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Mind-Body Approach to Treating Developmental Trauma in Adolescents: A Group Therapy Manual for Residential Treatment Facilities

A Project Presented to
The Graduate Facility of
Minnesota State University Moorhead

By

Kayla Prosser

In Partial Fulfillment of the

Requirements for the Degree of

Master of Science in

Clinical Mental Health Counseling

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Abstract

Among the most traumatized youth are those placed in residential treatment centers. This population reports exposure to abuse and neglect at an alarming rate in comparison with the general population. These youth are often described as irritable and angry and characterized by antisocial, delinquent and problematic behaviors. As such, they are assigned diagnostic labels based on checklists of surface level symptoms while trauma histories and chronic stress are ignored or minimized. As a result, treatment focuses on management of disruptive behaviors as opposed to addressing the root cause of the dysfunction, the trauma. Developmental trauma impacts an individual in a multitude of ways. One of the most critical and overlooked consequences of traumatic experiences is the effects on the body. Developmental trauma has significant neurophysiological effects that must be addressed in order for treatment to be truly effective. This can be achieved through the use of an integrated mind-body approach. The manual presented here does just that by incorporating components of cognitive behavioral therapy (CBT), dialectical behavior therapy (DBT) and mindfulness based stress reduction (MBSR) techniques to be used in a group setting with adolescence in a residential treatment facility.

Introduction

Each year, over 3 million children are reported for abuse and neglect in the United States (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). School problems, substance use, family dysfunction, parental substance abuse, family criminal involvement, poverty and organic problems have been found to be the most significant risk factors for criminal behavior in youth and out of home placement (McMackin, Tansi, &LaFratta, 2004). Among the most traumatized youth are those removed from family, school, and community to be placed in residential treatment settings (Foltz et al., 2013). Youth in residential treatment centers (RTC) are often described as irritable and angry and characterized by antisocial, delinquent and struggle with behavioral problems (Zelechoski et al. 2013). They suffer significant impairments in attention, mood, emotion regulation and self-control, and interpersonal difficulties, all of which are associated with developmental trauma (Zelechoski et al. 2013). These externalizing behaviors mask trauma and therefor become pathologized by a long list of seemingly unrelated diagnoses such as oppositional defiance disorder, conduct disorder, attention deficit hyperactivity disorder, post traumatic stress disorder, anxiety, and depression that impact the youth (Zelechoski et al. 2013). Treatment is then focused on managing disruptive behaviors as opposed to understanding the individual's experience to foster healing.

To effectively provide treatment for adolescences in RTC, we must first recognize the root cause of their dysfunction. Developmental trauma, which is prevalent at alarming rates for this population, comprises normal development of the stress management system, creating dysregulation of emotions and behavior, which are the core issues behind the mental health symptoms displayed by traumatized children (Foltz et al., 2013). It impacts the body even more so than the mind, and treatment should be focused on treating both (van der Kolk, Roth,

Pelcovitz, Sunday, & Spinazzola, 2005). An integrated mind-body approach combining classic cognitive behavioral therapy (CBT) and dialectical behavior therapy (DBT) with mindfulness based stress reduction (MBSR) intervention shows great promise in fostering healing for traumatized adolescents. Presented here is a curriculum for implementing this integrated approach in a group therapy setting in a residential treatment facility.

Purpose

The purpose of this manual is to serve as a guide to providing trauma informed care to adolescence in a residential treatment center using mind-body approaches within a group therapy setting.

Awareness of developmental trauma in adolescence is often absent or lacking, even in the most experienced and practiced professionals (Habib, Labruna, & Newman, 2013). Youth in RTC are among the youth most affected by developmental trauma and because there is currently no comprehensive diagnosis available, are "consistently receive disruptive behavior diagnosis at greater rates than any other diagnosis (including PTSD) and diagnoses with mood disorders" (Habib, Labruna, & Newman, 2013, p.718). This does not provide an accurate conceptualization of the individual and without this awareness, providers are unable to meet the needs of these youth.

Lack of awareness of trauma histories and implications are likely responsible for the lack of trauma informed treatment approaches in RTC. There are few structured trauma informed treatment modalities that have been implemented and even fewer have been evaluated (Habib, Labruna, & Newman, 2013). Few treatments have been applied systematically and oftentimes treatments may be used that are in direct conflict with one another, even within the same setting (Habib, Labruna, & Newman, 2013). Perhaps these two factors largely contribute to the low

treatment outcomes of the traumatized youth in residential treatment centers (Habib, Labruna, & Newman, 2013). Early and accurate identification of developmental trauma and specialized treatment are keys to healing and preventing adult criminology and pathology.

Literature Review

Presentation and Diagnosis of Trauma

Diagnostic labels, though necessary for treatment, are controversial within the counseling profession. Diagnoses can help categorize symptom presentation, identify the goals of treatment, and serve as a quick reference to understanding what the individual is struggling with. Diagnoses also pathologize behavior and fail to account for the individual's experience precipitating the dysfunction as well as what maintains it. Diagnostic labels are based on checklists of surface level symptoms and are often assigned after only one or two meetings with a client.

Perhaps those experiencing the most injustice of diagnostic labels are individuals who have experienced chronic stress and traumatic events. Diagnostic assessments often minimize or ignore chronic stress and trauma histories as well as the impact of these experiences on mental and physical health (D'Amico, 2016). Traumatized individuals develop a wide array of maladaptive patterns in response to trauma and chronic stress and have a wide array of presentation depending on the stage of development they experienced the events, the social supports available, and the relationship to the origin of the trauma (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). The presentation of these coping mechanisms can vary greatly, especially in children.

Research consistently shows that the standard post-traumatic stress disorder (PTSD) diagnosis fails to capture the symptoms of traumatized individuals (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). This is observed even more frequently within the

children and adolescent population. In fact, PTSD is often times not the most common psychiatric diagnosis in children with histories of abuse and neglect (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). In a study of 364 abused and neglected children, the most common diagnoses in order of frequency were as follows: separation anxiety, oppositional defiant disorder (ODD), phobic disorders, PTSD, and attention deficit hyperactivity disorder (ADHD) (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Anxiety, depression, suicidal ideation, poor academic achievement, unmodulated aggression and impulse control, attention and dissociative problems, substance abuse, interpersonal problems with caregivers, peers and subsequently marital partners, and juvenile delinquency have all been associated with exposure to trauma during childhood (Buckholdt, Weiss, Young, & Gratz, 2014; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Victims of prolonged interpersonal trauma have high rates of dysfunction in affect regulation, impulsivity, memory and attention, self-perception, interpersonal relations, somatization and systems of meaning (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). These experiences have significant impacts across all domains, including behavioral, social, affective, somatic, and self-attribution (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

In a study done by van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola (2005), it was found that the earlier the interpersonal trauma occurs and the longer the duration, the more significant the impact on functioning and complex the psychopathology, extending well beyond PTSD symptomology. Individuals in the study displayed problems with affect dysregulation, aggression against self and others, dissociative symptoms, somatization, and character pathology (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Many other studies have found significant associations between histories of physical and sexual assault with psychological and physical

health disorders in adolescence and adulthood, such as substance use, borderline personality, antisocial personality, eating disorders, dissociative disorders, affective disorders, somatoform, cardiovascular, metabolic, immunological, and sexual disorders (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

Currently there is no accurate diagnosis for developmental trauma that can account for the various degrees of presentation. This leads to a long list of seemingly unrelated comorbid disorders. In fact, PTSD does not account for all symptoms and is found as a comorbid disorder as well. The Nation Comorbidity Survey found that 84% of people with PTSD had another lifetime diagnosis (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). The Australian National Comorbidity Study of 10,600 individuals found that 88% of the sample with PTSD had at least one other diagnosis, most commonly major depressive disorder (48%) and alcohol abuse (52%) and 59% of the sample had 3 or more disorders. It is rare to find a pure PTSD diagnosis, as traumatized individuals present with a mix of symptoms such as depression, anxiety, and somatization (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Additionally, trauma consistently shows up in studies of various personality disorders, affective disorders, impulse disorders, antisocial disorders, substance use, and dissociative disorders, even in populations where trauma is not a central concern (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Van Dijke et al. found "difficulties modulating the intensity and or duration of emotional arousal mediated the relationship between childhood traumatic experiences by primary caregiver and borderline personality pathology (Buckholdt, Weiss, Young, & Gratz, 2014). Other studies also support a relationship between borderline personality disorder and childhood exposure to violence and emotional dysregulation in relationships between traumatic exposure (Buckholdt, Weiss, Young, & Gratz, 2014).

Van Der Kolk and his team of researchers have proposed a provisional diagnosis of Developmental trauma disorder (DTD) to accurately categorized the presentation of symptoms in traumatized children and adolescence with a history of traumatic events such as abuse, witnessing domestic violence, loss of a parent due to divorce, incarceration or death, unstable parental permanency, etc. in the primary caregiving relationship. The proposed diagnosis identifies impairments in attachment, cognition, affect regulation, self-concept, behavior regulation, dissociation, and maturation/biological, all have been identified in traumatized youth. While developmental trauma can be a result of a single event, most children report experiencing multiple traumas. The age of onset, duration, severity, and perception of the event(s) influence the degree symptoms are observed and the resulting functional impairments (Teague, 2013).

Without a classification that comprehensively characterizes these symptoms and impairments, individuals are given a long list of unrelated diagnoses and treatment focuses on behaviors rather than the underlying developmental trauma causing it. To truly be effective in helping traumatized youth health from their experiences, we must look beyond their disruptive behavior and long lists of diagnostic labels attempting to account for these behaviors to truly understand the root cause of suffering and shift treatment towards proper interventions, focusing on the mind and body.

Traumatized Youth in Residential Treatment Facilities

Developmental trauma is one of the highest risk factors for juvenile crime and predictor of out of home placement (McMackin, Tansi, & LaFratta, 2004). School problems, substance use, intelligence, family dysfunction, parental substance abuse, family criminal involvement, poverty and organic problems have been found to be the most significant risk factors for criminal behavior in youth (McMackin, Tansi, &LaFratta, 2004). Additionally, early age of offense and

prior criminal behavior increased an individual's youth significantly (McMackin, Tansi, &LaFratta, 2004). Among the most traumatized youth are those removed from family, school, and community to be placed in residential treatment settings (Foltz et al., 2013). These youth have been found to "exhibit high rates of exposure to violence, elevated levels of emotion dysregulation, and high levels of PTSS and BP pathology" (D'Amico, 2016, p. 885). Additionally, these individuals experience extreme and lasting behavioral, emotional and interpersonal difficulties (Habib, Labruna, & Newman, 2013).

Foltz et al. (2013) conducted The Adolescent Subjective Experience of Treatment Study with interviews and Adverse Childhood Experience (ACE) scores obtained from a sample of 50 youth (29 male, 21 female) residing in 5 different residential treatment centers with an average age of 15.7 (10-18) 1. The study found that 56% had 4 or more ACEs compared to the average adult of 12.5%. 45% had two Axis I diagnoses, and 34% had three. Individuals with the highest ACE scores had primary or secondary diagnoses of PTSD and those with Bipolar Disorder. Only five had a primary diagnosis of PTSD. Those with a secondary diagnosis of PTSD had primary diagnoses of Bipolar Disorder, Conduct Disorder, ADHD, Major Depressive Disorder, and Oppositional Defiant Disorder. Perhaps one of the most disheartening findings is a large majority of youth reported feeling unloved. This is the most basic example of developmental trauma.

This is a consistent finding in the research. Connor et. all (2004) used a large sample of youth in a residential treatment center (RTC) to investigate primary diagnoses of this population. It was found that 49% were diagnosed with a disruptive behavior disorder such as conduct disorder, ADHD, and 31% were diagnosed with affective or anxiety disorder, 14% with a psychotic disorder and 8% with other (developmental, personality disorders, tic) (Zelechoski et al. 2013). All these disorders include difficulties with attention, mood, and disruptive behavior,

which are all associated with trauma. Connor et al. (2004) also found a high level of medical health diagnoses (40%) in this population of youth, including asthma, obesity, seizure disorders, and other neurological disorders (Zelechoski et al. 2013). Warner and Pottick (2003) found that youth in RTC have a higher rate of family problems (72%), school problems (57%), skills deficits (22%) aggression (66%), delinquent behavior (34%) and substance abuse problems (31%) compared to youth not in treatment (Zelechoski et al. 2013). Briggs et. all (2012) compared 525 traumatized youth in RTC to 10,000 youth who were not in RTC. It was found that those in RTC were significantly more likely to experience difficulties with attachment, substance use, suicidal ideation, self-injurious behavior, externalizing behavior and criminal behavior (Zelechoski et al. 2013). There was also a relationship between the number of traumas experienced and the degree of impact on each life domain. As the number of trauma exposure increased, as did the functional impairment (Zelechoski et al. 2013). National Child Traumatic Stress Network Core Data further supports this in their study of 92 youth in residential care which found that youth in care had a much broader range of exposure to trauma than youth not in care (5.8 vs 3.6 separate types on average) (Habib, Labruna, & Newman, 2013). Physical and sexual abuse are of the most common in addition to witnessing violence. In a large study complete by Habib, Labruna, and Newman (2013), it was found that in 1300 youth in RTC, more than half had experienced physical abuse, over one third had been sexually abused and another third had witnessed domestic violence. These findings have been replicated in many other studies. In addition to domestic violence, it has been reported that roughly 87% of children in RTC have witnessed or experienced severe community violence such as stabbings, killings, fighting, etc. (Habib, Labruna, & Newman, 2013).

Impact of Trauma on the Mind and Body

According to van der Kolk, "Trauma is our most urgent public health issue" and "we have the knowledge necessary to respond effectively" (Wilkinson, 2016, p.244). Abuse and neglect are extremely common in our society and research undoubtedly confirms the effects that persist over the lifespan van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). The Adverse Childhood Experience (ACE) study is the largest of its kind and one of the best representations of long term effects of childhood trauma. The ACE study found that certain adverse experiences in childhood significantly increase the risk for illness, criminal behavior, substance use, mental and physical health issues, and poor quality of life (Felitti et.al, 1998). As an individual's ACE score rises, meaning the more adverse experiences they have in childhood, the higher their risk for mental and physical health issues and early death (Felitti et.al, 1998). The study found that adverse childhood experiences lead to social, emotional and cognitive impairments. Trauma often creates intense pain and internal conflict which overwhelms the psyche (Felitti et.al, 1998). The body choses survival responses to reduce the pain and internal conflict created (Felitti et.al, 1998). To cope with these impairments, individuals adopt health-risk behaviors which lead to disease, disability, and social problems, ultimately resulting in early death (Felitti et.al, 1998).

