Good Practice Briefing

Empowering and creative techniques to enhance therapeutic engagement

April 2011

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Introduction

Sharing Our Strengths

WRC and Women and Girls' Network (WGN) have been funded by London Councils to deliver a four-year project, Sharing Our Strengths, aimed at providing second tier support to London's violence against women and children sector through the sharing of knowledge, skills and good practice and the facilitation of networking and partnerships. The project will run from February 2009 to March 2013.

This support is primarily available free of charge to organisations funded under the London Councils specifications which cover violence against women and children (43, 59, 60, 61 & 63, 62, 65, 69, 70 and 72).

What support does the project provide?

The support will come in a number of forms:

1. Accredited training for frontline workers
2. Professional exchange seminars
3. Good practice briefings and template policies
4. Training and 1-1 support on monitoring and evaluation and infrastructure issues
5. Monthly email newsletter - email ellen@wrc.org.uk to subscribe
6. 6-monthly discussion and networking meetings for funded organisations
7. Membership of WRC's online women's sector network
8. Quality assurance guide

For more information, please see www.wrc.org.uk/sharingourstrengths

Professional Exchange Seminars

WGN and WRC are providing a programme of Professional Exchange Seminars (PES) as part of the Sharing Our Strengths project. The seminars will bring together practitioners to discuss and explore issues relating to best practice around violence against women (VAW). The seminars aim to help develop a multi-disciplinary community of shared learning, knowledge and practice by promoting and encouraging professional networking. From each PES a good practice briefing will be written which not only serves as an event report, but also as a resource for those working in the sector

Empowering and Creative Techniques to Enhance Therapeutic Engagement

The seminar on Empowering and Creative Techniques to Enhance Therapeutic Engagement (held in October 2010) aimed to provide a context to understand the complexities of women's responses to gender based violence. The workshop introduced participants to Complex Traumatic Stress Disorder and the neuroscience of the trauma cycle as a means to contextualise the life alteration, impact and legacy of experiences of violence.

The workshop focused on strengths based therapeutic interventions to work holistically with mind, body and spirit, using cognitive, behavioural and creative exercises. It explored current theories regarding women's recovery referring to concepts such as empowerment, resilience, post traumatic growth and signature strengths. The workshop aimed to provide participants with a range of techniques and strategies to ensure clients are supported to engage with their experiences of trauma incorporating holistic and creative processes.

This Good Practice Briefing

This briefing is designed to give an overview of the theory and practice covered in the seminar and is aimed at those working on the front line with women who have experienced violence.

If you are interested in an in-depth training courses on these issues, please see the WRC website for details of the accredited training programme delivered by WGN, ***Counselling and Therapeutic Interventions for Working with Women Overcoming Experiences of Violence: A Multicultural and Feminist Approach:*** www.wrc.org.uk/accreditedtraining

For more information on the work of WGN: www.wgn.org.uk

For more information on this briefing, the above training course or for general enquiries, please contact:

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Complex Traumatic Stress Disorder

Complex Traumatic Stress Disorder (CTSD) was first described by Judith Lewis Herman, in her ground breaking book Trauma and Recovery (1994). A core component of CTSD is the psychological injury due to the following conditions:

- prolonged exposure to trauma
- multiple types of traumatic experiences
- lack or loss of control
- disempowerment within a context of either captivity or entrapment

In contrast, post traumatic stress disorder (PTSD) typically develops from exposure to a single traumatic event and fails to capture some of the core characteristics of CTSD i.e. the pervasiveness, multiple, repetitive traumas, and acutely high levels of chronic stress. CTSD describes the spectrum of symptoms related to experiences of captivity and psychological fragmentation, including:

- loss of a sense of safety, trust and self-worth
- re-victimisation
- loss of a coherent sense of self and personal agency

Who is most likely to experience CTSD?

Women with a history of subjection to totalitarian control over a prolonged period (months to years) who are trapped and unable to flee. Examples include survivors of:

- domestic violence
- childhood physical or sexual abuse
- prostitution
- organized sexual exploitation

Other examples include hostages, prisoners of war, concentration-camp survivors, and survivors of some religious cults.

Symptoms / effects of CTSD

Six clusters of symptoms meet the diagnosis for CTSD.

