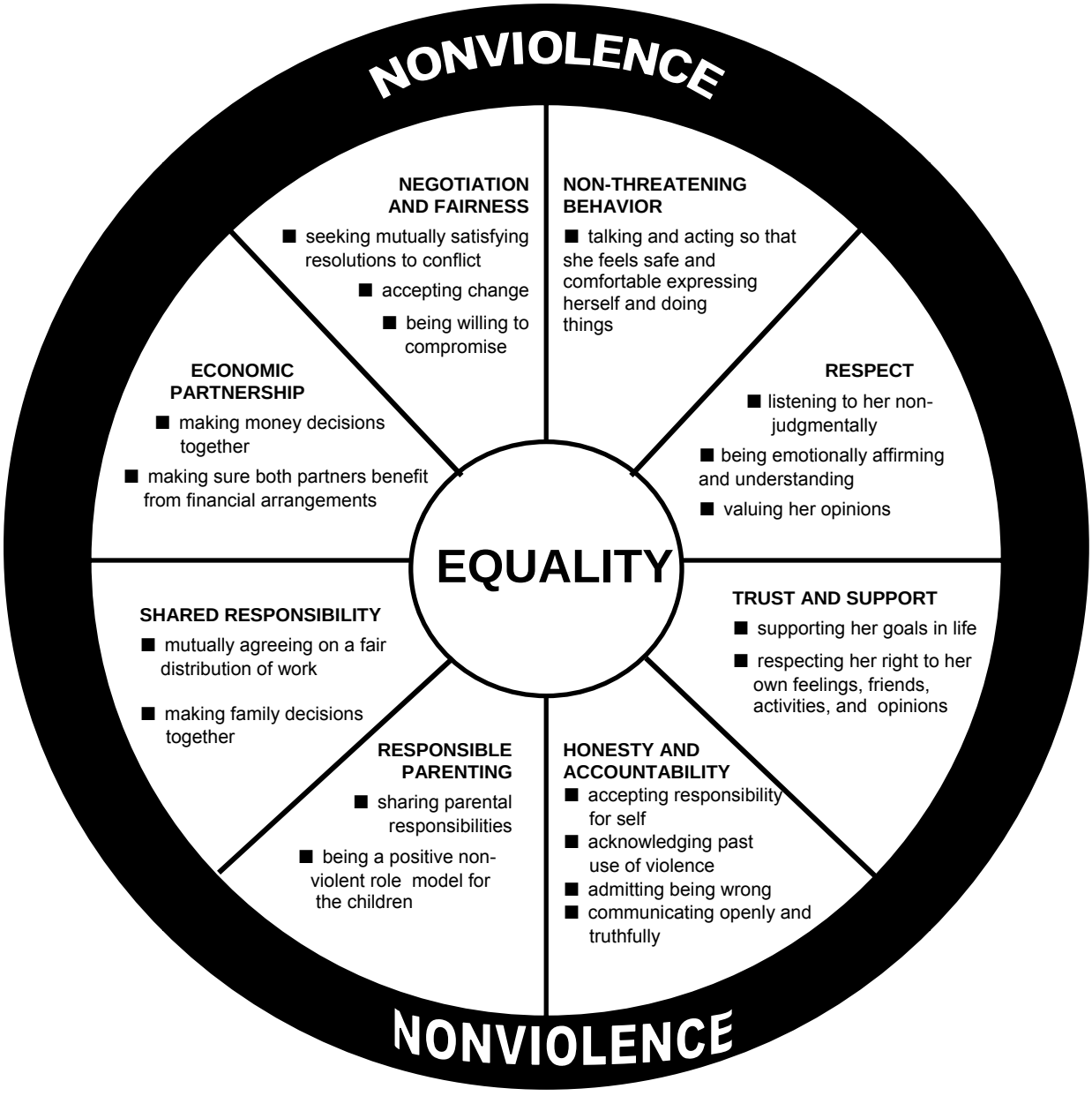
HANDOUT 14b:
RELATIONSHIP WHEELS

Domestic Abuse Intervention Project. (1986). *Power and control tactics of men who batter educational curriculum.* Duluth, MN: Minnesota Program Development, Author.

HANDOUT 14b (cont.)



Domestic Abuse Intervention Project. (1986). *Power and control tactics of men who batter educational curriculum.* Duluth, MN: Minnesota Program Development, Author.

HANDOUT 14c:
WHY DO VICTIMS STAY WITH ABUSERS?

THE SITUATION

- Depending on money from the abuser makes it hard to imagine how to survive on one's own. If there are children, there is fear that they will go hungry or not have clothes.

- Friends and family may not believe the abused person. They may never see the abuser's bad side. If they have tried to help in the past and the victim returned to the abuser, they may be disappointed or angry and not offer help again.

- There is a lot of failure to understand domestic violence. For example, some clergy may preach about the sanctity of marriage and advise keeping the relationship at any cost. Some counselors may side with the abuser. Some law enforcement officers may minimize the situation, not arrest abusers, and not treat the victims with respect. Some doctors may not do anything about obvious signs of abuse in their patients.

- There are increased threats by the abuser when the victim tries to leave, including threats to kill the victim, children or other family members, or threats to commit suicide. Female victims may have knowledge of other battered women who were killed after leaving their abusers.

ATTITUDE AND EFFECTS OF ABUSE

- The victims may love the abusers. They believe the violence is temporary or caused by unusual circumstances. They hope that it will stop soon. (This hope is reinforced by periods of time when there is no abuse and the partner is loving or at least civil.)

- The victims may believe that they should understand their attacker and help them to stop the abuse. For women especially, this is part of a wife's or girlfriend's role. If she can't help her partner, she may think that she is failing in the role of the nurturer.

- Victims may believe in the value of keeping the family together, putting this value above their personal pain and fear. Victims may feel pressure from family, friends, or religion to do this.

- There may be feelings of not being capable such as feeling that one must have a partner to get by in the world, even though the partner is abusive.

- Growing self-blame and self-doubts about the victim's value as a person, judgment, capabilities, and attractiveness (effects of abuse) may eat away at the victim's self-esteem. ("Maybe my partner's right; maybe I'm exaggerating." "How could I manage on my own?" "How will I ever find anybody else?")

- The victims may believe that all men (or women) are abusive. This is reinforced by growing up in a culture in which physical aggressiveness is considered courageous or by being raised by abusive parents.

Adapted from a handout by the National Coalition Against Domestic Violence, Austin, TX

Phase IV: Distress Tolerance
Staying Healthy in Stressful World

Chapter 15: CRISIS MANAGEMENT AND RECOVERY

Margo Fleisher-Bond and Sharon Slavin

SESSION OUTLINE

RATIONALE

As members increasingly recognize their strengths and gain confidence and skills in relating to others, it is important to talk about how to handle crises that threaten their recovery. This group discusses some ways members may have handled crises in the past and brings together all the new coping methods they have learned in these groups to handle crises.

GOALS

1. Members will be able to describe the types of crises that have been threats to their sobriety and well-being in the past.
2. Members will acknowledge and honor the methods used in the past to deal with crises, and they will increase their awareness of the consequences of continuing these methods.
3. Members will be able to describe new ways they have learned of coping with crises.

QUESTIONS

1. *What crises have threatened your recovery in the past or might in the future?*
2. *When you're in crisis, what are some potentially harmful things you think about doing?*
3. *When you did those things in the past, what happened?*
4. *What are some better ways to cope in a crisis?*
5. *How can you find the courage to change the ways you react to a crisis?*

EXERCISE

Empowering Ways of Coping with Crisis. Members discuss empowering methods for managing their intense feelings during a crisis situation. Each member makes a list on an index card of the new empowering strategies she thinks she can use and decides where to keep the list so she can find it in a time of crisis.