Professionals, caregivers, and other supports are often distracted by the disruptive behavior used as a coping mechanism and feel a sense of urgency for intervention in order to manage the behavior (Foltz et al., 2013). Rather than seek to understand the purpose of the behavior and the individual's experience, the behavior is attributed to genetic liability, "chemical imbalance" or intentional defiance (Foltz et al., 2013). As a result, treatment is often focused on managing the symptoms by use of medication, punishment/reward systems, and exclusion as

opposed to healing the source of the dysfunction (Foltz et al., 2013). Developmental trauma leaves an imprint on the mind which has consequences for how an organism operates in order to survive in the present (Wilkinson, 2016). It compromises normal development of the stress management system, creating dysregulation of emotions and behavior, which are the core issues behind the mental health symptoms displayed by traumatized children (Foltz et al., 2013). In addition to impacting the stress management system, developmental trauma also creates dysfunction in attachment and attunement, which are critical for healthy development and relationships with others (Wilkinson, 2016). Developmental trauma impacts the mind, body and spirt and for treatment to truly be effective at healing as opposing to managing symptoms, treatment must focus on both (Wilkinson, 2016).

Self-regulation and self-soothing are developmental tasks of every child (Pointon, 2004). The process of acquiring these skills begins in infancy. During this time, infants look to their primary caregiver to provide “affect regulation through sounds, facial expression, touch, holding and/or rocking, which help a baby modulate its own physiological arousal” (Pointon, 2004, p.11). The child learns from these experiences and uses them as a foundation in which they can find their own way of coping with external stress (Pointon, 2004). If an individual enters a state of high physiological arousal as a result of stress and loses capacity for self-regulation for a period of time but is able to use their environment or respond to those around them they will be more likely to cope effectively and regain rational thinking (Pointon, 2004). Those who are unable to do so, remain in a heightened state and are unable to calm themselves (Pointon, 2004). As a result, they “take leave of their senses, organizing their internal world around the trauma,” creating a lack of balance between the rational and emotional brain (Pointon, 2004, p.11).

Neurophysiological Effects of Trauma

Our understanding of the effects of trauma on the brain and how this impacts emotions, thinking and behavior has grown exponentially and continues to grow with advances in technology. Bessel van der Kolk, professor of psychiatry and director of Trauma Center in Boston has been studying this effect for several years and has made significant contributions to the field of neuropsychology (Pointon, 2004). He is the author of more than 100 peer reviewed scientific papers and several books on topics including self-mutilation, dissociation, the effects of trauma and effectiveness of various treatment approaches using science (physiology, brain scans, biofeedback, etc.) to support his theories (Pointon, 2004). Van der Kolk discusses how after trauma, "the world is experienced with a different nervous system" (Wilkinson, 2016, p53). Symptoms of those who have experienced trauma result from a chronic hyperarousal of "innate survival responses within the central nervous system" (Wilkinson, 2016, p53). This system is constantly evaluating for potential threats and typically occurs subconsciously via several neurological structures (D'Amico, 2016). If "a possible threat is perceived as relevant, defensive responses or activated" (D'Amico, 2016, p. 60).

Van der Kolk's research supports the theory that the imprint of trauma is mainly on the limbic system, which is the part of the brain responsible for determining what is safe and what is dangerous within the environment and sending signals to respond accordingly (Pointon, 2004). The brain stem is part of this system and is responsible for automatic processes such as breathing, sleeping, urinating, and chemical balances (Pointon, 2004). The amygdala, also part of this system, is responsible for detecting danger and sending out alarm signals (Pointon, 2004). The more helpless the person felt when the alarm was triggered, the more sensitive the detector is likely to be which increases risk of trauma in the future. The more events that occur, the more

sensitive this alarm (Pointon, 2004). Children are especially likely to feel helpless in traumatic situations which impacts their fight or flight response. They may resort to freezing, numbing or dissociating as their only options to "leave" the situation (Pointon, 2004). Learning to feel safe in their bodies again will help them navigate how they feel, which are both necessary for healing (Pointon, 2004). The brain's reticular activating system filters out information it registers as unimportant (roughly 99% of all stimuli) and determines level of importance based on what it has been trained to respond to (Pointon, 2004). In traumatized individuals, this system doesn't filter information out as effectively, creating hypervigilance. Anything associated with the trauma (largely unconscious) is let through the filtering system which has the potential to activate the alarm system (Pointon, 2004). This system malfunction can be observed in individuals who have an extreme reaction or over reaction to a seemingly benign incident, or seemingly explode without warning. The frontal lobe, responsible for planning, rationalizing, speech, and inhibiting inappropriate behavior, also malfunctions by readily shutting down in traumatized individuals, which inhibits their ability to downregulate their alarm response when no real danger is present (Pointon, 2004). This process has been observed in brain scans of traumatized individuals, which explains why these individuals have trouble rationalizing, planning, thinking clearly, and communicating what they are experiencing (Pointon, 2004). Speech and language is particularly challenging due to the inhibition of the Broca's Area of the brain, which is responsible for speech.

Neurophysiological states are influenced by "trauma associated memory on nervous, endocrine, and musculoskeletal function" (D'Amico, 2016, p.61). Healthy nervous systems are able to successfully negotiate the threat and once safety is reestablished, "defensive responses are downregulated and physiology returns to homeostatic baseline" (D'Amico, 2016, p.60). In post-

traumatic states, the dysfunction results from this system's failure to downregulate defensive responses (D'Amico, 2016). Trauma creates neurological changes in which there is a heightened engagement of the survival response and a "downregulation of the modulation functions of the neocortex" (D'Amico, 2016, p.61). The orbitofrontal and medial prefrontal cortices involved in higher level assessment of potential threat and mediate further activation or downregulation of arousal response are impacted, which is further supported by brain scans demonstrating a decreased volume in the prefrontal and frontal cortices (D'Amico, 2016).

Trauma also impacts neurological pathways, creating alternate routes for memories formed during extreme stress (Pointon, 2004). These memories imprint on people's sensory systems and stay in the memory bank unprocessed (Pointon, 2004). These memories then become more procedural in nature (D'Amico, 2016). Procedural memory gives rise conditioned, unconscious sensorimotor responses which directly and powerfully influence physiology and behavior (D'Amico, 2016). While the narrative element of a traumatic memory is often fragmented, procedural memory largely governs behavior and bodily response (D'Amico, 2016). These neurophysiological disruptions occur not only in people who meet diagnostic criteria for PTSD, but also for traumatized individuals who do not meet criteria (D'Amico, 2016).

Children, with developing brains, "are both neurologically and circumstantially most vulnerable to high incidents of exposure to traumatic stressors" (D'Amico, 2016, p. 61). These changes in the brain are also linked to other chronic diseases such as immune, endocrine, nervous, digestive, addiction, and chronic pain (D'Amico, 2016). This also explains much of the behavior and emotional dysregulation exhibited by traumatize individuals. Individuals cannot simply think clearly, communicate, and make good choices simply because you tell them to or threaten punishment (Pointon, 2004). While the trauma narrative is worth telling, the individual

must change their reaction to the events as opposed to simply desensitizing themselves to the story. In order to gain the ability to self-regulate our physiology, we need to reset the body (Pointon, 2004). Past influences on the emotional brain must be processed and let go, which involves more than cognition (Hamiel, 2005). The limbic system must be calmed and the prefrontal cortex must be engaged in order to transform their experience (Pointon, 2004). This requires connecting individuals with their bodies and with the autonomic nervous system (Hamiel, 2005).

Treatment for Developmental Trauma

According to van der Kolk, "it is our bodies more than our minds that control how we respond to trauma" (Pointon, 2004, p. 10). Van der Kolk supports Jung's view that the mind and body are inseparable and treatment must incorporate both (Pointon, 2004). DBT and CBT are among the most practiced modalities for treatment of trauma, however, both lack the mind-body approach (Pointon, 2004). CBT is the most common type of talk therapy and is generally regarded as effective. Words are important to give an individual a sense of direction, meaning, and acknowledge their experience as true and valid. It can also bring a sense of empowerment and belongingness. Telling one's story can also be retraumatizing (Pointon, 2004). CBT has been shown to have nonresponse rates up to 50% in those diagnosed with PTSD (Pointon, 2004. CBT requires talking about the trauma, but the trauma gets in the way of talking due to deficits in verbal memory, anxiety, and greater activation of the brain's alarm system (D'Amico, 2016; Wilkinson, 2016). This inhibits the person's ability to identify and describe emotional states (Buckholdt, Weiss, Young, & Gratz, 2014). CBT has important components that should be implemented into treatment, however, this modality alone is not always effective at treating developmental trauma (Hamiel, 2005). Additionally, DBT has demonstrated success for

individual's presenting with a wide range of psychological difficulties with emotional dysregulation including co-occuring substance use and borderline personality disorder, binge eating, depression, and co-occuring PTSS and borderline personality disorder (D'Amico, 2016). Again, it does not incorporate a bodily approach which may explain the missing component that could increase success rates in treating developmental trauma. Using integrated approaches that combine physiological components as well as mindfulness components are the keys to creating a more powerful form of therapy (Hamiel, 2005).

Integrated Mind-Body Approaches to Treatment

Mind body complimentary healthy practices include acupuncture, massage, meditation (including mindfulness meditation, movement therapies, relaxation (breathing, guided imagery, progressive muscle relaxation), spinal manipulation, t'ai chi or quigog, yoga, dance, martial arts, healing touch and hypotherapy (Burnett-Zeigler, Schuette, Victorson, & Wisner, 2016). Mind body approaches are mind body complimentary health approaches and mindfulness based interventions used collectively and are "essential components of mindfulness based interventions such as mindfulness based stress reduction and mindfulness based cognitive therapy" (Burnett-Zeigler, Schuette, Victorson, & Wisner, 2016, p. 115). Several reviews have demonstrated significant effectiveness of mind-body approaches at improving symptoms of depression, anxiety and chronic health conditions (Burnett-Zeigler, Schuette, Victorson, & Wisner, 2016).

Reviews of yoga based interventions for treatment of depression found decreases in symptoms of depression, anxiety, improved quality of life and well-being, decrease in stress hormones (adrenocorticotropic hormone, cortisol) and improved sleep quality (Hamiel, 2005). Reviews also found significant decreases in anger, neurotic symptoms and limitations of role activities due to emotional problems, and low frequency heart rate variability (Hamiel, 2005).

Yoga encourage individuals to be self-aware and remain connected with their bodies, even when in destress (Hamiel, 2005). It helps in self-regulation, empowering, and remaining grounded, all of which are often times lacking in individuals who have been traumatized (Pointon, 2004; Wilkinson, 2016). The muscular activity also helps regulate physiology with controlled breathing and blood flow (Hamiel, 2005).

Mindfulness based stress reduction has also shown promising results within youth. MBSR incorporates practices such as mindful breathing, walking, eating, body scans, yoga, and other activities to foster openness, awareness, and focused attention on the moment (Van Vliet et al., 2017). Mindful mediation is the practice of "intentionally paying sustained attention to ongoing sensory, cognitive, and emotional experience without elaborating or judging any part of the experience" (Wilkinson, 2016, p.243). This is achieved by becoming aware of different sensations, noises, thoughts, and feelings inside one's body by consciously focusing to what is inside (Wilkinson, 2016). By observing with openness, compassion, and curiosity instead of rejecting or feeding into a thought, one is able to register and let go (Hamiel, 2005). Mindfulness meditation involves viewing a thought as just a thought and helps create acceptance as the basis for change by shifting focus of attention and promoting acceptance of the present moment (Hamiel, 2005).

Burnett-Zeigler, Schuette, Victorson, and Wisner (2016) examined the effectiveness of MBSR by reviewing 18 studies previously conducted using MBSD interventions to treat mental health symptoms among disadvantage populations. Roth et. al. (2004) conducted a study at an urban community health center with primarily Hispanic (64%) and low-income participants with a variety of mental and physical health issues and found improvement in general health, social functioning, vitality, physical and emotional role functioning, and a trend towards significant

improvements on the bodily pain and mental health based on self-report (Burnett-Zeigler, Schuette, Victorson, & Wisner, 2016). Participants also reported positive experiences with the program and reported improved interpersonal relationships and communication, more restful sleep, decreased use of pain and anxiety medications, and greater sense of overall well-being in addition to a significant decrease in their total number of medical and chronic care visits (Burnett-Zeigler, Schuette, Victorson, & Wisner, 2016). Smith et all (2015) studied the effectiveness of a 4 week MBSR program on 23 patients at a community mental health center and found a 20% reduction in stress, increased mindfulness, and improvements in social functioning, mental health, physical health and overall wellbeing, even when implemented for a short time period (Burnett-Zeigler, Schuette, Victorson, & Wisner, 2016). Hick and Furlotte (2010) used MBSR intervention with 22 participants with multiple mental and physical health issues at a community mental health center (Burnett-Zeigler, Schuette, Victorson, & Wisner, 2016). All but 1 was homeless. Individuals reported increased self-compassion and life satisfaction, less depression and improved relationships and were able to positively shift perspectives related to life experiences (Burnett-Zeigler, Schuette, Victorson, & Wisner, 2016). Dutton et all (2013) used MSBR intervention with 53 African American women of low income and diagnosed with PTSD (Burnett-Zeigler, Schuette, Victorson, & Wisner, 2016). They also had a history of intimate partner violence, were clinically depressed, had lifetime trauma including childhood sexual abuse. The program consisted of 10 weekly 1.5-hour long sessions. Of the 70% that completed, all reported increased awareness, self-acceptance, self-empowerment, nonreactivity, improved selfcare and decreased distressed (Burnett-Zeigler, Schuette, Victorson, & Wisner, 2016).

Reviews consistently demonstrated completion rates of 66-70% which is slightly higher than retention rates reported for other evidenced based techniques (Burnett-Zeigler, Schuette, Victorson, & Wisner, 2016). Another common report among studies was the evidence of feasibility and acceptability among high risk and disadvantaged individuals (Burnett-Zeigler, Schuette, Victorson, & Wisner, 2016). Individuals consistently reported believing the skills were important, were interested to practice interventions and make them part of daily living, even after the program ended (Burnett-Zeigler, Schuette, Victorson, & Wisner, 2016).

Results for MBSR in adolescence, though few in number, also yield promising results. Van Vliet et al. (2017) also completed a review of studies already complete using MBSR techniques in adolescent and children populations. Biegel et all (2009) completed an 9-week MBSR program for youth consisting of 102 adolescents (14-18) who were either current or past patients at a psychiatric outpatient clinic. Results found significant reductions in anxiety, depression, somatization, and sleep difficulties in addition to increased self-esteem and improvements in global functioning compared to the control group who received traditional psychotherapy alone (Van Vliet et al., 2017). These results were also reported during the 3 month follow up (Van Vliet et al., 2017). Bogels et al (2008) used MBSR interventions for youth ages 11-17 in an outpatient program at a community mental health center. Participants showed improvements in internalizing and externalizing symptoms compared to controls who received traditional psychotherapy alone. These results were maintained during the 8 week follow up (Van Vliet et al., 2017).