1. <u>Alterations in affect regulation, including:</u>

   - persistent dysphoria[1]
   - chronic suicidal preoccupation
   - self-injury
   - explosive or extremely inhibited anger (may alternate)
   - compulsive or extremely inhibited sexuality (may alternate)

[1] Dysphoria is an unpleasant or uncomfortable mood, such as sadness (depressed mood), anxiety, irritability, or restlessness

2. Alterations in consciousness, including:

   - amnesia or hypermnesia[2] for traumatic events
   - transient dissociative episodes
   - depersonalization/derealization
   - reliving experiences, either in the form of intrusive post-traumatic stress disorder symptoms or in the form of ruminative preoccupation

3. Alterations in self-perception, including:

   - sense of helplessness or paralysis of initiative
   - shame, guilt, and self-blame
   - sense of defilement or stigma
   - sense of complete difference from others (may include sense of specialness, utter aloneness, belief no other person can understand, or nonhuman identity)

4. Alterations in perception of perpetrator, including:

   - preoccupation with relationship with perpetrator (includes preoccupation with revenge)
   - unrealistic attribution of total power to perpetrator
   - idealization or paradoxical gratitude
   - sense of special or supernatural relationship
   - acceptance of belief system or rationalizations of perpetrator

5. Alterations in relations with others, including:

   - isolation and withdrawal
   - disruption in intimate relationships
   - repeated search for rescuer (may alternate with isolation and withdrawal)
   - persistent distrust
   - repeated failures of self-protection

6. Alterations in systems of meaning:

   - loss of sustaining faith
   - sense of hopelessness and despair

Psychological effects

- Major depressive illness
- Suicidal ideation
- Memory loss
- Dissociation
- Self harm
- Substance misuse
- Sleep disturbances
- Eating problems

[2] Exceptionally exact or vivid memory

- Aggressiveness
- Anxiety
- Phobias
- Lack of confidence / self esteem

Long term damage

- Neurological damage from brain injuries
- Eye / sight problems
- Kidney damage
- Liver damage
- Immune system disorders
- Coronary disease
- Cancer
- Repeat victimisation
- Intergenerational violence
- Enduring mental health problems
- Changes in identity
- Early onset dementia
- Mortality rate drastically compromised potentially by 10- 15 years

The Neuroscience of Trauma

Old brain

The old brain has evolved over millions of years. It is motivated to seek safety, food, shelter and social interaction. It is associated with the following:

- *Emotions* – anger, anxiety, sadness, joy and lust
- *Behaviours* – fight/ flight, stop, withdraw and engage
- *Relationships*- sex, power, status, attachment and tribalism
- *Archetypes* – social mentalities, care seeking – children seek out protection and care providing
- Co operation
- Competition
- Sexuality

Its processing systems are innate, fast, involuntary, hard to verbalise, part of the emotional memory and specific.

New Brain

Two million years ago there was a genetic shift with the development and creation of cerebral cortex and most importantly frontal lobes which enabled:

- Imagination
- Planning
- Ruminations
- Integration of mental abilities

Processing systems are; evolved, slow, reflective, easy to verbalise, engages with cognitive competencies, learns social rules, is a slower and voluntary system.

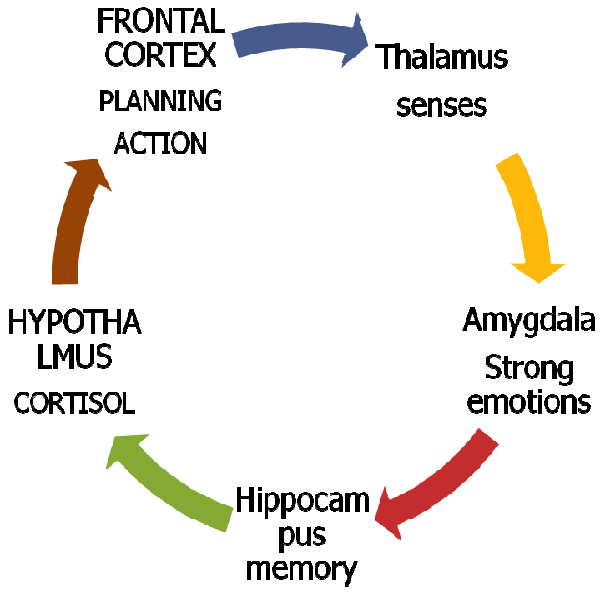
All humans are high wired for self protection and over millions of years, humans have developed a number of super fast early danger detector systems. Survival is not dependent on thinking, but on getting out of the way.