SUPPLIES

Chalkboard or equivalent, index cards, pens or pencils

INTRODUCTION

Start each group session with a brief review of the members' current issues. Specifically focus on women with safety and/or emergency issues. Review members' emergency crisis numbers and members' Personalized Safety Plans.

As you continue to increase your self-awareness and skills in relationships with others, it is important to talk about how to handle crises that may threaten your recovery. In this group we will talk about some ways you may have handled crises in the past, and we will review all the coping methods you have learned before in these groups to handle crises.

Question 1: ***What crises have threatened your recovery in the past or might in the future?***

Typical Responses	
Having a fight with someone I care about	*Losing a relationship*
Death in my family	*Financial problems*
Getting triggered	*Flashbacks*
One of my children getting into trouble	*Dealing with family problems*
Getting sick	*Losing my job*

Question 2: ***When you're in crisis, what are some potentially harmful things you think about doing?***

Typical Responses
I want to run away.
I think about drugs and how they can calm me down.
I want a man to hold me and tell me that everything will be O.K.
I want to eat, eat, eat—fill myself up.
I'll go to a bar, get lots of attention, and escape reality.
I just want to get drunk.
I think about cutting or burning myself to release the unbearable tension.
I want to go to bed and feel sorry for myself.
I want to stay in bed and not get up.

Question 3: ***When you did those things in the past, what happened?***

Typical Responses
When I ran away it only made matters worse. It felt good to run away but when reality hit it was terrifying.
After I used drugs I felt really depressed and just wanted to get high again.
The guy got sick of me depending on him all the time—wasn't there for me.
I would feel so guilty about eating that I'd just hate myself even more.
I usually ended up getting really drunk and going home with someone I hardly knew.
I had to hide from everyone that I was cutting, and when I told my counselor I was doing it I was put on a suicide contract.
When I quit using crack I just went to bingeing and purging again.

Question 4: ***What are some better ways to cope in a crisis?***

Typical Responses
Stay put. Call my sponsor and let her know what is going on. Ask her for help.
Go to a meeting and share that I have been thinking about using.
Call a friend and ask for advice.
Pray.
Think, "Will this behavior solve anything?"
Remember that I do have strength. I have survived! I am able to cope. I am not alone.
Go to my church. Even if there isn't a service going on, I feel safe there.
Tell myself, "This, too, shall pass," and "One day at a time."
Wherever I'm feeling unsafe, I just leave!
Do my breathing exercise.
Spend time with people who care about me.
Take a long walk.
Listen to uplifting music.

You will begin to feel more at ease when it appears that there is a consistent and safe path through crisis. Practice the methods that you identify and observe the results.

Question 5: How can you find the courage to change the ways you react to a crisis?

Typical Responses
I can tell myself that it is O.K. to take care of myself.
I can help someone else in recovery—get out of myself.
I can tell myself that my new coping techniques will work.
I can attend my self-help group more often.
I can remember "The darkest hour is only 60 minutes," "Thinking is not doing," and "Feelings are not facts."
I can tell myself that my Higher Power is on my side.

EXERCISE: Empowering Ways of Coping with Crisis

- Ask each member to make a list on an index card of new coping strategies she thinks she can use and decide where to keep the list so she can find it in a time of crisis. One good source of ideas is the **blocks** on cards from the Self-Esteem Game (Chapter 10).

CLOSURE

In the past, crises have been a time to throw you off track, perhaps send you into cycles of behaviors you did not want to be a part of. There is now the possibility that crises can actually be opportunities—opportunities to rise to new levels of empowerment and recovery, self-care, and friendship.

Take just a moment to take some deep breaths and notice how you feel throughout your mind and body. Breathe again and recall the most positive thought about yourself you have had this week. Think it again and breathe.

Next week we will talk about the healing we have done from violence, substance abuse and mental illness. It will be rewarding to look at how far you've come in your recovery.

Phase IV: Distress Tolerance
Staying Healthy in a Stressful World

Chapter 16: RELAPSE AND RECOVERY

Fred Fearday

SESSION OUTLINE

RATIONALE

Recovery is a lifelong process of discovery that involves a potential for relapse. In this session we will look at progress on the road to recovery—what has worked, what has helped, and what still needs to be done. It is important for their recovery that women begin to understand what they control in the recovery process and what barriers they have overcome so far. They must also become aware of what steps lie ahead.

GOALS

1. Members will appreciate how far they have come on the road to recovery and personal healing.
2. Members will acknowledge and appreciate their work of healing from abuse, substance abuse, and mental illness.
3. Members will look at future steps on their road to recovery, understand that relapse may be a part of recovery, and know how to get back on the path.

QUESTIONS

1. *What recovery skills have been important for you?*
2. *What obstacles have you overcome so far on your road to recovery?*
3. *What has been your greatest strength in your personal healing?*
4. *What is the next step to continue your recovery?*

EXERCISE

Treasures to Share. Members write on slips of paper important personal strengths, people, and places that have been important to their personal healing and their hopes and dreams for the future. The slips are gathered and read.

SUPPLIES

Chalkboard or equivalent, slips of paper, pens or pencils

INTRODUCTION

Start each group session with a brief review of the members' current issues. Specifically focus on women with safety and/or emergency issues. Review members' emergency crisis numbers and members' Personalized Safety Plans.

This is the last group in this program. Now we will take some time to review and treasure what we have learned. Has anyone had thoughts about other empowering ways of coping with crises?

Question 1: ***What recovery skills have been important for you?***

Typical Responses	
Reaching out to other people	*Standing up for myself*
Telling other people what I feel	*Being determined*
Telling other people what has happened to me	*Working on my spirituality*

It is important for your future recovery that you recognize skills that have been helpful in dealing with obstacles to recovery. You have probably made many critical decisions in reaching out for help and dealing with trauma, mental illness, and substance abuse. As recovery continues, you will become more reliant on nonprofessional supports, and it will be helpful to focus on community sources of help.

Question 2: ***What obstacles have you overcome so far on your road to recovery?*** (Harris, 1998, p. 204)

Typical Responses	
Hating myself when I relapsed	*Blaming myself for the abuse*
Thinking my abuse/trauma was not important	*Thinking I could control my substance use*
Feeling helpless at times	*Shyness*
Flashbacks to the abuse	*Fear*
Feeling depressed and down	*Losing hope for myself*
Thinking that no one cares about me	*The lack of support in my family*
Lack of money	*Finding friends who don't use*

Discussion Question:

Can you name some obstacles to your recovery that cannot be removed and must be accepted as they are?

Question 3: ***What has been your greatest strength in your personal healing?*** **(**Harris, 1998, p. 203)

Typical Responses	
Determination, persistence	*Courage to leave my abusive situation*
Becoming honest with myself	*Spirituality*
Faith	*Hope*
Understanding the connection between my trauma experiences and my substance abuse and mental illness	*My ability to find new friends* *Dealing with my mental illness* *AA, NA, Double Trouble, DMDA*

Question 4: ***What is the next step to continue your recovery?***

Typical Responses
Get my own place to live
Set limits with my kids
Have a better relationship with my family (son, mom, sister, etc.)
Get my kids back
Keep being honest about what I need to do
Get serious about taking my medications
Continue to work the 12 Steps
Carry the message of recovery to others
Help others who have been through trauma

EXERCISE: Treasures to Share

For some of you, today is your last session in this group. To recognize what we have shared together, I would like all of you to write down a personal treasure that you would like to share with others in the group. A personal treasure is something that has been important for you in your recovery that you would like to share with the group. This could be a personal characteristic like honesty, the time and location of your AA home group, the name of your medication, a helpful saying, or anything you think has been important in your recovery. After you write one down, put it in a pile in the middle of the room. Once everyone is done, members will pick out a slip of paper and share the treasure with the rest of the group.