Review of qualitative studies have also found MBSR interventions to beneficial, highlighting significant improvements in interpersonal relationships, school achievement, and physical health (Van Vliet et al., 2017). Himelstein et al (2012) conducted a qualitative study by

interviewing 23 adolescent males in a juvenile detention center who participated in mindfulness based program. All participants reported improvements in wellbeing, self-regulation, self-awareness, and a more accepting attitude toward treatment (Van Vliet et al., 2017). Broderick Metz (2009) conducted interviews with 120 females ages 17-19 who completed a 10-week mindfulness program while at school and also found improved emotional wellbeing, emotion regulation and program satisfaction (Van Vliet et al., 2017).

Van Vliet et al. (2017) conducted their own qualitative study of 28 adolescents equally split between male and female in a residential treatment center for youth with psychological, behavioral, and emotional concerns. Primary diagnoses were ODD or conduct (50%), ADHD (50%) and RAD (21%). 86% met criteria for at least 2 disorders and several symptoms of diagnosable disorders but did not meet full criteria. Youth participated in an 8-week MBSR program that were 2 hours each week. The program consisted of didactic instruction, experiential exercises and practice, group discussion, and self-reflection. Meditations such as walking meditations, scans, loving kindness meditations, mindful eating, sitting, etc. were used in addition to deep breathing techniques and yoga. Psychoeducation was used to discuss qualities of mindfulness, recognition of choice points and consequences of actions, stress response cycle and mindful communication. Following program completion, individuals reported improved mood, enhanced relationship to self, increased self-control, improved problem solving, awareness of the present and enhanced personal relationships. All perceived the program as beneficial and reported these effects both short term as well as at the 3 months follow up (Van Vliet et al., 2017).

Theoretical Framework

Adolescence who have experienced trauma struggle with attention, mood, emotion regulation and self-control, and interpersonal difficulties. (DeRosa et al., 2016). The following are adaptations to chronic stress and developmental trauma:

> "1. Affect and impulses (upset or angered easily, trouble calming down, impulsivity, self-destructive behaviors) 2. Somatization and physical health (e.g. multiple, chronic physical complaints, autoimmune disorders) 3. Attention and information processing (dissociation) 4. Self-perception (e.g. self as damaged, shameful, guilty) 5. Sense of meaning and purpose in life (hopeless and pessimistic about the future) and 6. Interpersonal relationships (e.g. problems with trust, assertiveness, and multiple unstable relationships." (DeRosa et al., 2016, p.0-16)

This manual is based on three therapeutic interventions that have been integrated to treat developmental trauma in youth using a mind-body approach. The interventions are:

-Dialectical Behavior Therapy (DBT) for Adolescence (Miller, Rathus, & Linehan, in press)

-Trauma Adaptive Recovery- Group Education and Therapy (TARGET) (Ford, Mahoney, & Russo, 2004)

-Trauma Sensitive Yoga (Rhodes, 2015; Perry, 2009; van der Kolk et al., 2014)

Dialectical Behavior Therapy (DBT) and TARGET model will be used to address maladaptive behaviors and thoughts with a delicate balance of encouragement to change and validation of current perspective and coping strategies (DeRosa et al., 2016). The facilitator maintains the belief that that each individual is doing the best they can and wants to improve while also expecting that each can do more and try harder with the right tools and environment

(DeRosa et al., 2016). After identifying the adolescence's "wisdom" and "kernel of truth," group leaders must build on that perspective to help identify and rebuild adaptive skills the survivor already possesses within themselves (DeRosa et al., 2016).

Trauma Sensitive Yoga helps address the somatic impact of trauma by building a healthy mind-body connection, which is often lacking in traumatized individuals (Rhodes, 2015; Perry, 2009; van der Kolk et al., 2014). When a person experiences such distress, often times the body will try to communicate that the organism is out of balance through aches, pains, and other physical ailments or chronic conditions as observed in the Adverse Childhood Experiences study (van der Kolk et al., 2014). Traumatized individuals are often disconnected from their bodies or numb out these experiences. Additionally, traumatized individuals experience significant neurophysiological dysfunction which impacts the entire nervous system (van der Kolk et al., 2014).

Trauma Sensitive Yoga utilizes mindfulness to facilitate the development of healthy mind-body connections and reset the nervous system to bring them back into balance. The Trauma Center in Massachusetts has been incorporating yoga into treatment under the direction of Dr. Bessel van der Kolk since 2003 and has been found to be an effective adjunct to psychotherapy for children who have experienced physical and sexual abuse (van der Kolk et al., 2014). The Art of Yoga Project (AYP), another leader in the field of trauma recovery, combines neuroscience based interventions to integrate yoga and the creative arts (Perry, 2009). The Child Trauma Academy is also a major supporter of mind-body interventions and "recommends yoga, meditation, and expressive arts as part of essential therapeutic interventions" in the treatment of traumatized youth (Perry, 2009).

This manual has been adapted from the SPARCS (Structured Psychotherapy for Adolescents Responding to Chronic Stress) Program in order to better fit the needs of traumatized youth in a residential treatment facility (DeRosa et al., 2006). SPARCS program is designed as a closed group that is 16 weeks long and requires an outlined set of participate parameters (DeRosa et al., 2006). Residential treatment centers for youth typically do not maintain conditions for structured, closed groups with rigid participant requirements, especially if the group is long in duration. There is a high rate of admissions and discharges, which makes the census inconsistent. This would make retention for a 16-week program challenging. Additionally, the number of residents may vary greatly and there may be a wide range of ages and a significant difference in male to female ratio. Also, new members would have limited opportunity to join the group, as they would have to wait until the current program is complete.

With the adapted version, ideal conditions for participants are outlined, however, this can be adapted to fit the needs of the resident population. Additionally, with an 8-week duration, retention rates are likely to be higher and the opportunity for new members to join increases, as the group will be started more frequently. The group can also be adapted to allow new members to join, at the discretion of the facilitator. Lastly, SPARCS lacks a formal mind-body integrated approach (DeRosa et al., 2006). This adapted version includes a trauma sensitive yoga component during every session, as well as meditation techniques to further the mind-body integration experience.

Method

Each group session will run one hour and a half. Before completing the yoga sequence, members will be given a midsession 10-minute break.

Participants

Participants will be adolescents ages 15-17 residing in residential treatment facilities. Ideally, males and females will have separate groups. If there are not enough members of the same gender to have separate groups, the program can be adapted to accommodate a combined group of both males and females. The maximum members in one group allowed will be 8. Care should be taken to assure that participants within a group are developmentally similar to foster group cohesion and skill-building, however, this is not always achieved in this setting. Facilitators will explain modules in a variety of ways if necessary to ensure understanding of every participant.

Facilitator Qualifications

Facilitators will be mental health professionals, or individuals who have graduated from an accredited program and are working towards licensure under direct supervision of a mental health professional, who have understanding and experience with traumatized youth. The group can be led with 1 or 2 facilitators. The following attributes in a facilitator will help ensure a positive group experience: prepares ahead of time for each session, is trustworthy, credible, available, reliable and consistent, hopeful, warm and compassionate, energetic, emotionally mature, sets healthy boundaries and respects confidentiality, is sensitive and responsive to multicultural issues, is dedicated to and interested in the healing experience of traumatized youth, is a content expert (has read and understands this guide), and is skilled as a facilitator (has had prior experience in conducting a group).

Facilitators must also be reliable and emotionally constant. They should be culturally sensitive, nonjudgmental and supportive. Language should be clear and simple. Group facilitators should set the standards for an acceptable way of relating with others throughout the group.

Group Guidelines

Group members will be asked to create a list of rules they would like to maintain within the group. The following rules must be followed:

1. Uphold confidentiality and limits to confidentiality
2. No electronic devices are permitted
3. Respect for all group members (i.e.one person speaks at a time and uses attending behavior, no put downs, talk about and focus on own treatment, do not talk about others or attempt to control their treatment, no name calling, etc.)
4. Must be sober to attend group

Grounds for Dismissal

Failing to adhere to group guidelines may be grounds for dismissal. The use of drugs or alcohol, breaking confidentiality, and the use of electronic devices will be non-negotiable grounds for dismissal.

Confidentiality and Informed Consent

Confidentiality and limits to confidentiality will be explained to residents as well as their parents and/or guardians upon admission to the residential treatment facility. Confidentiality and limits to confidentiality, including under what circumstances leaders are mandated to report child maltreatment and threats of harm to self and others, will be reviewed with group members prior to beginning the group and throughout the group process. Informed consents will be given to

each participant to sign, stating that they understand the risks of participating in the group, that the group is voluntary and they can leave at any time without penalty and will adhere to the rules. (Appendix A)

Treatment Outcomes

The target goals of this program are to increase functioning in the following areas:

1. Emotional problems
2. Conduct problems
3. Hyperactivity
4. Peer problems
5. Prosocial interactions
6. Complains of physical pain

Assessment

The Strengths and Difficulties Questionnaire (SDQ) for ages 4-17 is the instrument that will be used to assess for treatment outcomes 1-5. A Likert scale of 1-10 will be used to assess for complains of physical pain, with 10 being the highest possible pain level. The SDQ-S4-17 and Likert scale measure will be administered pre-group admission and post-group completion to assessment for success in treatment outcomes. (Appendix A)

Group Manual

Module One: Mindfulness meditation, Stress, Trauma and the Body, Trauma Sensitive Yoga

Mindfulness Meditation: 3-Minute Body Scan Meditation to Cultivate Mindfulness (See Appendix B)

Stress, Trauma and the Body: The first topic of discussion will be situations that aren't safe or don't feel safe and developing a plan of what to do during these situations. Next, the group will discuss the impact of trauma on the body using an activity ("Bottle About to Burst") as a visual representation. Common reactions to trauma will be identified. Using the activity and psychoeducation provided, members will reflect on their own individual responses to trauma. (See Appendix D for handouts and complete instructions).

This module begins the discussion of the impact of trauma on the body.

Trauma Sensitive Yoga Exercise: Level 1 (See Appendix C)

Module Two: Mindfulness meditation, Getting Focused: Introduction to Mindfulness, Trauma Sensitive Yoga

Mindfulness Meditation: 3-Minute Body Scan Meditation to Cultivate Mindfulness (See Appendix B)

Getting Focused: Introduction to Mindfulness: Psychoeducation on the DBT concept of mindfulness and the states of the mind-emotional mind, reasonable mind, and wise mind, that drive human behavior. A role play activity using different states of mind will be used to better demonstrate these concepts. (See Appendix E for handouts and complete instructions)

Trauma Sensitive Yoga Exercise: Level 1 (See Appendix C)

Module Three: Mindfulness meditation, Mindfulness: The Path to Wise Mind, Trauma Sensitive Yoga

Mindfulness Meditation: 3-Minute Body Scan Meditation to Cultivate Mindfulness (See Appendix B)

Mindfulness: The Path to Wise Mind: This session continues to build on the previous session by completing a mindfulness activity, reviewing the states of mind, and providing psychoeducation on why mindfulness is important. The "what" and "how" skills of mindfulness are introduced in this section. (See Appendix F for handouts and further instruction)

Trauma Sensitive Yoga Exercise: Level 1 (See Appendix C)

Module Four: Mindfulness meditation, Distress Tolerance: Distract and Self Sooth, Trauma Sensitive Yoga

Mindfulness Meditation: 3-Minute Body Scan Meditation to Cultivate Mindfulness (See Appendix B)

Distress Tolerance: Distract and Self Sooth: This section will identify distress tolerance skills (soothe and distract), what they are, when to use them, and allow opportunity to practice use. (See Appendix G for handouts and further instruction)

Trauma Sensitive Yoga Exercise: Level 1 (See Appendix C)

Module Five: Mindfulness meditation, Trauma and Trust, Trauma Sensitive Yoga

Mindfulness Meditation: 3-Minute Body Scan Meditation to Cultivate Mindfulness (See Appendix B)

Trauma and Trust: This section provides psychoeducation on the definition of abuse and trauma as well as the types of social supports. The impact of trauma on interpersonal relationships, specifically trust, will also be explored. Members will identify good sources of support. (See Appendix H for handouts and instruction)

Trauma Sensitive Yoga Exercise: Level 1 (See Appendix C)

Module Six: Mindfulness meditation, LET'M GO, Trauma Sensitive Yoga

Mindfulness Meditation: 3-Minute Body Scan Meditation to Cultivate Mindfulness (See Appendix B)

Let M' Go: This session is designed to help members better cope with stressful situations in the present that may be triggered as a result of previous trauma. This is accomplished by identifying triggers, feelings, thoughts, assigning meaning to what's important, identifying what they want out of the situation, and available choices. (See Appendix I for handouts and instruction)

Trauma Sensitive Yoga Exercise: Level 1 (See Appendix C)

Module Seven: Mindfulness meditation, Labeling Triggers and Managing Emotions, Trauma Sensitive Yoga

Mindfulness Meditation: 3-Minute Body Scan Meditation to Cultivate Mindfulness (See Appendix B)

Labeling Triggers and Managing Emotions: This session continues to build on the previous session by exploring triggers and the regulation of emotions, specifically anger. They will gain practice at identifying triggers and coping with the intense emotions that may result. (See Appendix J for handouts and instruction)

Trauma Sensitive Yoga Exercise: Level 1 (See Appendix C)

Module Eight: Mindfulness meditation, Mind Body Connection, Trauma Sensitive Yoga

Mindfulness Meditation: 3-Minute Body Scan Meditation to Cultivate Mindfulness (See Appendix B)

The Mind-Body Connection: In this section, the is a focus on the "mind body connection" and somatization using mindfulness practices to identify how each individual's body responds to trauma. Members will also utilize art to provide a visual of their mind body connection. (See Appendix K for handouts and instructions)

Trauma Sensitive Yoga Exercise: Level 1 (See Appendix E)

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Appendices

Strengths and Difficulties Questionnaire

S 11-17

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain . Please give your answers on the basis of how things have been for you over the last six months.

Your name.. Male/Female

Date of birth...

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	☐	☐	☐
I am restless, I cannot stay still for long	☐	☐	☐
I get a lot of headaches, stomach-aches or sickness	☐	☐	☐
I usually share with others, for example CD's, games, food	☐	☐	☐
I get very angry and often lose my temper	☐	☐	☐
I would rather be alone than with people of my age	☐	☐	☐
I usually do as I am told	☐	☐	☐
I worry a lot	☐	☐	☐
I am helpful if someone is hurt, upset or feeling ill	☐	☐	☐
I am constantly fidgeting or squirming	☐	☐	☐
I have one good friend or more	☐	☐	☐
I fight a lot. I can make other people do what I want	☐	☐	☐
I am often unhappy, depressed or tearful	☐	☐	☐
Other people my age generally like me	☐	☐	☐
I am easily distracted, I find it difficult to concentrate	☐	☐	☐
I am nervous in new situations. I easily lose confidence	☐	☐	☐
I am kind to younger children	☐	☐	☐
I am often accused of lying or cheating	☐	☐	☐
Other children or young people pick on me or bully me	☐	☐	☐
I often offer to help others (parents, teachers, children)	☐	☐	☐
I think before I do things	☐	☐	☐
I take things that are not mine from home, school or elsewhere	☐	☐	☐
I get along better with adults than with people my own age	☐	☐	☐
I have many fears, I am easily scared	☐	☐	☐
I finish the work I'm doing. My attention is good	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that you have difficulties in any of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress you?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

Your Signature .... Today's Date ....

Thank you very much for your help

Scoring the Strengths & Difficulties Questionnaire for age 4-17

The 25 items in the SDQ comprise 5 scales of 5 items each. It is usually easiest to score all 5 scales first before working out the total difficulties score. 'Somewhat True' is always scored as 1, but the scoring of 'Not True' and 'Certainly True' varies with the item, as shown below scale by scale. For each of the 5 scales the score can range from 0 to 10 if all items were completed. These scores can be scaled up pro-rata if at least 3 items were completed, e.g. a score of 4 based on 3 completed items can be scaled up to a score of 7 (6.67 rounded up) for 5 items.

Table 1: Scoring symptom scores on the SDQ for 4-17 year olds

	Not True	Somewhat True	Certainly True
Emotional problems scale			
ITEM 3: Often complains of headaches… *(I get a lot of headaches…)*	0	1	2
ITEM 8: Many worries… *(I worry a lot)*	0	1	2
ITEM 13: Often unhappy, downhearted… *(I am often unhappy….)*	0	1	2
ITEM 16: Nervous or clingy in new situations… *(I am nervous in new situations…)*	0	1	2
ITEM 24: Many fears, easily scared *(I have many fears…)*	0	1	2
Conduct problems Scale			
ITEM 5: Often has temper tantrums or hot tempers *(I get very angry)*	0	1	2
ITEM 7: Generally obedient… *(I usually do as I am told)*	2	1	0
ITEM 12: Often fights with other children… *(I fight a lot)*	0	1	2
ITEM 18: Often lies or cheats *(I am often accused of lying or cheating)*	0	1	2
ITEM 22: Steals from home, school or elsewhere *(I take things that are not mine)*	0	1	2
Hyperactivity scale			
ITEM 2: Restless, overactive… *(I am restless…)*	0	1	2
ITEM 10: Constantly fidgeting or squirming *(I am constantly fidgeting….)*	0	1	2
ITEM 15: Easily distracted, concentration wanders *(I am easily distracted)*	0	1	2
ITEM 21: Thinks things out before acting *(I think before I do things)*	2	1	0
ITEM 25: Sees tasks through to the end… *(I finish the work I am doing)*	2	1	0
Peer problems scale			
ITEM 6: Rather solitary, tends to play alone *(I am usually on my own)*	0	1	2
ITEM 11: Has at least one good friend *(I have one goof friend or more)*	2	1	0
ITEM 14: Generally liked by other children *(Other people my age generally like me)*	2	1	0
ITEM 19: Picked on or bullied by other children… *(Other children or young people pick on me)*	0	1	2
ITEM 23: Gets on better with adults than with other children *(I get on better with adults than with people my age)*	0	1	2
Prosocial scale			
ITEM 1: Considerate of other people's feelings *(I try to be nice to other people)*	0	1	2
ITEM 4: Shares readily with other children… *(I usually share with others)*	0	1	2
ITEM 9: Helpful if someone is hurt… *(I am helpful is someone is hurt…)*	0	1	2
ITEM 17: Kind to younger children *(I am kind to younger children)*	0	1	2
ITEM 20: Often volunteers to help others… *(I often volunteer to help others)*	0	1	2

Total difficulties score: This is generated by summing scores from all the scales except the prosocial scale. The resultant score ranges from 0 to 40, and is counted as missing of one of the 4 component scores is missing.

'Externalising' and 'internalising' scores: The externalising score ranges from 0 to 20 and is the sum of the conduct and hyperactivity scales. The internalising score ranges from 0 to 20 and is the sum of the emotional and peer problems scales. Using these two amalgamated scales may be preferable to using the four separate scales in community samples, whereas using the four separate scales may add more value in high-risk samples *(see Goodman & Goodman. 2009 Strengths and difficulties questionnaire as a dimensional measure of child mental health. J Am Acad Child Adolesc Psychiatry 48(4), 400-403).*

Generating impact scores

When using a version of the SDQ that includes an 'impact supplement', the items on overall distress and impairment can be summed to generate an impact score that ranges from 0 to 10 for parent- and self-report, and from 0 to 6 for teacher-report.

Table 2: Scoring the SDQ impact supplement

	Not at all	Only a little	A medium amount	A great deal
Parent report:				
Difficulties upset or distress child	0	0	1	2
Interfere with HOME LIFE	0	0	1	2
Interfere with FRIENDSHIPS	0	0	1	2
Interfere with CLASSROOM LEARNING	0	0	1	2
Interfere with LEISURE ACTIVITIES	0	0	1	2
Teacher report:				
Difficulties upset or distress child	0	0	1	2
Interfere with PEER RELATIONS	0	0	1	2
Interfere with CLASSROOM LEARNING	0	0	1	2
Self-report report:				
Difficulties upset or distress child	0	0	1	2
Interfere with HOME LIFE	0	0	1	2
Interfere with FRIENDSHIPS	0	0	1	2
Interfere with CLASSROOM LEARNING	0	0	1	2
Interfere with LEISURE ACTIVITIES	0	0	1	2

Responses to the questions on chronicity and burden to others are not included in the impact score. When respondents have answered 'no' to the first question on the impact supplement (i.e. when they do not perceive themselves as having any emotional or behavioural difficulties), they are not asked to complete the questions on resultant distress or impairment; the impact score is automatically scored zero in these circumstances.

Cut-points for SDQ scores: original three-band solution and newer four-band solution

Although SDQ scores can be used as continuous variables, it is sometimes convenient to categorise scores. The initial bandings presented for the SDQ scores were 'normal', 'borderline' and 'abnormal'. These bandings were defined based on a population-based UK survey, attempting to choose cutpoints such that 80% of children scored 'normal', 10% 'borderline' and 10% 'abnormal'.

More recently a four-fold classification has been created based on an even larger UK community sample. This four-fold classification differs from the original in that it (1) divided the top 'abnormal' category into two groups, each containing around 5% of the population, (2) renamed the four categories (80% 'close to average', 10% 'slightly raised, 5% 'high' and 5% 'very high' for all scales except prosocial, which is 80% 'close to average', 10% 'slightly lowered', 5% 'low' and 5% 'very low'), and (3) changed the cut-points for some scales, to better reflect the proportion of children in each category in the larger dataset.

Table 3: Categorising SDQ scores for 4-17 year olds

	Original three-band categorisation			Newer four-band categorisation			
	Normal	Borderline	Abnormal	Close to average	Slightly raised (/slightly lowered)	High (/Low)	Very high (very low)
Parent completed SDQ							
Total difficulties score	0-13	14-16	17-40	0-13	14-16	17-19	20-40
Emotional problems score	0-3	4	5-10	0-3	4	5-6	7-10
Conduct problems score	0-2	3	4-10	0-2	3	4-5	6-10
Hyperactivity score	0-5	6	7-10	0-5	6-7	8	9-10
Peer problems score	0-2	3	4-10	0-2	3	4	5-10
Prosocial score	6-10	5	0-4	8-10	7	6	0-5
Impact score	0	1	2-10	0	1	2	3-10
Teacher completed SDQ							
Total difficulties score	0-11	12-15	16-40	0-11	12-15	16-18	19-40
Emotional problems score	0-4	5	6-10	0-3	4	5	6-10
Conduct problems score	0-2	3	4-10	0-2	3	4	5-10
Hyperactivity score	0-5	6	7-10	0-5	6-7	8	9-10
Peer problems score	0-3	4	5-10	0-2	3-4	5	6-10
Prosocial score	6-10	5	0-4	6-10	5	4	0-3
Impact score	0	1	2-10	0	1	2	3-10
Self-completed SDQ							
Total difficulties score	0-15	16-19	20-40	0-14	15-17	18-19	20-40
Emotional problems score	0-5	6	7-10	0-4	5	6	7-10
Conduct problems score	0-3	4	5-10	0-3	4	5	6-10
Hyperactivity score	0-5	6	7-10	0-5	6	7	8-10
Peer problems score	0-3	4-5	6-10	0-2	3	4	5-10
Prosocial score	6-10	5	0-4	7-10	6	5	0-4
Impact score	0	1	2-10	0	1	2	3-10

Note that both these systems only provide a rough-and-ready way of screening for disorders; combining information from SDQ symptom and impact scores from multiple informants is better, but still far from perfect.

Appendix B: A 3-Minute Body Scan Meditation to Cultivate Mindfulness

A brief mindfulness meditation practice to relax your body and focus your mind.

Begin by bringing your attention into your body.

You can close your eyes if that's comfortable for you.

You can notice your body seated wherever you're seated, feeling the weight of your body on the chair, on the floor.

Take a few deep breaths.

And as you take a deep breath, bring in more oxygen enlivening the body. And as you exhale, have a sense of relaxing more deeply.

You can notice your feet on the floor, notice the sensations of your feet touching the floor. The weight and pressure, vibration, heat.

You can notice your legs against the chair, pressure, pulsing, heaviness, lightness.

Notice your back against the chair.

Bring your attention into your stomach area. If your stomach is tense or tight, let it soften. Take a breath.

Notice your hands. Are your hands tense or tight? See if you can allow them to soften.

Notice your arms. Feel any sensation in your arms. Let your shoulders be soft.

Notice your neck and throat. Let them be soft. Relax.

Soften your jaw. Let your face and facial muscles be soft.

Then notice your whole-body present. Take one more breath.

Be aware of your whole body as best you can. Take a breath. And then when you're ready, you can open your eyes.

Appendix C: Trauma Sensitive Yoga Sequence

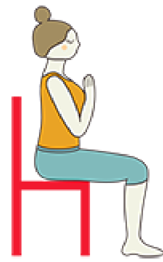
A slow yoga sequence to work with the somatic nervous system of the trauma survivors: Yoga Poses, Cues, Steps, and Breath Information

Yoga Sequence Builder for Yoga Teachers: Plan your yoga classes, build yoga sequencing foundation with sequence guides, and get yoga sequencing ideas with daily yoga sequences and reference cues. Learn more at www.tummee.com

1. Level 1

Trauma survivors always live in fear and have no control over their physical and emotional changes. And when they choose the path of therapeutic healing with yoga, it is the yoga instructor's duty to look at each survivor as an independent individual and choose the poses in the sequence keeping each survivor's situation in mind.

The below sequence, is just to give an idea and example.
Here at this stage, we are using these poses for those survivors who need extra care, and time to know and connect with their bodies, all over again, at their own pace.

- 

12B

Inhale-Exhale

120s

2. Hands Chest Chair

A. Start seating, all the participants in the class on their respective chairs.

B. Giving them time to settle, watch their body language and judge their situation without asking too many questions.

C. If someone is not comfortable sitting in front of the class, or is not comfortable showing their back to others, let them choose their own spot of comfort. It could be close to the wall

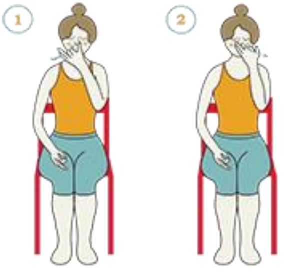
or at the corner of the class.
Make them sit around in a circle, would also be a good idea.

D. After they have settled, let them join their palms in namaste, close to their chest in Hands Chest Chair pose, while having their eyes OPEN, as they may not be comfortable shutting their eyes.

E. Let them just go with the flow of breath requesting them to count as they breath, if it is OK for them. The counting can go to 12 breaths.

F. As they breath, their focus would slowly be towards the sensation of the air through their nostrils, which brings them to start body connection. Making the instructions clear and conveying them in a polite tone, would be encouraged.

Placing cushions for their back, hips and feet will give more support and comfort.

- 

16B

Inhale-Exhale

120s
3. Nadi Shodhana Chair
A. After the 12 counts of breathing seated in Hands Chest Chair, let them relax.

B. Requesting them and showing them how to place the thumb and the ringer finger at the tips of their nostrils, teach them to breathe ONE nostril at a time.

C. While closing their right nostril, they breathe through their left nostril (inhale and exhale) in counts of 8.

D. Releasing and repeating with the right nostril, (inhale and exhale) through the right

nostril only for counts of 8.

E. They may take lesser time to complete 8 rounds, as their breathing would be fast and not deep. You could ask them to repeat and also request them to choose that nostril first which is smooth and comfortable.

F. They can work longer with the nostril that is smooth and easy, as this would give them a feeling of satisfaction and comfort. The idea here in this pose, is to open their nostrils to help them breath better while doing each pose in this sequence.

G. Let them settle, to go back to just breathing normally, after the completion of the variation of Nadi Shodhana Chair.

-

8B

Inhale-Exhale

60s

4. Chair Upward Hand Stretch Pose (Chair Urdhva Hastasana)

A. Still seated, request them to raise their arms interlocking their fingers above their heads to go into Upward Hands Stretch Pose or Chair Urdhva Hastasana.

B. Show them how to inhale as they raise and exhale once in the pose, while holding the arms up for counts of 8. Show them the movement of the body as the breathing happens.

C. The stretching of the arms here helps them to ease the body pain around the muscles close to the shoulders and the neck, as with trauma, these muscles hold back and become stiff and tight.

D. CHRONIC BODY PAIN, is one of the main symptoms of Trauma and Stress, as the muscles get tight and remain under fear always. Opening up these muscles slowly starting

with the upper body here will help to improve in the breathing and the stiffness.

E. Choosing not to do this pose, by the survivors should be appreciated, as raising the arms may hold them back and bring back some memories. The alternative is to request them to bring their arms in FRONT of them.

-

10B

Inhale-Exhale

180s
5. Chair Seated Side Stretch Pose
A. From Urdhva Hastasana, allow them to settle and relax with both their body and their breath.

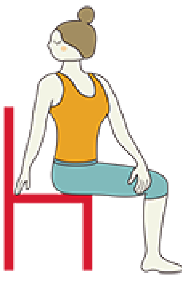
B. Preparing for the next pose, Seated Side Stretch Pose. Show them how to raise their arms above your head towards the opposite side while slowly looking up.

C. Raising your arms above slowly activates the sides of your back, flexing your hips and arms.
This will help them to release the tightness around the various muscles and also help them to feel their bodies with each movement and each breath.

D. Giving them time to understand this pose and the time to feel the stretch, continue demonstrating the pose with the breathing.