Discussion Questions:

What more would need to change for you to feel you had recovered?

If you relapse, what will you do to get back to recovery?

CLOSURE

Phase IV was about using the skills you have learned to improve the quality of your lives as you heal from violence and abuse, substance abuse, and mental illness. For those of you who haven't completed all of the groups, in Phase I we will talk about building more safety in our lives, how our minds, bodies, and emotions work together, and what it means to be a woman in this society. Next week we will go over the format of the group in detail and we will talk about issues of empowerment and personal safety.

- Thank everyone for coming to this group and doing challenging but rewarding work on healing. Recognize anything that the group members found particularly meaningful and useful during this group.

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APPENDIX A
PRINCIPLES OF CLINICAL INTERVENTIONS

The Clinical Interventions Committee developed the following principles for consideration by the Triad Project. The committee seeks to define the meaning of these important principles for the project, report on some of the discussion points around these principles, and report our vision on how these principles might be actualized in our interventions. Although we have studied the treatment literature, the principles are derived primarily from our collective experience. The Clinical Interventions Committee has developed these principles but hopes that a dialogue will occur within the Project that further develops and gives meaning to them.

The principles of recovery, empowerment, and survival emphasize positive outcomes for women. The remaining principles speak to the project's philosophies that underlie treatment for women with Triad issues.

RECOVERY

Definition: *a personal journey in pursuit of wholeness: living in harmony with others, assuming personal responsibility, achieving a sense of purpose, hope for the future, and peace of mind. Recovery is a life-long process of discovery that involves a potential for relapse.*

Discussion points:

- Recovery may erroneously denote that clients will recover to a pre-illness/pre-substance abuse/pre-abuse state of living that clients had not actually experienced.
- Recovery may imply that clients have not done any work on their own prior to our treatment/intervention.
- It is a central concept of self-help approaches in substance abuse.
- Some Consumer/Survivors/Recovering (C/S/R) women at the National Steering Committee expressed concerns about the use of this term. These concerns were primarily related to the first discussion point.
- The goals of treatment should focus on positive life goals—work, safe home environments, healthy parenting, and relationships—not symptom relief alone.
- Spirituality is a key element of recovery.
- Recovery is a process not an event. A woman will never be recovered but can stay recovering if she continues to take steps that support recovery.
- Women often seek connectedness and intimacy as part of their recovery.

Actualization:

- The use of 'recovery' language will be emphasized in clinical interventions.
- The goals of treatment should emphasize life goals rather than symptom relief alone.
- The search for spirituality will be recognized as important for recovery.
- The input of recovering women is sought.

EMPOWERMENT

Definition: *to understand options in an environment that promotes choice and the means to pursue those choices. In addition, clients must perceive that they have the ability to make genuine choices. This requires that a woman have sufficient confidence in herself to make such choices.*

Discussion points:

- In a group setting, members hear about the choices made by other members, and this serves to build the confidence of other group members who confront difficult choices.
- The authority of therapists is potentially problematic, as survivors of trauma often seek to please those in authority rather than trust their own decisions.

Actualization:

- Clinical interventions will honor the experiences of women. Coping strategies developed by women when faced with abuse will be respected as having been their best ways to cope with dysfunctional environments.
- Careful attention to the use of authority in relationships with C/S/R women is required.
- Sharing sources of knowledge with C/S/R women is used to empower them in their decision-making.
- Service interventions designed for the Project will respond to the feedback of C/S/R persons.

SURVIVAL

Definition: *to take responsibility for dealing with the personal consequences of trauma while understanding that one does not bear responsibility for being a victim of trauma. To value those coping strategies that allowed one to survive violence and to understand that new strategies are needed to deal with the emotional consequences of past violence and create safe environments for oneself and one's family. To shift one's identity from that of "victim" to that of a "survivor" who can thrive in the present.*

Discussion points:

- It is important in terms of self-esteem to define oneself as a survivor who has used reasonable coping strategies, because of the limited choices that were available in one's environment to deal with violence. Coping strategies used by survivors are best understood as ingenious adaptations to untenable situations of violence.
- Survivors of violence have often used drinking, drugging, and self-injury as a means to numb feelings.
- Survivors have often assumed personal blame and "badness" to explain why the trauma occurred.
- Women are helped by reframing their thinking about the coping strategies used to deal with violence from negative labels, such as *sick, bizarre, and mentally ill*, to survivor labels, such as *self-protection, ingenious, and creative adaptations*.

- Because sexual, physical, and emotional abuse violates one's sense of trust and security in relationships establishing trust in a treatment relationship presents significant challenges for the survivor and providers of services.
- When the perception of reality has been distorted by violence perpetrated within dependent relationships, survivors have often struggled to understand the realities of their relationships.
- Survivors have been helped by learning new coping strategies related to managing stress, setting personal boundaries, self-soothing, and creating safe personal environments.
- Amazing transformations have occurred for victims of violence who have shifted their identity to that of a survivor.

Actualization:
- Use language that recognizes the strength of survivors.
- Be sensitive to issues of self-blame.
- Recognize significant relationship challenges facing the individual who has been abused.

INTEGRATED SERVICES

Definition: *services should be provided simultaneously for mental health, substance abuse, and trauma issues by the same staff in the same setting. Integrated treatment is the most effective method of providing services to women with co-occurring mental health and substance use disorders who have survived violence. Treatment approaches and philosophies should be compatible and blended. Staff is to be cross-trained to provide integrated services.*

Discussion points:
- Fully integrated services will not be possible in all settings in the district. When full integration is not possible due to resource limitations, clinical interventions will need to include collaborative relationships to provide hybrid mental health, substance abuse and trauma services.
- There is a complex interaction among these three problem areas that is not readily simplified. The impact of trauma on the lives of women with co-occurring disorders is not fully understood.
- The impact of trauma on the lives of women has often been minimized and denied.

Actualization:
Triad Women's Project staff will be trained to provide clinical services for all three problem areas.

READINESS

Definition: *the acceptance of help for problems related to mental illness, substance abuse, and violence occurs for women in different degrees and stages. Ongoing assessment of a woman's readiness is needed to provide a correct fit between readiness and intervention efforts.*

Discussion points:
- C/S/R women are at various levels of readiness to utilize services.

- Treatment needs to change over time to meet the readiness of women to utilize various types and levels of service.
- It may be a useful construct to view women as moving through stages of recovery/empowerment. Stages of recovery/empowerment require different responses from clinicians so that all C/S/R women receive appropriate treatment. Viewing individuals as proceeding through stages assists clinicians and C/S/R women to recognize the gains made in recovery/empowerment and to formulate appropriate clinical responses.
- Although the construct of a stage model is useful it has limitations. These include assuming too much and thus failing to complete thorough assessments, and assuming that an individual will follow pre-set expectations about moving through stages of recovery. Thorough individualized assessment is always necessary.
- From this perspective, denial and relapse are part of the recovery process. The stage model guides clinicians in planning and deciding what interventions are appropriate at a particular point in time. It is important that everyone recognize that movement through these stages is not usually linear; rather, individuals will take various routes to recovery and empowerment.
- While a number of stage models exist in the literature, the committee decided to focus on the core issues of readiness. The primary issue is seen as the need to modify treatment in response to readiness of the client.

Actualization:

- While recognizing that resource limitations may place constraints on staff, clinical interventions will seek to be responsive to the readiness of project participants.
- Ongoing assessment is essential to be responsive to the needs of C/S/R women.

FLEXIBILITY

Definition: *to provide individualized attention to the needs of C/S/R women so that treatment addresses the diverse preferences and needs of the women receiving services. Flexibility reflects an attitude of collaboration between staff and clients. It recognizes that recovery is a personal journey and that C/S/R women need to be engaged in developing individualized treatment plans.*

Discussion points:

- The challenge will be for treatment to accommodate the individualized needs of women with Triad issues.
- C/S/R women are at different stages on the road to recovery, and the project needs to design interventions that meet clients where they are on this road.
- Overly structured approaches that do not attend to the needs and preferences of clients are ineffective in the long term.
- Important areas requiring flexibility are required medication adherence, mandated abstinence, and diagnosis.
- While staff needs to be flexible, interventions need to adhere to established program structure and clinical approaches. Interventions need to be measurable across the sites.
- Flexibility will be needed to engage and retain clients in treatment.

Actualization:
- Interventions will need to have flexibility built into their designs.
- Interventions will require attention to the feedback given by staff members and participants.
- The structures of interventions will need to be adapted to individual needs while maintaining flexibility.

STRENGTH-BASED ASSESSMENT AND TREATMENT

Definition: *to identify what women do well and how they have coped with disempowering environments. Of equal importance is identifying positive support and care available in women's environments. It is vital that assessments focus on a woman's resilience, skills, life goals, and hopes for the future.*

Discussion points:
- A pathology focus leads to victim blaming and reinforcement of existing negative self-assessments.
- The strengths of a woman and her community can be mobilized to improve quality of life and outcomes of care.
- Assessment and treatment can make women feel worse if the focus of assessment is exclusively on symptoms and pathology.
- Strength based assessment is especially important for survivors of trauma who often perceive themselves as damaged and scarred.
- A woman's goals, confidence, and hope need to be vigorously reinforced.
- Strength-based assessment helps a woman move from a victim stance to a survivor stance.
- A woman's competencies in relationship building, care giving, and childcare should not be overlooked.

Actualization:
- Assessment instruments will focus on personal and environmental strengths.
- Treatment will reinforce a woman's goals, confidence, and hope.

SELF-HELP

Definition: *the process of C/S/R women helping other C/S/R women is a powerful tool for recovery. C/S/R women have powerful stories to share with each other. When one C/S/R woman shares her recovery story with another, both women are helped.*

Discussion points:
- Self-help has proven to be a powerful tool for recovery and empowerment. See also the principles of recovery and empowerment.
- Participation in self-help groups such as AA, NA, and Al Anon is part of recovery/empowerment and needs to be facilitated by the project. Barriers to self-help group participation need to be understood and addressed by the project.
- Hearing stories of recovery gives women with Triad issues hope and confidence.

- Coping strategies developed by women faced with abuse will be respected as having been their best ways to cope with dysfunctional environments. This is important to help women move from a victim stance to a survivor stance in relation to violence in their lives.
- C/S/R women are the experts in understanding their own needs. One person helping another is unparalleled in its ability to help both the person being helped and the person helping.

Actualization:
- Self-help principles will be incorporated into the design of clinical interventions.
- Interventions that are run by C/S/R women, such as warm lines, and self-help groups, will be valued in the project.
- Barriers to participation in self-help, such as the lack of transportation and childcare, will be identified and examined for possible solutions by the project and rectified when possible.
- C/S/R persons will be hired to work on the Project.
- C/S/R persons will be trained to provide services for the Project.

TRAUMA-INFORMED SERVICES

Definition: *to provide services that reflect an understanding of the complex impact of trauma on the lives of survivors. Attention is given to survivor safety and the development of collaborative, trusting relationships. Goals of treatment focus on growth, mastery, and efficacy rather than on the absence of symptoms.*

Discussion points:
- Assessment should routinely ask about histories of sexual, physical, and emotional violence and trauma. Abuse by the service delivery system should be recognized.
- Trauma-informed services should be routine within the service delivery system.
- Research indicates that trauma is a significant issue for many consumers of mental health and substance abuse services.
- Trauma-specific services are those services specifically designed for individuals who present with trauma issues.
- Appropriate training is needed to reduce retraumatization and inappropriate treatment of women with Triad issues. The use of coercion should be minimized, and if necessary the use of coercion should be made explicit.

Actualization:
- All staff in the service delivery system will be given information on the complex impact of trauma and its potential influence on co-occurring disorders.

GENDER-SPECIFIC SERVICES

Definition: *to provide services that are designed to meet the unique needs and strengths of women. Services must recognize and respect the value women place on interdependency, nurturing relationships, and the communication of feelings.*

Discussion Points:

- Women with mental health, substance abuse and trauma issues require gender- specific responses. These include exploring evolving gender roles, victimization, stigmas of women who abuse alcohol and other drugs, social discrimination, physiological differences in metabolizing alcohol and other substances, HIV risk, fear of losing children, sex trade activities, and economic dependency.
- Perinatal women face difficulties with accurate diagnosis, childcare and custody concerns, health coverage, and the stigma attached to perinatal women who use substances.
- Women with trauma issues often do not feel safe around men.
- Childcare needs must be considered in the design of services for women.
- Minority groups of women require specialized attention and outreach, e.g., lesbians, Haitians, migrant farm workers, Hispanics, African Americans.
- Attention needs to be given to the special needs of women in substance abuse treatment. Many substance abuse programs focus on the needs of men, who are usually in the majority in substance abuse programs.

Actualization:

- Women-only groups.
- Transitional housing for women, together with their children will be provided.
- Recognition that women's needs are different than men's needs.

CULTURAL SENSITIVITY

Definition: *the quality or condition of being capable of perceiving and respecting a woman's ethnicity when providing outreach, assessment and treatment.*

Discussion points:

- The experience of psychosocial stress has been linked to substance use and mental illness. Among minorities such stress may be greater due to discrimination, poverty, inadequate employment and educational opportunities, and a sense of powerlessness.
- The unique resources and strengths, as well as, the healing practices of ethnic groups that arise out of their cultural experiences should be understood and valued.
- The Project needs to be attentive to the ethnic-specific strengths and needs of minority groups in the District especially African American and Hispanic women, who are a significant proportion of the District's population. Although a relatively small minority District-wide, Haitian women are believed to be largely under served and require specialized outreach.
- The Project needs to understand existing barriers to treatment for minority women and to minimize such barriers. Treatment strategies will be developed that lessen language and cultural barriers to treatment.
- Mistrust, language barriers, transportation, and transient housing are barriers to migrant women obtaining services.

- Various culturally based attitudes and beliefs regarding mental health, substance abuse, and violence need to be well understood by service providers.
- Treatment services in the first language of C/S/R women are of critical importance.
- In order to provide culturally competent services staff will require training to improve their understanding of cultural differences.

Actualization:
- Cultural competency training will be provided to staff.
- Providing services in the first language of the participant will be vigorously pursued.
- Special outreach will be provided to women who are migrant farm workers.
- Bi-lingual, bi-cultural staff will be hired to serve Hispanic women.
- To the extent possible the ethnicity of staff on the Project will resemble that of C/S/R women in the District.