E. Choosing not to look up here is OK. And choosing not to do this pose, then they can be requested to bring the arms to SHOULDER level as variation.

F. Holding the chair let them slowly count for 5 breaths, in this pose, releasing and repeating with the other side.

- 

8B

Inhale-Exhale

120s

6. Chair Seated Twists

A. While still seated, request them to come forward while sitting close to the edge of the chair, and making sure the feet are comfortable on the floor.

B. Show them to inhale and with exhalation, turn the torso gently towards the right, looking back if possible. Placing on arm on the thighs and the other on the back of the chair, show the movement of the spine and the chest.

C. This pose with the gentle twist will open the tight shoulders, stiff neck, tight hips and lower back while encouraging prana flow without much effort.

D. It is not necessary to give the benefits of the practice of each pose, but on the other hand, requesting them to breath loud and deep, will help them connect with their bodies.

E. Let them try to remain in this Chair Seated Twists, for about 4 breaths or counts, showing them the movement of the body and the chest in general while at the pose.

F. Releasing to repeat with the other side, counting for 4 breaths or 4 counts.

-

5B

Inhale-Exhale

60s

7. Seated Forward Fold Pose on Chair

A. After the practice of Chair Seated Twists, allow the students to just relax at their own pace. Taking breaks should be encouraged to help them feel less pushed and make them feel that they are under control.

B. The comfort of the mind here is most important and respecting that will help them connect with you more.

C. Moving on with the sequence, show them the movement of Head Down while seated on the Chair. Inhaling stretching upwards and while exhaling going down while resting the palms on the floor and placing the face close to the thighs or knees.

D. After stretching upwards and sideways, a forward bend completes the movement of the spine. Here moving forward, the spine stretches giving a gentle stretch to the lumbar area where the prana flows upwards and downwards.

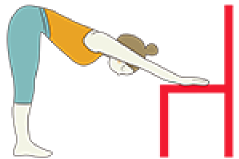
E. Showing them the breathing technique while compressing their abdomen, make the breathing loud and deep.

F. DIGESTION gets affected with Trauma and there are cases where one can develop IBS (Irritable Bowel Syndrome) when it is a stage of PTSD (Post- Traumatic Stress Disorder). Hence in this pose, a gentle slow massage with deep breathing, can be helped to reduce this symptom and also increase the digestion levels.

G. Choosing not to do this pose due to pressure on the belly is OK, and as an alternative, you could show them to go forward in this pose, but not press the entire belly, while

stretching the arms out in front of you.

H. Staying here for about 5 counts or 5 breaths is encouraged, while releasing and repeating it for the second time.

- 

5B

Inhale-Exhale

60s

8. Downward Facing Dog Pose Variation Chair (Adho Mukha Svanasana Variation Chair)
A. Releasing from the previous pose, allow the practitioner to relax and take rest.

B. Standing in front of the chair, either facing the back of the chair or the seated part of the chair should be their choice.

C. Inhale, and raise upwards and as you exhale bend forward while placing the hands on the chair stretching the arms and the legs completely, in Adho Mukha Svanasana Variation.

D. This pose is best done , making sure they don't have their back facing others. Here stretching the arms and the hips will help them open up the tight hips while working with their tired legs and feet.

E. Showing them how to breathe while holding the balance, and choosing between looking up or looking down. The flow of blood towards the head, in this pose may bring discomfort to some, and hence, modify the pose. Looking straight or choosing not to bend completely as per the body comfort should be encouraged.

F. Holding the body here for count of 5 breaths or more, and then to release and practice again.

-

8B

Inhale-Exhale

120s

9. Warrior Pose Ii Chair (Virabhadrasana Ii Chair)

A. While all the above poses in the sequence were practiced to just open the body with deep loud breathing, a small addition of strength and power pose to help them feel accepted and confident is added.

B. Practicing Virabhadrasana II or Warrior Pose II on the chair is all about encouraging confidence and balance. While this pose is considered to be powerful when done standing, the benefits derived here would be more towards balance and strength.

C. Showing them how to place the legs on the chair while spreading them to one's comfort, extend the arms out at shoulder level while gazing at the arm in front of you.

D. Help them to learn to balance with slow instructions and making sure not to touch them while they try this pose. Allowing them to take their time to get comfortable in this pose is very important.

E. Choosing not to do this pose, then as a variation, they can sit with the lower body in Virabhadrasana while their arms can rest on the sides. Breathing loud and deep for about 4 counts, and then releasing to turn towards the other side to repeat.

F. Make sure that the instructions are slow and clear while also the voice is polite and humble.

Let them take time to rest and relax before practicing with the other leg.

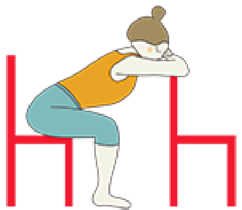
-

0s

10. Deep Rest

Ending the sequence with DEEP REST with the next pose.

No pose should be done if the survivor / student is uncomfortable or not ready.



12B

Inhale-Exhale

360s

11. Seated Forward Fold Pose Two Chairs

A. By now their breathing would be better and they may have gotten comfortable with the breathing too.

B. Seated on the chair, place another chair in front of them. Resting the arms on the back of the chair in front of you, show them the posture Seated Forward Fold Pose, to completely come to relax with the breathing and the body.

C. Here this pose will help them rest the entire body, while the breathing should be soft and deep, if possible.

D. Choosing not to do this pose, they can practice relaxing while just seated on the chair with their hands in Namaste in front of their chest, or on their thighs, as they started in the beginning.

E. Beginning to get comfortable with the sequence one could request them to repeat if OK.

F. Each student should be encouraged to relax in this pose, whenever he/ she wants and give them time to understand, adapt, adjust and practice at their will.

12.
The idea of practice of the various poses, is not to build flexibility, or to master the number of breaths in the given time, but to just open up the tight muscles. Muscles around the joints tend to get tight, with stress related to trauma, giving rise to body aches and pain. Hence working with opening up these muscles while the movement is slow and steady is what is needed.

Making them repeat the sequence all over again, or the choice of any two or more of the poses in the sequence that encourages them to feel comfortable can be done. Pushing them beyond their comfort zone is uncalled for.

Appendix D: Stress, Trauma and the Body

Safety Planning

► Managing personal safety now is critical (present this to group in third person). Refer to "Safety Planning" and complete as a group.

► Facilitate discussion; be sure to get the group to discuss situations that aren't safe or don't feel safe-what to do, where to go, whom to talk to

►What should kids do when they don't feel safe? Where should they go?

- Go someplace safe
    - Go to someone you trust-parent, grandparent, teacher, friend, neighbor ·.
        - Go to a place with lots of people around-mall, store,
        - Police or fire department
        - Church/synagogue/mosque
- Call someone
    - Should include other family members, friends, neighbors, teacher, clergy, call 911
    - Discuss calling 911-when, why, their thoughts, feelings and reservations

Activity: "Bottle About to Burst"

► Ask for 3 volunteers who do not mind getting wet. Give two volunteers a bottle of club soda/soda water/seltzer. Give the other a bottle of water (all bottles should appear the same)

► Tell them to shake the bottles while the discussion occurs

► Have group identify sources of stress or feelings that get bottled up inside

- Ask-What kinds of things stress you out?
- You've had little to no sleep the past few days
- People in your house were fighting a lot
- Something embarrassing happens in school
- Your family is thinking of moving
- List stressors and feelings on board or flipchart
- Volunteers shake bottle after each stress or feeling is identified

► Transfer analogy to soda bottles

- What is happening inside this bottle?
    - When we get full of feelings, pressure builds up inside
- Feels like a bottle about to burst
- Feels like can't hold it all in anymore

► Open 1st bottle: Tell one volunteer with a club soda/seltzer bottle to open it quickly. What happens when we bottle things up?

- You explode

    - Pressure gets released all at once-soda/feelings come pouring out all at the same time
    - Things get messy

► Open 2nd bottle: Have volunteer open bottle of FLAT water (do not reveal that it is only water)

- This time there is no explosion
    - Sometimes when things are bottled Up for too long, you go numb, like you don't have any feelings at all
    - Sometimes you feel flat- don't get sad, or angry
- What's wrong with feeling numb?
    - Don't feel good things either- happy, excited
        - Feelings are important- they tell you when something is wrong (e.g. if you put your hand on the stove, the heat and pain tell you it's dangerous and you pull away- if didn't feel it, you would get burned). If you don't have feelings, you might not know when you're in danger (e.g. you're in a dangerous neighborhood, you feel scared, so you are careful. So being scared could be helpful-it protects you)
    - Highlight extremes of how people handle stress: explode or go numb

► Open 3rd bottle: Volunteer opens last bottle (filled with club soda water) slowly-

- With each turn, identify what coping strategies do you/can you use to keep from exploding or going numb?
    - Talking to a friend, watching T.V., listening to music
    - What about having a safety plan? Safety plans can help you cope
- Slow release pressures/stress little at a time. What happened with the bottle?
    - It didn't explode
    - Didn't go flat
- Let out the pressure slowly, a little at a time
- How we opened the bottles (released the pressure) is what made the difference

► How is this like how you can manage stress?

How we release our stress and feelings makes a difference in whether or not we explode or go numb

- Bottling it up results in going numb or exploding [like when we opened it fast)- usually makes things worse
- Opening slowly releases pressure without problems
- Letting feelings out a little at a time prevents things from getting worse

The Body's Alarm System

► When faced with trauma or chronic stress, the mind/body sometimes has a hard time getting back on track

- Before discussing body's response, lead discussion of what trauma is:
  - Trauma examples: Seeing someone getting seriously hurt or die, seeing family members having physical fights, being in a serious accident, physical/sexual abuse, date rape, being beaten up, natural disasters like Hurricane Katrina, combat, terrorism (like9/ll)

Discuss reactions to trauma (Handout "The Body's Alarm System")

- How does the mind/body deal with stressful, upsetting, shocking, saddening, confusing things?
- How does your body react to stress?
  - Prepares for "fight or flight" or "freezes"-heart pounds to pump blood to arms, legs; breathe faster; pupils dilate to see things better
    - Example: walking down street, hear screaming getting louder and louder, heart starts pounding-body gets ready to fight danger or run,
- Discuss the difference between normal stress reactions and reactions to extreme stress/trauma
- Refer to handout: left side = normal stress reactions, right side = extreme or traumatic stress reactions

Normal Stress = alarm goes off in your head, it signals your body to act; you cope, maybe act or do something, alarm shuts off

Extreme stress = alarm goes off, at times you may not even know why and often nothing you do can shut it off

- Problem is the body doesn't know the difference between the danger now, stress from something in the past, or stress from an exam or an argument with a friend
- An alarm goes off as if you are in danger, even if you're not, and you may not know why-it's a sudden alarm signal - like a lightning bolt hitting you-the alarm goes off, but your brain can't figure out what the problem is or what to do
- When stress is ongoing, the alarm is constantly on-body can't shut it off- doesn't help over long run, can hut

Consequences of when body's alarm system gets stuck in "on"

- Feeling overwhelmed, confused, terribly unsafe, upset, angry may not be able to figure out why
- May act impulsively and self-destructively to make the noise stop
- Can make you physically sick
- May learn to ignore the alarm-this can be dangerous

How to "turn off" (or down) alarm in bodies when under stress

- Fighting, doing drugs or alcohol might shut down alarm
  - This can be dangerous-Like shutting off fire alarm while fire still burning out of control-you are still in danger
  - Might feel better right now because don't hear alarm noise but not better for the long term
- Use skills learned in group
  - You will learn a lot of skills that help you deal with this in this group

How Can Trauma Affect Life?

Discuss reactions to trauma-refer to Handout "Reactions to Trauma" and write symptoms on board as they are pointed out

- Ask for general examples-do not prompt for specific examples from their own lives unless they spontaneously offer them
- Ask them to think about kids they know-what happens to those kids when bad things happen in their lives?
  - What do/did they do?
- What are some ways that extreme stress/trauma reactions can interfere with someone's life?
  - Space out-friends think you're not listening
  - You don't trust anyone so you feel isolated

Normalize

- These are normal reactions to abnormal event: trauma
- This is what anyone who has experienced a trauma feels
- Causes struggle at home, school, with friends
  - Even if someone looks like they're not handling things well, that person may be trying their best to hang in there

Offer solutions-During this group, you will learn skills for dealing with the problems that interfere with your life now

Reminders of the Trauma

I think about what happened when I don't want to. I have dreams about what happened. I feel like it's happening again, right now. I get really upset when something reminds me of it.

My heart pounds and I sweat when something reminds me of it.

Avoiding Reminders of the Trauma

I try to avoid thoughts, feelings, activities, people and places that remind me of the trauma. I can't even remember all of stuff that happened. After it happened, I wasn't really interested in things. I don't feel attached to other people anymore. I don't feel stuff (emotions) like I used to. I don't think my future will be good.

Wound Up/Jumpy

I have problems falling asleep or staying asleep. I get angry really easy. I have trouble concentrating. I'm always super-alert, on guard, and watchful. I'm really jumpy and easily startled by loud noises or when somebody sneaks up on me.

Mental Shutdown (Dissociation)

People tell me I'm spacing out a lot. I feel like people and things aren't real, or like I'm in a dream. I feel like I'm watching myself from outside, or don't know who I am, like separate parts of me take control of my life.

Stress=*TheBody's Alarm System!*

NORMAL STRESS vs. **STRESS & TRAUMA**

=

DEALING WITH PROBLEMS vs. **FEELING OVERWHELMED**

BODY SIGNALS
Heart pounding
Rapid breathing
Stomach/head/muscle ache
Fight or flight

BODY SIGNALS
Heart feels like bursting
Gasping, feeling smothered
Muscles feel Hke exploding
Overreacting or freezing

FEELINGS
Excited or worried
Frustrated, determined
Angry or scared
Some loss of control
Worried about yourself

FEELINGS
Terrified or panicked
Enraged or aggressive
Hopeless or doom
Helpless or out of control
Worthless, like a failure

THINKING
Some clear thinking
Someclear memories

THINKING
Confused, mentally shut down
Memory like a broken puzzle

ACTIONS
Acting rapidly
Facing problems
Taking on challenges
Searching for solutions

ACTIONS
Automatic reflexes or freezing
Avoiding problems
Taking risks
Making a mess of your life
{at school, with family, with friends)

Which Bottle Were You?

PRACTICE SHEET

After a difficult/stressful situation, complete the following and bring this to the next session:

Briefly, what happened?

Which soda bottle were you like? (circle one)

Exploding bottle Flat bottle

Why?

Trying to Feel In Control/Emotionally Safe

I drink or drug to try to forget so I can control what I remember. Sometimes I just say no to what grown-ups tell me-it makes me feel more in control, I won't let myself eat; I can at least control that. I make myself throw up because I am afraid of losing control of my eating and gaining weight. I eat to feel better emotionally.