CONFIDENTIALITY

Definition: *to protect the identity and privacy of individuals seeking and receiving services.*

Discussion points:
- The need to protect confidentiality is vital to the success of the project.
- Confidentiality in rural areas is especially important.
- Women still in unsafe environments may suffer violence if their confidentiality is not maintained.
- Women need to feel that the environment is safe in order to engage in treatment. Confidentiality is important for women to feel safe.
- The committee discussed two concerns:
  A) staff seemed to hide behind confidentiality rather that take appropriate steps to involve a woman's support system in her care, and
  B) some staff members inappropriately act as if confidentiality allows them to prevent clients from seeing the client's clinical record.

Actualization:
- Group interventions planned for the project will emphasize the importance of keeping private information disclosed within groups confidential.

APPENDIX B
THE DEVELOPMENT AND COURSE OF CO-OCCURRING DISORDERS AND THE IMPACT OF VIOLENCE

The development and course of co-occurring disorders
Co-occurring disorders refers to the presence of at least one mental health disorder and at least one substance abuse disorder simultaneously in the same individual. The disorders are not symptoms of the other(s) or directly caused by the other disorder(s), although having one disorder increases the chances of having the other. Co-occurring disorders often interrelate with one disorder affecting the development, onset, course, and severity of the other disorder(s). The symptoms of one disorder often exacerbate symptoms of the other disorder(s).

Co-occurring disorders includes a wide range of disorders that differ in their severity, course, and cause. Because of this wide range only general statements about the development and course of co-occurring disorders can be made here. One can make more precise statements when referring to specific disorders.

The development, onset, course, and severity of co-occurring substance abuse and mental health disorders are influenced by a number of biological, psychological, and social factors. These factors interact in a complex way with some being protective and others increasing vulnerability to substance abuse and mental health disorders. Protective factors for a woman might include a nurturing family environment, the absence of congenital susceptibility to substance dependence, and effective social skills. When individuals are exposed to sufficient risk factors not mitigated by protective factors, these disorders result. Some biological, psychological, and social factors *are:*

- Biological: chemical imbalances, biochemical errors of metabolism, congenital predisposition and vulnerabilities, physical illnesses, and prenatal care
- Psychological: personality traits, personal skills and abilities, psychological defenses, psychological supports, social skills, levels of stress, and personal defenses and vulnerabilities
- Social: familial and social environment, external stressors, violence, poverty, racism, gender bias, social support, peer groups, social pressures, and cultural attitudes toward alcohol and other drugs

The impact of violence on the development and course of co-occurring disorders
Violence is widespread in our society and significant in the lives of most people who seek mental health and substance abuse treatment. Yet there is often a failure to recognize the impact of violence on the lives of women and its role in the development and course of psychiatric and substance abuse disorders. Violence is often traumatizing and can affect a woman's perception of the world, her relationships, her cognitive functioning, her vocational choices, her abuse of substances, and her mental health. The impact of violence can be broad and pervasive. The greater the intensity and duration of the violence, the greater the potential for life-long *emotional* problems for survivors of violence. The degree and type of support offered by the environment in

response to the violence has the potential to mitigate or exacerbate the long-term emotional consequences of the violence.

The traumatizing effects of violence on the lives of women are often not recognized by treatment professionals, family, friends, and society. This failure to recognize the impact of violence reinforces messages from abusers and authority figures that women should deny and minimize the impact of violence. A lack of a supportive response to their victimization often leads women to accept undeserved blame and hence feel ashamed, and the failure of treatment professionals to recognize the impact of violence further encourages these feelings. Some mental health and substance abuse treatment approaches have exacerbated feelings of self-blame, low self-esteem, and other psychological effects of violence by discounting its impact. For example, behaviors that were originally adapted by survivors to defend themselves from violence are often pathologized and mistakenly attributed to psychosis. A special concern is that denying the impact of violence leads to a failure to understand both the negative psychological consequences of seclusion and restraint and the need to use more collaborative and empowering approaches to de-escalation.

When the impact of violence is considered, the substance abuse and mental health treatment needs of traumatized women are better understood. Assessment, treatment, and relationship building should be done through a lens of trauma. A trauma lens refers to considering a possible history of violent experiences to explain a woman's actions and to identify her treatment needs. When working with survivors of violence it leads to a fuller understanding of trauma-related symptoms such as substance abuse, affective numbing, dissociation, flashbacks, suppressed memory, self-injury, boundary confusion, and the emotional reliving of the trauma experience. These trauma-related symptoms have often been misattributed to other causes. The failure to recognize reactions to violence in women leads to misdiagnosis and inappropriate treatment. Through a trauma lens the influence of violence on the development of mental health problems and the use of substances to cope with the emotional consequences of trauma become clearer. Treatment approaches that acknowledge the impact of violence and empower women to recognize the consequences of violence will assist women to gain perspective, improve their self-esteem, reject self-blame, learn more adaptive coping techniques, and assert control over decisions about the safety of themselves and their families.

APPENDIX C
DSM-IV CRITERIA FOR SUBSTANCE ABUSE AND DEPENDENCE

SUBSTANCE ABUSE

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

(1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)

(2) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)

(3) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)

(4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

SUBSTANCE DEPENDENCE

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

(1) tolerance, as defined by either of the following:
(a) need for markedly increased amounts of the substance to achieve intoxication or desired effect
(b) markedly diminished effect with continued use of the same amount of the substance

(2) withdrawal, as manifested by either of the following:
(a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
(b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

(3) the substance is often taken in larger amounts or over a longer period than was intended

(4) there is a persistent desire or unsuccessful efforts to cut down or control substance use

(5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects

(6) important social, occupational, or recreational activities are given up or reduced because of substance use

(7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

Specify if:

With Physiological Dependence: evidence of tolerance or withdrawal (i.e., either Item 1 or 2 is present)

Without Physiological Dependence: no evidence of tolerance or withdrawal (i.e., neither Item 1 nor 2 is present)

Course specifiers:

Early Full Remission: This specifier is used if, for at least 1 month, but for less than 12 months, no criteria for Dependence or Abuse have been met.

Early Partial Remission: This specifier is used if, for at least 1 month, but less than 12 months, one or more criteria for Dependence or Abuse have been met (but the full criteria for Dependence have not been met).

Sustained Full Remission: This specifier is used if none of the criteria for Dependence or Abuse have been met at any time during a period of 12 months or longer.

Sustained Partial Remission: This specifier is used if full criteria for Dependence have not been met for a period of 12 months or longer; however, one or more criteria for Dependence or Abuse have been met.

On Agonist Therapy: This specifier is used if the individual is on a prescribed agonist medication, and no criteria for Dependence or Abuse have been met for that class of medication for at least the past month (except tolerance to, or withdrawal from, the agonist). This category also applies to those being treated for Dependence using a partial agonist or an agonist/antagonist.

In a Controlled Environment: This specifier is used if the individual is in an environment where access to alcohol and controlled substances is restricted, and no criteria for Dependence or Abuse have been met for at least the past month. Examples of these environments are closely supervised and substance-free jails, therapeutic communities, or locked hospital units.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

APPENDIX D
LIST OF HANDOUTS

APPENDIX E
RECOMMENDED BOOKS AND WEB ADDRESSES

Trauma, Abuse, and Violence

BOOKS:

Adult Children of Abusive Parents : A Healing Program for Those Who Have Been Physically, Sexually, or Emotionally Abused. **Author:** Steven Farmer. **Year:** 1990. **Publisher:** Ballantine. **Description:** *This book examines the lack of boundaries, chaos, denial and rigid role-playing that exist in dysfunctional families—and then reveals the ways to overcome them with a step-by-step self-help program that includes exercises and journal work for recovery. *Approximate cost: $10.*

The Battered Woman's Survival Guide: Breaking the Cycle. **Author:** Jan Berliner Statman. **Year:** 1995. **Publisher:** Taylor Publishing Co. **Description:** *This book is one of several recommended by the National Coalition Against Domestic Violence Hotline. *Approximate cost: $19.*

Chain Chain Change—For Black Women in Abusive Relationships. **Author:** Evelyn C. White. **Year**: 1995 (2nd edition). **Publisher:** Seal Press. **Description***: This book is a later edition of a book recommended by the National Coalition Against Domestic Violence Hotline. *Approximate cost: $10*

The Courage to Heal: A Guide for Women Survivors of Childhood Sexual Abuse. **Authors:** Laura Davis and Ellen Bass. **Year:** 1994 (3rd revision). **Publisher:** Harper and Row. **Description***: This book and the accompanying workbook provide valuable guidance to survivors as they identify abuse, confront it, and move confidently past it and into a healing future. *Approximate cost: $18.*

The Courage to Heal Workbook: For Women and Men Survivors of Child Sexual Abuse. **Author:** Laura Davis. **Year:** 1990. **Publisher:** Harper-Collins. **Description***: This is a workbook that can be used along with the guide or by itself. Approximate cost: $18.*

Trauma and Recovery. **Author:** Judith Herman. **Year:** 1997. **Publisher:** Basic Books. **Description***: For consumers and service providers, this book offers insight into the entire spectrum of trauma from rape to terrorism and emphasizes integration as part of the healing process. *Approximate cost: $12.*

Trauma Recovery and Empowerment: A Clinician's Guide for Working with Women in Groups. **Authors:** Maxine Harris and the Community Connections Trauma Work Group. **Year:** 1998. **Publisher:** The Free Press. **Description***: This book informed the Triad Group model and is recommended for clinician's doing group work in a variety of settings regarding trauma and abuse issues of women. The book includes additional chapters on special populations such as working with men, women with parenting issues, severe mental illness, or those who are incarcerated. *Approximate cost: $33.*

Trust after Trauma: A guide to relationships for survivors and those who love them. **Author:** Aphrodite Matsakis. **Year:** 1998. **Publisher:** New Harbinger. **Description***: For consumers and providers, this guide explains the effects of trauma on relationships and includes case histories from trauma survivors and many helpful questionnaires and exercises. *Approximate cost: $16.*

WEBSITES:

David Baldwin's Trauma Information Pages. **Web Address:** http://www.trauma-pages.com. **Description:** *The purpose of this site is to provide information for clinicians and researchers in the traumatic-stress field including information about PTSD, easy and detailed reading lists, trauma and disaster articles and resources, a trauma bookstore, trauma web links, and chat and email discussion links.*

National Center for PTSD. **Web address:** http://www.ncptsd.org. **Description:** *This educational resource provides information on PTSD and other consequences of traumatic experiences; instructions on the use of the Pilot Database system (a worldwide literature index); clinical information on diagnosis, disaster intervention, and treatment; and links.*

Sidran Traumatic Stress Foundation. **Web Address:** http://www.sidran.org. .**Description:** *This site provides information and resources on trauma including articles, links, and a list of trauma-related books by subject, title, or author.*

Trauma Taskforce. **Web address:** http://fmhi.usf.edu/trauma/resources.html. **Description:** *This site offers links to journals, databases, tutorials, organizations, and research.*

Mental Health: Schizophrenia, Bipolar Disorder, Depression

BOOKS:

Bipolar disorder: A guide for patients and families (John Hopkins Press Health Book). **Author:** Francis Mark Mondimore. **Year:** 1999. **Publisher:** John Hopkins University Press. **Description:** *The book contains information about symptoms/diagnosis, treatment, etiology, and living with the disorder or with one who has the disorder. Chapters on preparation for emergencies and on the role of the family and suggested resources may be especially useful. *Approximate cost: $14.*

Cognitive Behavioral Treatment of Borderline Personality Disorders and the Skills Training Manual for Treating Borderline Personality Disorder. **Author:** Marsha Linehan. **Year:** 1993. **Publisher:** The Guilford Press. **Description***: The book and accompanying manual informed the Triad Group model and are recommended for any clinician who wants to increase his/her knowledge about teaching mindfulness skills, interpersonal effectiveness skills, emotion regulation skills, and distress tolerance skills. *Approximate book cost: $50. *Approximate training manual cost: $25.*

Coping with Schizophrenia: A Guide for Families. **Authors:** Kim Mueser and Susan Gingerich. **Year:** 1994. **Publisher:** New Harbinger Publications. **Description***: Recommended by NAMI, this is a practical, informative book for consumers and providers. *Approximate cost: $13.*

Surviving schizophrenia: A manual for families, consumers and providers. **Author:** E. Fuller Torrey. **Year:** 1995 (3rd Edition). **Publisher:** Harper Perennial. **Description***: This book is a valuable resource that educates the reader about the illness, etiology, treatment, and how to not only survive but also thrive. *Approximate cost $13.*

The Dual Disorders Recovery Book: A Twelve Step Program for Those of Us with Addiction and an Emotional or Psychiatric Illness. **Author:** Hazelden Foundation. **Year:** 1993. **Publisher:** Hazelden Information Education. **Description:** *This book describes what its title suggests. *Approximate cost: $11.*

When Feeling Bad Is Good. **Author:** Ellen McGrath. **Year:** 1994. **Publisher:** Bantam. **Description:** *The author provides clear, rational, cultural explanations for women's depression and offers action-oriented approaches to dealing not only with the depression itself but also with the factors contributing to it. Approximate cost: out of print.*

WEBSITES:

Consumer Organization and Network Technical Assistance Center (CONTAC). **Web Address:** http://www.contac.org. **Description:** *This is a site dedicated to support and promote consumer self-help activities including materials development and dissemination, training, skill development, interactive communication opportunities, networking and other activities intended to promote self-help, recovery and empowerment.*

Expert Consensus Guideline Series. **Web Address:** http://www.psychguides.com. **Description:** *For treatment providers, this site provides downloadable articles summarizing the latest consensus on guidelines for the treatment of severe mental illnesses. It also has patient-family guides, and useful links***.**

Internet Mental Health. **Web Address:** http://www.mentalhealth.com. **Description:** *This is a free encyclopedia of mental health information including information on disorders, medications, links, and even an online diagnostic program.*

Knowledge Exchange Network (KEN). **Web Address:** http://www.mentalhealth.org. **Description:** *This site offers mental health information for service providers and consumers. There is information in Spanish, links, a database, a kid's area, and free publications/pamphlets that are easy to order.*

Mental Health Recovery. **Web Address:** http://www.mentalhealthrecovery.com/resources.html. **Description:** *This site by Mary Ellen Copeland includes articles on a variety of subjects including mental illness, trauma, suicide, relapse and recovery. The site also has a depression quiz, a crisis plan worksheet, and a good selection of books indexed by topic. She even offers her home-made maple syrup for a nominal fee!*

Mental Health Links by Dr. Bob. **Web Address:** http://uhs.bsd.uchicago.edu/dr-bob/mental.html. **Description:** *Intended for professionals, this site provides links for almost any mental health issue imaginable, including links regarding ethics, diagnosis, chat rooms, articles, organizations, publications, and psychiatry departments.*