Extreme Risk-Taking or Self-Harm

I do dangerous things, hanging out where I could get hurt. I get relief by cutting, punching, or hurting my body.

Hopelessness and Self-Blame

I think about dying as a way to stop the feelings. I feel like religion and that spiritual stuff is worthless or just messes people up-I don't want anything to do with it. I feel like I'm a bad person-I feel guilty, like everything's my fault, even if people tell me it's not. know that nothing will ever get better or be O.K'.

Problems in

Relationships It's easier to think about everyone else. I don't pay attention to what I really want. I'm different from everyone around me. No one can understand what I've been through. I can't trust anyone; everyone lets you down or uses you and hurts you sooner or later.

Breakdown of the Body

I hurt all the time, and I get sick all the time-doctors can't find anything wrong with me. It's like my body is messed up.

Appendix E: Getting Focused: Introduction to Mindfulness

Mindfulness means being in the present, being aware of what is happening and what you are doing, observing what is going on, participating fully in what is going on around you. By learning to live in the present, you can have a life that is more in tune with your feelings and your activities.

The three primary states of mind are:

- Reasonable Mind
- Emotion Mind
- Wise Mind

Reasonable Mind

A person is in Reasonable Mind: when they are approaching things intellectually, thinking logically, planning behavior, paying attention to empirical facts (facts that can be observed or measured or counted), focusing their attention, and when they are "cool," that is, not emotional in their approaches to solving problems.

Some examples of **Reasonable Mind** might be:

- calling the bus station to find out the bus schedule, instead of just walking over and hoping to find a bus
- planning for an outing several days before
- measuring the ingredients to bake a cake
- asking a saleswoman the details about something you want to buy
- studying for a test
- looking up information on the Internet

Have you done any of these things?
What are some other examples of the way you use Reasonable Mind?
How can Reasonable Mind be helpful?
Can you think of any times when it is not helpful to be in Reasonable Mind?

Emotion Mind

A person is in Emotion Mind when their thinking and behavior are controlled mostly by their emotions. Logical thinking and planning are difficult, facts may be distorted or made larger or more important, thoughts and behaviors might be said to be "hot," and the energy of the behavior tends to match the intensity of the feelings.

Some examples of emotion mind might be:

- having a fight with someone you disagree with
- going on a trip on an impulse, without planning
- cuddling a puppy
- going out to fly a kite just for the fun of it
- snapping at a salesperson because they don't have the item you want
- putting an expensive item on your credit card just because you like it

Have you done any of these things?
What do you do when you are in Emotion Mind?
In what ways can it be helpful or good to be in Emotion Mind?
What are ways that it might not be helpful to be in Emotion Mind?

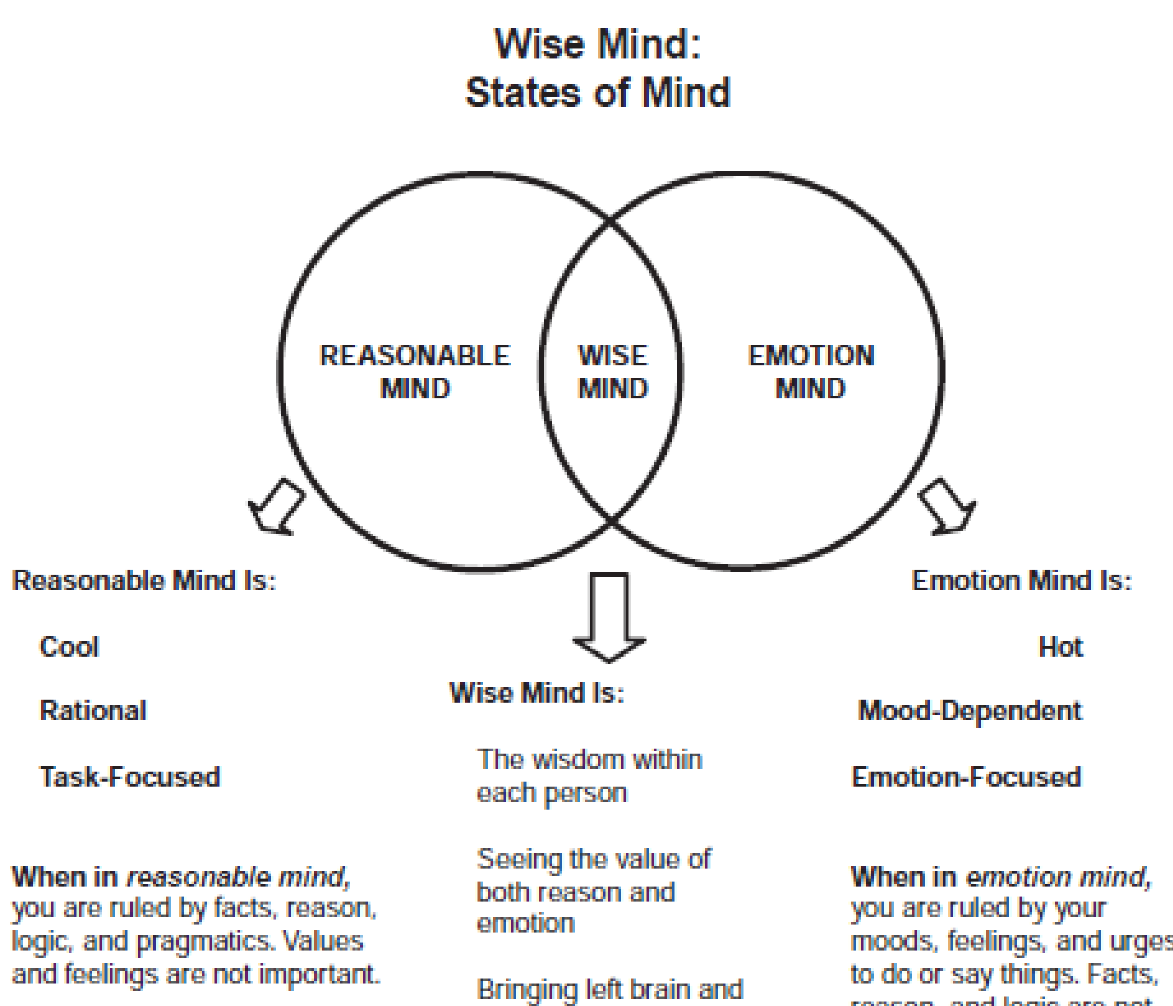
Wise Mind

Wise Mind is the coming together, the overlap of Reasonable Mind and Emotion Mind. But when they come together or overlap, they produce something bigger than either of them were separately. What is added is intuition, a feeling of "knowing" what's right, a felt sense, a sense that some people feel in their body (head, heart, stomach or somewhere else) that something is just right, the right thing to do or the right way for things to be. You can experience intuition about what's right or appropriate without thinking about it, without knowing it intellectually, just feeling it.

Do you ever have this intuition that something just "feels right?" The right thing to do or say or plan for? Could you give us an example?

Do you have this sense of knowing somewhere in your body? Where? (I feel it in my midsection, around my belly. Something there tells me that I am doing what's good for me, what's effective, the best thing in the moment.)

Do you have other ways of knowing this? This is what we mean by Wise Mind. It takes into account your logical thinking and planning and your emotions, but it's something more, a place of calmness and wisdom.


Wise Mind:
States of Mind
REASONABLE MIND
WISE MIND
EMOTION MIND
Reasonable Mind Is:
Cool
Rational
Task-Focused
When in reasonable mind, you are ruled by facts, reason, logic, and pragmatics. Values and feelings are not important.
Wise Mind Is:
The wisdom within each person
Seeing the value of both reason and emotion
Bringing left brain and right brain together
The middle path
Emotion Mind Is:
Hot
Mood-Dependent
Emotion-Focused
When in emotion mind, you are ruled by your moods, feelings, and urges to do or say things. Facts, reason, and logic are not important.

Role-Play: Wise Mind Charades

► Members act out a scenario

- Get 4 volunteers - one for each state of mind and one who will play a neutral role (will be tough, but fair). (Do not reveal role assignments to the rest of the group. They will be asked to guess).
- One group leader leaves room with volunteers (help determine who plays which state of mind, plan role-play, plan what they would say, how to act)
  - Volunteers can make up scenarios or use something from own lives
  - Group leaders can provide scenarios
- Each of the 3 states of mind will play one of 3 different people negotiating the same problem simultaneously
  - E.g. 3 employees: one in Wise Mind, one in Emotion Mind, and one Reasonable Mind. The fourth volunteer plays the part of the person with whom they are negotiating (e.g. employer). This character is tough but fair.
  - E.g. each of the 3 states of mind play siblings talking to a parent (the 4th volunteer)- asking to extend curfew to let them go to a party or negotiating consequences for a bad grade
  - E.g. 3 states of mind l to play the girlfriend, 2 to be her friends. Upset with boyfriend (the 4th volunteer) about why he didn't call
  - E.g. 3 states of mind play students trying to schedule a make-up exam with teacher (4th volunteer) or get an extension on a paper.
- Volunteers act out scenario for group
- After scenario, members can interview volunteers
- Have members ask questions to figure out state of mind
  - Discuss how members figured out which state of mind Tone, body language, choice of words, etc.
  - If volunteers had trouble staying in character, discuss why it was difficult
  - Ask: Which state of mind is more likely to get what they want?
  - How likely is Emotion Mind (with all the yelling/ attitude/crying, etc.) to get what he/she wants?

How likely is Reasonable Mind (who is not paying attention to his/her wants) to get what he or she wants?

what is mindfulness?

Have you ever noticed that when you are doing quite familiar and repetitive tasks, like driving your car, or vacuuming, that you mind is often miles away thinking about something else? You may be fantasising about going on a vacation, worrying about some upcoming event, or thinking about any number of other things.

In either case you are not focusing on your current experience, and you are not really in touch with the 'here and now.' This way of operating is often referred to as *automatic pilot* mode.

Mindfulness is the opposite of automatic pilot mode. It is about experiencing the world that is firmly in the 'here and now.' This mode is referred to as the *being* mode. It offers a way of freeing oneself from automatic and unhelpful ways of thinking and responding.

Benefits of Mindfulness

By learning to be in mindful mode more often, it is possible to develop a new habit that helps to weaken old, unhelpful and automatic thinking habits. For people with emotional problems, these old habits can involve being overly pre-occupied with thinking about the future, the past, themselves, or their emotions in a negative way. Mindfulness training in this case does not aim to immediately control, remove, or fix this unpleasant experience. Rather, it aims to develop a skill to place you in a better position to break free of or not 'buy into' these unhelpful habits that are causing distress and preventing positive action.

Core Features of Mindfulness

Observing

The first major element of mindfulness involves observing your experience in a manner that is more direct and sensual (**sensing mode**), rather than being analytical (**thinking mode**). A natural tendency of the mind is to try and think about something rather than directly experience it. Mindfulness thus aims to shift one's focus of attention away from thinking to simply observing thoughts, feelings, and bodily sensations (e.g., touch, sight, sound, smell, taste) with a kind and gentle curiosity.

Describing

This aspect of mindfulness relates to noticing the very fine details of what you are observing. For example, if you are observing something like a tangerine, the aim is to describe what it looks like, what is its shape, colour, and texture. You might place a descriptive name to it, like "orange", "smooth", or "round". The same process also can be applied to emotions (e.g. "heavy", "tense").

Participating Fully

An aim of mindfulness is to allow yourself to consider the whole of your experience, without excluding anything. Try to notice all aspects of whatever task or activity you are doing, and do it with your full care and attention.

Being Non-Judgemental

It is important to adopt an accepting stance towards your experience. A significant reason for prolonged emotional distress relates to attempts to avoid or control your experience. When being more mindful, no attempt is made to evaluate experiences or to say that they are good, bad, right, or wrong, and no attempt is made to immediately control or avoid the experience. Accepting all of one's experience is one of the most challenging aspects of mindfulness, and takes time and practice to develop. Bringing a kind and gentle curiosity to one's experience is one way of adopting a non-judgmental stance.

Focusing on One Thing at a Time

When observing your own experience, a certain level of effort is required to focus your attention on only one thing at a time, from moment to moment. It is natural for distracting thoughts to emerge while observing, and there is a tendency to follow and 'chase' these thoughts with more thinking. The art of 'being present' is to develop the skill of noticing when you have drifted away from the observing and sensing mode, into thinking mode. When this happens it is not a mistake, but just acknowledge it has happened, and then gently return to observing your experience.

How to Become Mindful

Mindfulness is a skill that takes time to develop. It is not easy, and like any skill it requires a certain level of effort, time, patience, and ongoing practice. Mindfulness can be taught in a number of ways. Meditation is one of the key techniques used in mindfulness training, but not the only technique. Contact your mental health professional for further information on mindfulness training and whether it may be suited to your needs.

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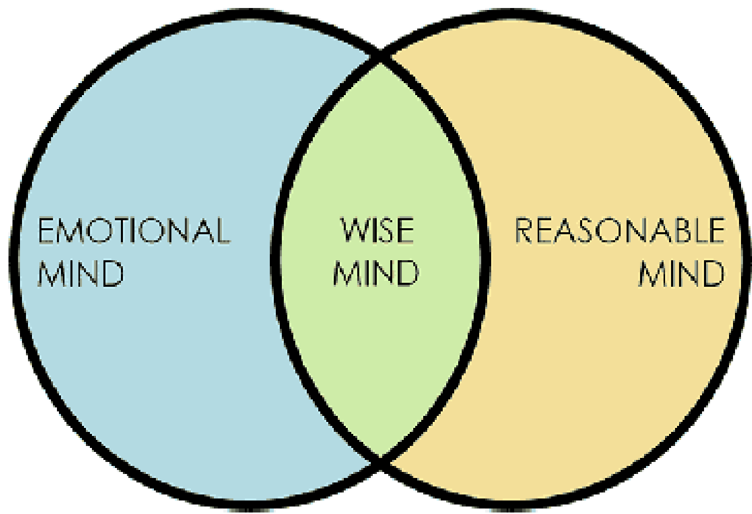
Appendix G: Path to Wise Mind

The Wise Mind

Your mind has three states: The reasonable mind, the emotional mind, and the wise mind. Everyone possesses each of these states, but most people gravitate toward a specific one most of the time.



A person uses their **reasonable mind** when they approach a situation intellectually. They plan and make decisions based off of fact.

The **wise mind** refers to a balance between the reasonable and emotional halves. They are able to recognize and respect their feelings, while responding to them in a rational manner.

The **emotional mind** is used when feelings control a person's thoughts and behavior. They might act impulsively with little regard for consequences.

Describe an experience you've had with each of the three states of mind.

Reasonable	
Emotional	
Wise	

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Why is Mindfulness Important?

► Ask: You're doing something fun. Are you more or less likely to enjoy yourself if you are being mindful?

- Will have more fun if you are paying attention, really "there" and fully participating in what you' re doing

► Ask: When you're doing something, are you likely to be successful and get it done the way you want if you are being mindful?

- Give example relevant to your group (e.g. homework, housework, job)

► Explore how mindfulness can help deal with Emotional Leftovers:

- You've had some really stressful experiences/trauma in the past and now you have a hard time trusting people. You're having a good time at a party with your boyfriend/girlfriend. However, you start to think that maybe he/she is flirting too much and can't be trusted. You get angry or upset or cold to them even though they were just talking to people and having a good time. These are your Emotional Leftovers.
- Mindfulness helps you focus on the present, what is happening now, so that you don't let leftovers from the past get in the way of what is going on right now.

► Ask: Has rn1yone ever made a decision that was driven by· Emotion Mind? ·

- E.g.: Mad because parents wouldn't extend curfew, so you stay out late anyway- even though you know it'll make things worse (e.g. get grounded)

► Ask: Has anyone ever made a decision that was driven by emotional leftovers?

- E.g.: Even though your boy/girlfriend is a pretty reasonable person, you lie to them about bumping into your ex, because afraid he/she will blow up at you the same way your father blows up at your mom.

► When you experience something stressful or upsetting, what are different ways to deal with it?

- Change it, numb out, ignore it, push it away, try to make it stop, tolerate it
- Generate a few specific examples
- What's wrong with avoiding mindlessly?
- Could make the situation worse Could put you in danger

- Can still affect you and you're less in control
- Feelings, stress may still come back

- By a/ways pushing away the feelings, you're actually keeping them around longer, and even making them stronger

►How can mindfulness help deal with stress or a problem?

- Observe what's stressing you [don't push them away), notice thoughts, feelings, reactions, la.be! them, step away from them so you can see more clearly,
- Gets you into Wise Mind
- Then you choose how to handle situation

► What if you think you're in Wise Mind, but you're not sure?

- Discuss how to tell whether or not you're in Wise Mind
- Ask yourself, are my emotions really intense?
- Intense emotions often a clue of Emotion Mind
- If the answer is "yes," wait till you're calmer- do a mindfulness activity
- Ask yourself, "Am I standing in the middle of both feeling and thinking?
- If the answer is "no", do a mindfulness activity
- Learning to be mindful, to focus, to breathe will help make the application of the modules be more effective. It is paramount to your success in reducing stress and coping.

Overview of MINDFULNESS (Wise Mind)
Using the What Skills:

- Observe
- Describe
- Participate

Using the How Skills:

- Non-judgmentally
- One-mindfully
- Effectively

Mindfulness Skills

Spending a lot of time in your head causes stress. There are always new things to worry about, conversations to rehearse, and activities to plan. Research tells us that when you live in the moment--that is, getting out of your head and being consciously aware of your surroundings--you will usually feel happier and experience less stress. With enough practice, you will learn to better control your thoughts and feelings. Below are some techniques to help you achieve this goal.

Mindful Activity

The goal of a *mindful activity* is to bring your thoughts into the present moment. To practice, first choose any activity where you notice your mind consistently wanders. This could be your commute home, while completing chores around the house, or just about anything else. Next time you do your chosen activity, attend to each of your senses. Below we use the example of going for a walk. It will be best to choose an activity you do regularly so you are sure to practice every day.

Vision	As you leave your home you immediately notice the bright blue sky, trees, and empty streets. As you pay closer attention you notice flowers along the sidewalk with a slight breeze causing them to tilt to their side every few moments.
Hearing	Each time the breeze passes, you can hear the leaves rustling in the wind. Occasionally, you hear the hum of a car passing on a nearby street. Birds are chirping somewhere up above.
Touch	You notice the warmth of the sun and the coolness of the breeze. With each step you feel your foot landing and then pushing off from the pavement.
Taste	You stop to pick up a coffee for your walk. You hold the drink in your mouth for a moment to savor the taste.
Smell	When the breeze floats by, you catch the smell of the flowers and the trees. As you continue your walk, you notice the smell of freshly cut grass by a neighboring home.

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Guided Body Scan

This guided body scan meditation is intended to help you enter a very deep state of relaxation. It is best if you can manage to stay awake throughout the entire exercise. It's important to remember to not try to relax. This will just create tension. What you'll be doing instead is becoming aware of each passing moment and just accepting what is happening within you, seeing it as it is. Let go of the tendency of wanting things to be different from how they are now and allow things to be exactly as you find them. Just watch the activity of your mind, letting go of judgmental and critical thoughts when they arise, and just doing what the exercise guides you to do as best you can.

Lie down in a warm and private place, dressed in loose and comfortable clothing at a time when you will not be interrupted. Closing your eyes, and letting your arms lie alongside your body, your feet falling away from each other and slowly bringing your attention to the fact that you are breathing. Not trying to control your breath in any way but simply experiencing it as the air moves in and out of your body and noticing your abdomen and feeling the sensations there as your breath comes into your body and your abdomen gently expands. Then noticing your belly deflate as the breath comes out of your body. And following the rhythmic movement of each breath…the rising of your belly on the inbreath and on each outbreath just letting go, letting your body become heavy as it sinks a little bit deeper into relaxation. Just bringing full attention to each breath in each moment.

Now bringing your attention to your feet, becoming aware of whatever sensations are there. If you are registering a blank as you tune in, then just experiencing nothing. And as you breathe in, imagine your breath moving all the way down to your feet and then when you reach your feet,

begin your outbreath and let it move all the way up your body and out your nose. So that you're breathing in from your nose and breathing out from your feet. And when you are ready, letting your feet dissolve in your mind's eye. Become aware of the shins and calf muscles and the sensations in the lower legs, not just on the surface but right down into the bones, experiencing and accepting what you feel here and breathing into it, then breathing out from it. Then letting go of your lower legs as you relax into the bed or mat. And moving now into the thighs and if there's any tension just noticing that. Breathing into and out from the thighs. Then letting your thighs dissolve and relax.

Shift your attention to your pelvis now. From one hip to the other. Noticing your buttocks in contact with the bed or the mat. And the sensations of contact and of weight. Becoming aware of the region of the genitals. And whatever sensations or lack of sensations you are experiencing. And directing your breath down into your pelvis, breathing with the entirety of your pelvis. And as you breath out, moving the breath back up through your body and out your nose, letting your pelvis soften and release all tension as you sink even deeper into a state of relaxed awareness and stillness. Totally present in each moment. Content to just be, and to just be right here as you are right now. Direct your attention now to your lower back. And just experiencing your back as it is. Letting your breath penetrate and move into every part of your lower back on the in-breath. And on the out-breath, just letting any tension, any tightness, any holding on just flow out as much as it will. And then letting go of your lower back. And moving up into your upper back now. Just feeling the sensations in your upper back. You may even feel your ribcage, in back as well as in front, expand on the in-breath. And any tightness, fatigue or discomfort in this part of your body, just letting them dissolve and move out with the outbreath as you let go and sink even deeper into stillness and relaxation.

And now shifting your attention to your belly again and experiencing the rising and falling of your belly as you breathe. Feeling the movements of your diaphragm, that umbrella-like muscle that separates your belly from your chest. And experiencing the chest as it expands on the in-breath and deflates on the out-breath. And if you can, tune into the rhythmic beating of your heart within your chest. Feeling it if you can. As well as the lungs expanding on either side of your heart. Just experiencing your chest, your belly, as you lie here…the muscles on the chest wall, the breasts, the entirety of the front of your body. And now just letting this region dissolve into relaxation as well.

Moving your attention now to your fingertips and to both hands together, just becoming aware of the sensations now in the tips of your fingers and thumbs where you may feel some pulsations from the blood flow, a dampness or a warmth or whatever you feel. Just feeling your fingers. And expand your awareness to include the palms of your hands and the backs of your hands and your wrists. And here again perhaps picking up the pulsations of the arteries in your wrists as the blood flows to and from your hands. And becoming aware as well of the forearms. And the elbows. Any and all sensations regardless of what they are. Allowing the field of your awareness to include now the upper arms. Right up to your shoulders. Just experiencing your shoulders and if there are any tensions, breathing into your shoulders and arms. And letting that tension dissolve as you breathe out. Letting go of the tension and letting go of your arms. All the way from your fingertips, right through to your shoulders. As you sink even deeper into a state of relaxed awareness. Just being present in each moment. Letting go of whatever thoughts come up or whatever impulses to move and just experiencing yourself in this moment.

And now focus your attention on your neck and throat and feel this part of your body, experiencing what it feels like perhaps when you swallow and when you breathe. And then letting it go. Letting it relax and dissolve in your mind's eye. Becoming aware of your face now. Focusing on the jaw and the chin, just experiencing them as they are.

Becoming aware of your lips and your mouth. And becoming aware of your cheeks now…and your nose, feeling the breath as it moves in and out at the nostrils. And be aware of your eyes. And the entire region around your eyes and eyelids. And if there's any tension, letting it leave as the breath leaves. And now the forehead, letting it soften to let go of stored emotions. And the temples. And if you sense any emotion associated with the tension or feelings in your face, just being aware of that. Breathing in and letting the face dissolve into relaxation and stillness. And now become aware of your ears, and back and top of your head. Now letting your whole face and head relax. For now, just letting it be as it is. Letting it be still and neutral. Relaxed and at peace.

Now letting your breath move through your entire body in whatever way feels natural for you. Through the entire length of your body. All of your muscles in a deep state of relaxation. And your mind simply aware of this energy, of this flow of breath. Experiencing your entire body breathing. Sinking deeper and deeper into a state of stillness and deep relaxation. Allow yourself to feel whole. In touch with your essential self in a realm of silence, of stillness, of peace. And seeing that this stillness is in itself healing. And allowing the world to be as it is beyond your personal fears and concerns. Beyond the tendencies of your mind to want everything to be a certain way. Seeing yourself as complete right now as you are. As totally awake right now.

As the exercise ends, bring your awareness back to your body again, feeling the whole of it. You may want to wiggle your toes and fingers. Allow this calmness and this centeredness to remain with you when you move. Congratulate yourself on having taken the time to nourish yourself in this way. And remember that this state of relaxation and clarity is accessible to you by simply paying attention to your breath in any moment, no matter what's happening in your day. Let your breath be a source of constant strength and energy for you.

Reference: Mindfulness Meditation, CD Series 1, Jon Kabat-Zinn

Appendix G: Distress Tolerance: Distract and Self Sooth

What Are Distress Tolerance Skills?

The distress tolerance skills are a set of tools that will help you manage intense emotional states without doing anything destructive.

Be aware that these skills will not necessarily wash away the emotional pain you are feeling or even make you feel less distressed. Instead, the goal of these skills is to prevent you from doing something that will make the situation worse.

These skills are best used when you are faced with a situation that you can't fix—there are many events in our life that we can't change, but that cause tremendous pain. In those situations, distress tolerance skills can be critically important.

Why Are Distress Tolerance Skills Important?

One of the most destructive symptoms of borderline personality disorder is impulsive behavior. Many people with BPD have problems with substance abuse, alcohol abuse, spending, reckless driving, physical violence, and impulsive sex.

In many cases, all of these impulsive behaviors are preceded by strong emotions. Here's how this works:

1. You have a strong emotion that is triggered by some event (e.g., rejection by a loved one.)
1. You feel and believe that the emotion is intolerable (e.g., "I cannot stand this feeling.")
2. You engage in an impulsive behavior in order to reduce the seemingly intolerable emotion (e.g., drink alcohol).
3. The behavior is reinforced because it works in the short term (e.g., you feel better temporarily).
1. Once the temporary effects of the impulsive behavior have worn off, you feel worse because: (a) the thing that was causing you to feel bad in the first place hasn't gone away, and (b) now you feel shameful about the impulsive behavior and its destructive consequences.

As you can see, impulsive behaviors are a pretty unhealthy way to deal with strong emotions, because while they sometimes "work" in the short-term (e.g., reduce distress), in the long term they actually make things worse. So, distress tolerance skills are an alternative to this cycle.

These skills help you get through the emotional pain without doing anything impulsive. In the long run, these skills lead to a healthier pattern and reduce emotional pain (because you are not engaging in so many destructive acts).

DISTRESS TOLERANCE
Using Crisis Survival: Distraction with Wise Mind Accepts

- **A** Activities
- **C** Contributing
- **C** Comparisons

- **E** Emotions - use opposite
- **P** Pushing Away
- **T** Thoughts
- **S** Sensations

Using Self Soothe with five senses:
- Taste
- Smell
- See
- Hear
- Touch

Using Improve the moment:

- **I** Imagery
- **M** Meaning
- **P** Prayer
- **R** Relaxation
- **O** One thing at a time
- **V** Vacation
- **E** Encouragement

Distress Tolerance Skills

Radical Acceptance

Sometimes you'll run into a problem that's simply out of your control. It can be easy to think "This isn't fair" or "I shouldn't have this problem", even though those ways of thinking only make the pain worse.

Radical acceptance refers to a healthier way of thinking during these situations. Instead of focusing on how you would like something to be different, you will recognize and accept the problem or situation as it is. Remember, accepting is not the same as liking or condoning something.

Learning to accept the problems that are out of your control will lead to less anxiety, anger, and sadness when dealing with them.

Situation	
You find out that you were not selected for a job where you felt that you were the best candidate.	
Typical Thinking	**Radical Acceptance**
"This isn't fair—I did everything right! I was the best one there. They can't do this to me."	"It's frustrating that I didn't get the job, but I accept that they felt someone else would be a better fit."

Self-Soothe with Senses

Find a pleasurable way to engage each of your five senses. Doing so will help to soothe your negative emotions.

Vision	Go for a walk somewhere nice and pay attention to the sights.
Hearing	Listen to something enjoyable such as music or nature.
Touch	Take a warm bath or get a massage.
Taste	Have a small treat—it doesn't have to be a full meal.
Smell	Find some flowers or spray a perfume or cologne you like.

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Distress Tolerance Skills

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Activity: Video Clip & Self-Soothe Practice

Before clip

► Have each member select 2 items using at least 2 senses, but don't actually take the items until after they watch the clip.

► Instruct members that they will practice self-soothing after watching a movie clip that might get their hearts racing a little. Remind them that they can monitor their pulse if they'd like.

► Watch a movie clip that people may find upsetting

- Clip should evoke moderate, but not extreme feelings of fear, anger, sadness
- Avoid triggering flashbacks - be cognizant of your movie choice (some members can be easily-triggered by even fairly mild material, whereas others may be emotionally detached from even the most extreme scenes)
- Movie possibilities include: Falling Down, Step Mom; Fatal Attraction; Cape Fear; Silence of the Lambs; Boyz·N the Hood; Bastard out of Carolina; The Outsiders
- If you are completely unable to use a film clip (i.e. have no access to a DVD or VCR), you can have members view distressing pictures (e.g. pictures of the aftermath of the Tsunami and Hurricane Katrina) for two minutes.