NAMI (National Alliance for the Mentally Ill. **Web address:** http://www.nami.org. **Description:** *NAMI is a grassroots advocacy organization dedicated to improving the lives of persons with severe mental illness. The site offers information about mental illness, book reviews, links, and much more.*

Schizophrenia. **Web address:** http://www.schizophrenia.com. **Description:** *The goal of this site is to offer a centralized resource of all information related to schizophrenia.*

Toward the Light. **Web Address***:* http://www.kodie.simplenet.com/depress.htm. **Description:** *This site includes information and links mostly about depression. It also provides information, links and on-line screening for depression, anxiety, and OCD and information on medications, links to personal pages, suicide information and resources, legal issues, and choosing a therapist/doctor.*

Alcohol, Substance Abuse, and Addiction

BOOKS:

Alcoholics Anonymous. **Author:** Alcoholics Anonymous World Services. **Year:** 1976 (3rd Edition). **Publisher:** Author. **Description:** *Used by Alcoholics Anonymous, the main purpose of this book is to share personal stories about how alcoholics have recovered. The AA program has evolved to include the Twelve Steps and the Twelve Traditions, which are included in the book. *Approximate cost: $5.*

Beyond the Influence: Understanding and Defeating Alcoholism. **Authors:** Katherine Ketcham and William Asbury. **Year:** 2000. **Publisher:** Bantam Books. **Description:** *An optimistic and compassionate book for service providers and the layperson, this book provides up-to-date research findings about the causes and consequences of alcoholism. *Approximate cost: $12.*

I'll Quit Tomorrow: A Practical Guide to Alcoholism Treatment. **Author:** Vernon E. Johnson. **Year:** 1990 (Revised Edition). **Publisher:** Harper & Row. **Description:** *Johnson offers insight into the steps that lead a person down the path of alcoholism. He offers advice on how to understand the addicted person, tools for family and friends, and an approach of love and compassion. *Approximate cost: $12.*

Living Sober. **Author**: Alcoholics Anonymous World Series. **Year:** 1975. **Publisher:** Author. **Description:** *This is a helpful recovery tool for living in sobriety. *Approximate cost: $4.*

Loosening the Grip: A Handbook of Alcohol Information. **Authors:** Jean Kinney and Gwen Leaton. **Year:** 1994 (5th Edition). **Publisher:** McGraw-Hill. **Description:** *This comprehensive text reviews historical perspectives, the etiology of the disease, and much more, and has cartoons drawn in the margin that humorously and metaphorically illustrate the points. Earlier versions may be available but are currently out of print and the 6th Edition was printed in 1999. *Approximate cost: $50.*

The Mother's Survival Guide to Recovery: All About Alcohol, Drugs and Babies. **Author:** Laurie Tanner **Year:** 1996. **Publisher:** Oakland, CA: New Harbinger Publications. *Approximate cost: $13.*

Narcotics Anonymous. **Author:** Narcotics Anonymous World Service Office **Year:** 1988 (5th Edition). **Publisher:** Author. **Description:** *This volume is intended as a textbook for every addict seeking recovery. It outlines the NA program, personal stories, the Twelve Steps of NA, and the Twelve Traditions of NA. *Approximate cost: $12.*

The Recovery Book. **Authors:** Al J. Mooney, Arlene Eisenberg, and Howard Eisenberg. **Year:** 1992. **Publisher:** Workman. **Description:** *This book offers a roadmap to recovery from alcoholism beginning with the decision to quit and ending with the challenges of relapse. *Approximate cost: $16.*

Turnabout: New help for the woman alcoholic. **Author:** Jean Kirkpatrick. **Year:** 1999. **Publisher:** Madrona Publishers. **Description:** *This program for women alcoholics is similar to AA but is based on 13 Empowering Statements for Acceptance created by the Women for Sobriety. *Approximate cost $12.*

APPENDIX F
THE 12 STEPS OF ALCOHOLICS ANONYMOUS

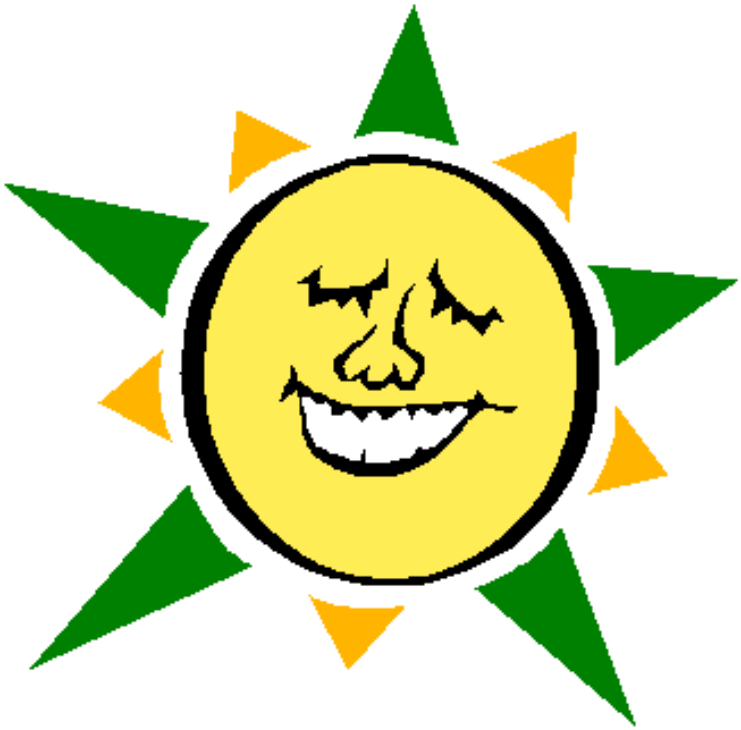
1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as *we understood Him*.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong, promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Alcoholics Anonymous World Services, Inc. (1976). *Alcoholics anonymous* (3rd ed.). New York: Author.

Appendix G

Workbook for Success

Workbook Instructions



INTRODUCTION

Setting and reaching goals that are important to you is a key to successful living. The workbook will help you plan and achieve the goals you set for yourself on the **Quality of Life Report**. You may also learn some things about yourself that will help you make new goals for yourself later on. Completing the workbook will not only help you reach these goals, it will help you learn skills that you can use to reach other goals you set for yourself throughout your life. You may want to ask other people (counselors, friends, family members, or peers) to help you complete this workbook.

You are going to make a plan for each of your goals. Your agreed-upon goals are probably very important to you--for example, improving your health, making new friends, going back to school, or getting a job.

HOW TO USE THE WORKBOOK

The workbook is a tool. It outlines three things you can do to make effective plans for achieving your goals: (1) Break your goals into smaller steps; (2) Identify barriers and resources for each step; and (3) Make changes in your plans based on the results of taking the steps. Use the separate workbooks with your name on the cover to create your plans for achieving your goals. A filled-out example of each chart is shown following the instructions for the chart, and more examples are shown in the **Help Section** booklet. If you have any trouble or are not confident that your plan will work, take a look at the examples there.

GOAL PLANNING CHART **(Instructions)**

Large goals like getting a job describe things that are important to you but do not tell you what to do next. Reaching large goals is easier if you divide them into smaller steps. Take a look at your agreed goals listed on your **Quality of Life Report**. Start with the first goal. Is this goal large? If it is, think of all the steps it will take to reach this goal. Under the goal, write the steps you will need to reach the goal. You may not need all 3 steps. If you need more than 3 steps, there is a form for steps 4 through 6. <u>One last step is the Reward Step. When you have completed all the other steps, reward yourself!</u> A blank sample of the GOAL PLANNING CHART you will use is on the next page. An example of one filled out is also shown.