After viewing the clip:

► Ask: What were people feeling? Thinking? What happened? What do you think will happen next?

► Have them pick up and use the items that they chose earlier

- What do you feel? Where do you feel it in your body?
- What happened when you used self-soothe?
- What did you learn?

Tolerance: Self-Soothe

► Have them check in with themselves again and ask if they feel any different.

- Self-soothe may or may not make them feel better at this moment; learning a new skill takes practice.
- Using distress tolerance skills does not necessarily mean someone will feel "better." In some situations, it may stop people from doing something that they might regret or something that could make the situation worse-acting out of emotion mind.
- Remind them not to be judgmental if it doesn't help now

► Discuss self-soothe items group members used- which worked best, why, etc.

Appendix H: Trauma and Trust

What is trauma?

Trauma may be experienced from varying sources and occur in varying degrees. It may be from physical or sexual assault, emotional or verbal abuse, violence (in the community or home), from surviving a natural disaster, or from the loss of a loved one, to name a few. It may even stem from multiple sources.

►Type 1: Physical abuse:

- Actual or attempted infliction of physical pain with or without use of an object or weapon
- Severe punishment
- Any act, or failure to act, which results in death, serious physical or emotional harm, sexual abuse, or exploitation of a child.

►Type 2: Sexual abuse/coercion:

- Someone touches, does something to private parts when you don't want them to, explicit sexual discussions in inappropriate situations
- Body is private, you have the right to protect it.
- Explore group norms about expectations with boy/girlfriends around sexual activity and coercion.
- Is it okay for someone's partner to force them to have sex?
- What advice might you give to someone in that situation?
- Why is it difficult for some people to feel it's ok to say no or feel like they have a choice?

►Type 3: Emotional abuse:

- E.g., Calling people names, cursing at them, making verbal threats or threatening someone with a weapon, destroying people's things, punching walls to scare them

General Effects of Trauma

► Based on things we've discussed so far and what you know, how do you think trauma/abuse affects kids?

► How might kids, who have experienced some of the things we just talked about feel physically?

- Trouble sleeping or eating
- Get headaches or stomach-aches
- Fatigued

► How might they feel emotionally?

- Scared
- Angry
- Sad

- Confused

Seeking Support

► Your relationships can help you with stressful situations

► Ask a volunteer to think of a problem or stressful situation

- E.g., Argument with friend, brother/sister, problem with teacher, failed test, bad work review, heard bad news

► If you had this problem and were looking for support, ask yourself 2 things

- What kind of support might I want?
- Who might be able to help me with the problem or to just feel better?

► Group leaders should prepare to make 4 lists on the flip chart and write down 4 different headings entitled:

- Emotional Support
- "Hanging out"
- Information or feedback and advice
- Giving a Hand (This includes tangible support like money and less tangible things like help with. homework or giving you a ride.)

► Let's take this stressful situation (described previously)

- What might someone want from other people that might help him/her to cope with this situation? What might you or your friends think would be helpful if you were in this situation?

► As group members generate different ideas, group leaders should write the suggestions under the appropriate category heading (listed above) on the flip chart.

► Using group members' examples, briefly define/describe each of these categories to types of social support.

► How might someone figure out whom to ask for help or support?

► Make a list of who COULD be a good source of this support, even if you haven't relied on them before? What type of support could they give you (listed above)?

- These individuals/relationships make up POTENTIAL support network.
- Same person's initials that were listed in the first handout may be listed in different categories here because they might be able to give you a different kind of support.
- For example, your uncle may be a person who gives you a hand and emotional support but he might be a good source in the future for Advice and Information about a problem at school.
- Same person's initials may be listed in more than one category

- Explanations for the different types of support can be found in
- Keep in mind that these categories also describe ways that you can give support or help others-especially when you can't "fix" their problem for them!

Appendix I: LET'M GO

Point to each letter as you review what each one stands for:

When you're stressed, the key is to figure out:

- Why you were losing it, or close to losing it (L)- what triggered you or got you going?
- What were your emotions (E)- what were all the different things you were feeling at the time?
- What were you thinking (T)- what was going through your head?
- (M) stands for making meaning. What do we mean by that?
    - Figuring out what is important to you in this situation based on your values and beliefs.
        - Ex. You got into a fight because someone threated a friend. Loyalty is important to you.
    - Figuring out ways you have helped others
        - You wanted to help your friend by protecting her
    - Thinking about the connection between things you've survived in the past and the choices that you make now. Making sense of what you have been through and thinking about what it means to you.
        - You blame yourself for not protecting little brother during family fights- now you're the first one to start something if you think that someone you care about is treated unfairly

What are some examples of beliefs/values that are important to people? (Write group members' ideas on flip chart)

Listen for and add:

- Justice, Fairness, Equality, Democracy- Why is it that bad things happen to good people? Why is life unfair at times?
- Honesty, Being trustworthy
- Loyalty: To friends, family, community, country, etc.
- Freedom to make choices-being empowered
- Kindness & Helping others: Friends, family, animals, strangers
- Spirituality- higher power, religion, etc.

► Next step "L" Losing it

- Ask for an example of a situation where someone might Lose it
- Ask: What's upsetting about this? Is there a connection to the behavior and the past?
- After extreme stress, it's very common for people to carry around "Emotional Leftovers" that makes it hard for them when they are reminded of the things they have been through.
- Triggers from trauma are different from regular stress- instead of short-lived feelings, feelings that are caused by trauma triggers just won't go away
    - Emotional Leftovers can worsen stress reactions

  - Reaction gets worse because the brain's alarm system is not turning off ·
  - Sometimes the more you try to ignore or push away trauma reactions the worse they get

► Next, "E" Emotion:

- When upset, we feel lots of different emotions at the same time. It's hard to think clearly.
- First step, what you are feeling:
- Group brainstorms other feelings they might be experiencing in scenario provided.
- Discuss:
  - Many emotions might happen at the same time: e.g. anger might be the first reaction which is followed by fear, hurt and shame.
  - By using and practicing names for specific emotions, you can better understand what you're feeling. e.g. anger might be different from feelings of annoyance, irritability, resentment, or even intense rage.
  - Accurately labeling and understanding emotions can help you think more clearly and re-organize your brain-adjust the alarm

Identifying all of your thoughts-not just your first response

- will turn down the alarm system
- may give you more information, more choices
- will help you get what you want

► Next, "M" Make Meaning:

- Ask questions, to elicit what the group believes is most important for someone in this situation. Find out how this is driven by core values, needs and beliefs.
- Questions that correspond include:
  - What is most important to her in this situation? E.g.;
    - Trust
    - Independence
    - Respect
- Five years from now, what would be important?
- What contribution have you made to your own life, or to others? E.g.:
- How can you make sense of what happened? How might experiences with family, friends, caregivers, etc. be impacting the response to this situation?
  - E.g.: Makes it difficult to trust having experienced many situations when primary caretakers were unavailable

Practice LET'M GO with a Group Member

► Time permitting, go through LET'M GO as described with a group volunteer (second volunteer if appropriate) who is willing to discuss a somewhat stressful event/recent experience. Leaders and members help the volunteer identify each step in LET'M GO.

Appendix J: Labeling Triggers and Managing Emotions

Identifying Your Triggers

► Ask: What are triggers?

- Triggers are reminders of painful stuff from the past that can lead to upsetting memories and intense feelings such as fear or anger
  - Shouting in the hallway
  - Stomach ache (reminds him of the pain)
  - Thinking about what to have for lunch or feeling hungry

► Reactions to trauma triggers can include many different feelings (e.g., sadness, fear, frustration, anger, worry, feeling helpless, hopeless, etc.)

- People may feel more than one feeling at a time when reminded of painful things from the past

Triggers

Trigger: A stimulus—such as a person, place, situation, or thing—that contributes to an unwanted emotional or behavioral response.

The Problem

Describe the problem your triggers are contributing to. **What's the worst**-case scenario, if you are exposed to your triggers?

Trigger Categories

Just about *anything* can be a trigger. To begin exploring your own triggers, think about each of the categories listed below. Is there a specific emotion that acts as a trigger for you? How about a person or place? List your responses in the provided spaces.

Emotional State	
People	
Places	
Things	
Thoughts	
Activities / Situations	

Tips for Dealing with Triggers

- Oftentimes, the best way to deal with a trigger is to avoid it. This might mean making changes to your lifestyle, relationships, or daily routine.
- Create a strategy to deal with your triggers head on, just in case. Your strategy might include coping skills, a list of trusted people you can talk to, or rehearsed phrases to help you get out of a troublesome situation.
- Don't wait until the heat of the moment to test your coping strategy. *Practice!*

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Triggers

In this section, you will develop a plan for dealing with your three biggest triggers. Review your plan regularly, and practice each of the strategies.

Describe your three biggest triggers, in detail.

Trigger		
	#1	
	#2	
	#3	

Describe your strategy for *avoiding* or *reducing exposure* to each trigger.

Trigger		
	#1	
	#2	
	#3	

Describe your strategy for dealing with each trigger head on, when they cannot be avoided.

Trigger		
	#1	
	#2	
	#3	

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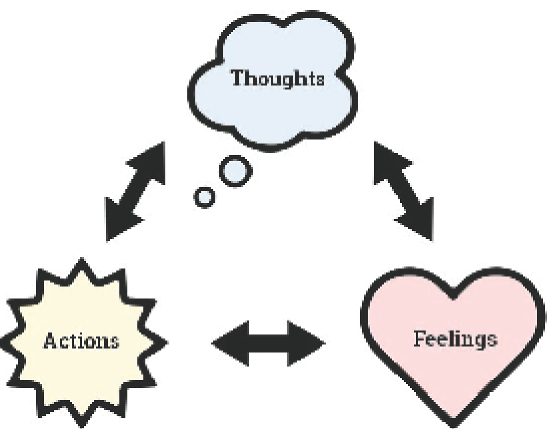
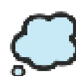
Thoughts Feelings Actions

Everyone has problems, both big and small. To better solve your big problems, it helps to learn how your **thoughts**, **feelings**, and **actions** are connected.

Imagine you have an upcoming test, and you think "I'm going to fail". Because of this thought, you start to worry. You are so worried that you feel sick just thinking about the test. Because it's so uncomfortable, you decide not to study.

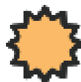
The thought ("I'm going to fail") led to a feeling (worry), which led to an action (not studying). What might have changed if you had a different thought?





Thoughts are the words that run through your mind. They're the things you tell yourself about what's going on around you. There are many different thoughts you could have about a single situation.

Feelings come and go as different things happen to you. You might feel happy, angry, and sad, all in one day. Some feelings are uncomfortable, but they are not bad. Everyone has these feelings from time-to-time.



Actions are the things you do, or the way you behave. Your thoughts and feelings have a big impact on how you act. If you feel happy, you are likely to do nice things. But if you feel angry, you might want to act mean.

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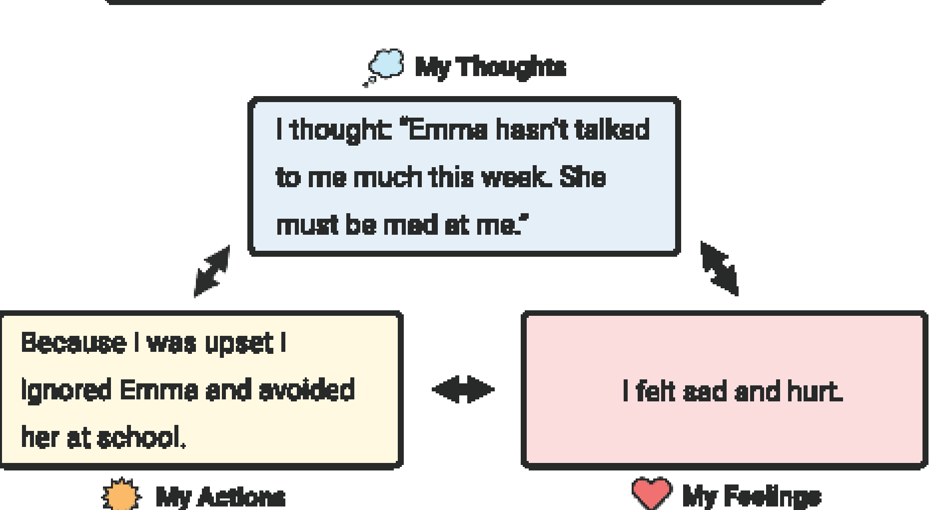
Thoughts Feelings Actions

What happened?
My friend Emma hasn't spoken to me as much as usual over the past week.



Just because you have a thought doesn't mean it's true. Your thoughts are guesses about why something happened, or about something that might happen. Coming up with new thoughts will help you see a situation differently.

	New Thoughts	New Feelings	New Actions
1	"Emma might be upset with me, but maybe not. I don't know."	Concerned that Emma *might* be upset, but I'm not as sad as I was.	Ask Emma if she is mad at me, or if she has another problem.
2	"Emma has probably been busy with school or something else."	Disappointed I haven't talked to Emma, but understanding.	I'll stay friendly with Emma, as usual. I'll be sure to say "hi" anyway.
3	"Maybe Emma is upset about something unrelated to me."	Worried about how Emma is feeling.	Ask Emma what's going on, and if she needs help.

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Thoughts Feelings Actions

	New Thoughts	New Feelings	New Actions
1			
2			
3			

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Appendix K: Mind Body Connection

Activity: Reading Body Messages

► Leader draws a simple outline of a gender-neutral figure (like a gingerbread man) onto Handout [or, may also use flipchart/blackboard to draw large outline)

► Place the handout on a flipchart and have everyone take turns describing where people feel different emotions in their body.

► Leaders color suggestions onto handout. Or, if. time allows, as members offer suggestions for where they feel emotions, ask them to come up to the chart and color in the emotion where they usually feel it.

- Use colors to show where in their bodies members experience different emotions.
    - Angry (red)
    - Sad (blue)
    - Happy (yellow)
    - Scared (black)
    - Nervous (orange)
    - Guilty (brown)
    - Jealous (green)
    - Pain (pink)
    - Calm (light blue)
    - Excited (purple))

At a minimum, include red (angry), blue (sad), yellow (happy), black (scared), and orange (nervous)

► Ask probing questions to help participants focus on task

- Think of a situation in which you have had these feelings: anger, sadness, happiness, fear, anxiety, etc.
- Ask: What clues does your body give you when you have these feelings?
- Ask: What do the clues feel like?
- Ask: Where do you feel them?
- Ask: How do you know when you're angry?
- Ask: Where do you feel happiness? Nervousness? Etc.

►Discover your road to recovery with your body

Art therapy: Have members draw an outline of a body on a sheet of paper. Members will then use markers, crayons, paint, etc. to express ways they can begin to listen to the voice of their bodies. Members can include self-care ideas, areas to pay particular attention to, highlight areas they feel positively about, etc.