GOAL PLANNING CHART

Goal #		
Step 1		
Step 2		
Step 3		
Reward Step		

GOAL PLANNING CHART **(Example)**

Goal #	*1*	*Make new friends.*
Step 1	*Make a list of places where I can meet people I like.*	
Step 2	*Go to 2 of these places within the next week.*	
Step 3	*Say hello, introduce myself, and say something about myself to at least two people at each place.*	
Reward Step	*Treat myself to a meal at McDonalds.*	

STEP QUESTIONS CHART (Instructions)

In the STEP QUESTIONS CHART, you'll examine each of the steps. Write down as many ideas as you can think of without worrying about whether they are good or bad ideas. A sample of this chart is shown below, and an example of one filled out is on the next page.

STEP QUESTIONS CHART

Goal #		
Step #		
Things like this step that I have done before.		
Problems I might have with this step.		
How I might solve these problems.		
Who or what will help me with this step		
How long will it take me to do this step?		

STEP QUESTIONS CHART (Example)

Goal #	*1*	*Make new friends*
Step #	*1*	*Make a list of places where I can meet people I like.*
Things like this step that I have done before.		
Made a list of my favorite movies. *Made a list of churches near me.*		
Problems I might have with this step.		
I don't know many places where I can meet people. *I don't know if the places are easy to get to.*		
How I might solve these problems.		
Ask others where I can meet people. *Ask them how I can get there.*		
Who or what will help me with this step		
Friends, counselors, my peer advocate *I might need to look at a map.*		
How long will it take me to do this step?		
3 days		

WEEKLY GOAL PROGRESS CHART (Instructions)

The next chart needs your careful attention. However, the WEEKLY GOAL PROGRESS CHART will help you keep track of your progress toward your goals.

1. Write your **Goal #,** the **Goa**l, and the **Date begun** in the first row.
2. Copy the steps from your **GOAL PLANNING CHART**.
3. For **Step 1**, in the box next to the **1-week report** box, write the date one week from the **Date begun**. Now fill in the **2-week, 3-week, and 4-week report** dates.
4. Copy the same dates in **Step 2** and **Step 3**.
5. You may want to add more steps, like **Step 4** in **Example 2,** or even make a new goal.

A sample of the WEEKLY GOAL PROGRESS CHART in shown on the next page, and two examples of charts that have been filled out are shown on the following pages.

WEEKLY GOAL PROGRESS CHART

Goal #			Date begun	
Step 1				
1-week report				
2-week report				
3-week report				
4-week report				
Step 2				
1-week report				
2-week report				
3-week report				
4-week report				
Step 3				
1-week report				
2-week report				
3-week report				
4-week report				
Reward Step				

WEEKLY GOAL PROGRESS CHART (Example 1)

Goal #	*1*	*Make new friends*	Date begun	*Oct 1*
Step 1		*Make a list of places where I can meet people I like.*		
1-week report	*Oct. 8*	*Made a list of 4 places I can go: library, church, drop-in center, Borders books. Step completed*		
2-week report	*Oct. 15*			
3-week report	*Oct. 22*			
4-week report	*Oct. 29*			
Step 2		*Go to 2 of these places within the next week.*		
1-week report	*Oct. 8*	*Went to the library, felt bad and stayed home a few days.*		
2-week report	*Oct. 15*	*Nothing accomplished. Stayed home.*		
3-week report	*Oct. 22*	*Went to Borders and to church. Felt good! Step completed*		
4-week report	*Oct. 29*			
Step 3		*Say hello, introduce myself, and say something about myself to at least two people at each place*		
1-week report	*Oct. 8*	*Talked to a guy in the library looking at magazines. He told me to go away.*		
2-week report	*Oct. 15*	*Nothing accomplished. Stayed home.*		
3-week report	*Oct. 22*	*Met a nice elderly couple in Borders. Talked to minister at church a little.*		
4-week report	*Oct. 29*	*Talked to two girls at Borders. Step completed*		
Reward Step		*N/A*		

WEEKLY GOAL PROGRESS CHART (Example 2)

Goal #	1	*Make new friends*	Date begun	*Oct 1*
Step 4		*Added step: Invite someone over for coffee.*		
1-week report	*Oct. 8*	*Nothing accomplished.*		
2-week report	*Oct. 15*	*Nothing accomplished. Stayed home*		
3-week report	*Oct. 22*	*Invited the elderly couple. They said no thanks but took me to a church dinner!*		
4-week report	*Oct. 29*	*Went to coffee with Jane, a girl I know from church. Step completed*		
Step 5		N/A		
1-week report	*Oct. 8*			
2-week report	*Oct. 15*			
3-week report	*Oct. 22*			
4-week report	*Oct. 29*			
Step 6		N/A		
1-week report	*Oct. 8*			
2-week report	*Oct. 15*			
3-week report	*Oct. 22*			
4-week report	*Oct. 29*			
Reward Step		*Went to McDonald's. Got a cheeseburger, fries, and a coke!*		

WHAT I LEARNED CHART (Instructions)

This chart shows what you learned working each of the steps--information that may be helpful when you work on other goals. A sample of the WHAT I LEARNED CHART in shown below, and an example of one filled out is on the following page.

Goal #		
Step 1		
What helped with this step?		
What got in the way?		
How difficult was this step?		
Was my timing okay?		
What did I learn?		
Step 2		
What helped with this step?		
What got in the way?		
How difficult was this step?		
Was my timing okay?		
What did I learn?		
Step 3		
What helped with this step?		
What got in the way?		
How difficult was this step?		
Was my timing okay?		
What did I learn?		

WHAT I LEARNED CHART (Example)

Goal #	*1*	*Make new friends*
Step 1		*Make a list of places where I can meet people I like*
What helped with this step?		*Talking to people.*
What got in the way?		*Nothing*
How difficult was this step?		*Piece of cake. Just asked a couple people.*
Was my timing okay?		*One day, not two!*
What did I learn?		*Nothing*
Step 2		*Go to 2 of these places within the next week.*
What helped with this step?		*Finding my way to places.*
What got in the way?		*After the library, it was hard to get motivated again. I felt blue and stayed home a few days.*
How difficult was this step?		*Pretty hard.*
Was my timing okay?		*Took longer than I expected.*
What did I learn?		*It's easier to plan to go somewhere than to do it!*
Step 3		*Say hello, introduce myself, and say something about myself to two people at each place.*
What helped with this step?		*I don't know.*
What got in the way?		*I felt worthless after the library experience.*
How difficult was this step?		*The first time was almost impossible! Then I was hurt. Then it got easier.*
Was my timing okay?		*Fair.*
What did I learn?		*Some people will like me; some won't!*

IMPROVING YOUR PLAN and PLANNING YOUR NEXT STEPS

Here are some things that might help you improve your plan or plan your next steps:

1. Continue thinking about the best way to reach your goals. You might think of additional steps you can take or better ways to take the steps you've already listed.
2. Get ideas and information about how to reach your goal by talking to other people or reading. Your counselors and friends can help. So can your family members. You can also visit drop-in centers and talk to people there who have goals like yours.
3. For each step that you tried to complete, think about what happened. Were you successful? If not, do you need to find a different way to complete the step? Do you need more information? Do you need assistance? Who can help you?

Space is provided on the blank charts to make detailed plans for reaching your personal goals. The forms may look long, but it's up to you how much time you spend and how quickly you complete them. The idea is to make the best possible plans to reach your goals. When you finish the plan for a goal, you will know what your next steps are. If you want to see more examples, look in the **Help Section** booklet.