Defensive Protective Behaviours – Flight, fight, freeze

- Stop – Hyper alert
- Hyper vigilance – early warning system predicts threat
- Flight – escape and prevent exposure to danger
- Fight – protect self by subduing threat or deter danger by exerting control over threat
- Hiding and camouflage
- Tonic immobility[3] freeze, play dead
- Cut off turn away from danger
- Demobilisation short term dissociation, long term submission

[3] Tonic immobility is a natural state of paralysis that animals enter when presented with a threat

Trauma Pathway



When the normal system for processing and responding to life is overwhelmed by powerful emotions such as those associated with violence and trauma i.e. terror and horror. The processing system becomes disorganised and disconnected at every single juncture. It is the alternating deactivation and hyper activation of the processing systems that creates the symptoms associated with PTSD and CTSD.

Aftermath

> *"The imprint of the trauma is in our animal brains not our thinking brains"*
> Bessel van der Kolk

After trauma, a number of different parts of the brain are affected, each with its own consequences.

The **amygdala** is often referred to as the smoke detector, as it has an incredibly fast response. It can be activated in 7 milliseconds and is primarily focused on threats to safety. In trauma responses the amygdala takes over brain functioning and causes the frontal lobes to shut down, inhibiting cognitive processing which are necessary for planning and action. The hippocampus (responsible for the storage and retrieval of factual, explicit memories) becomes either inhibited or hyper aroused. This creates either a dissociative state or an inability to forget.

The amygdala also has a memory function connected to frightening body experiences and when the amygdala is activated memories become frozen in time (without conscious awareness) and the past can be constantly experienced.

The **Broca's area**, located on the left side of the brain, is responsible for putting experiences into words and this area becomes inhibited and means that the individual is unable to verbalise their experiences.

The **hypothalamus** (responsible for the release of stress hormones) is constantly stimulated by the amygdala transmitting distress signals. The hypothalamus responds by releasing stress hormones such as adrenaline and cortisol causing heart palpitations and sweaty and shaky responses.

Finally, the **basal ganglion**, located in the cerebellum is connected to movement and how we engage with the world. After experiencing trauma, this becomes inhibited, leading to physical paralysis. Over time, the lack of physical movement becomes a psychological inertia characterised by an inability to move out of danger and contributes to women becoming trapped in violent relationships.

Individuals are left with an oscillation between hyper arousal, with symptoms such as:

- flashbacks
- hyper vigilance
- feeling unsafe, overwhelmed and angry

These symptoms are often followed by hypo arousal, which is characterised by feelings of numbness, shame and sadness, as well as dissociation and depression.

Once this system (i.e. the different parts of the brain listed above) is activated, the competing emotions and behaviours create conflicts and the brain becomes confused, overloaded and fragmented. The individual is left in a confused state, unable to identify or verbalise how they are feeling. At times, an individual will feel everything at once, i.e. sad, angry and anxious. These multiple reactions can switch the system into emotional paralysis, leaving the woman feeling only numb. This is compounded by environmental situations that create incompatible decisions, i.e. choosing one violates another and disorganises the system and leads to paralysis. For example, in cases of domestic violence where there is a dilemma associated with the decision to leave or stay with the perpetrator, the old brain drives towards attachment, trust and the social conditioning of staying with partner, whereas the new brain thinks logically about safety and leaving. This is a classic head vs. heart dilemma - both choices have equal validity and therefore women often choose neither and take no action.

Empowerment

Definition of empowerment

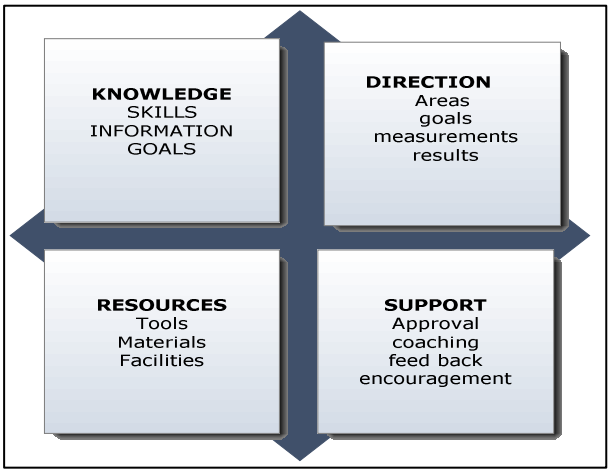
Since the early 1990s practitioners have been looking at the concept of empowerment to aid and increase a client's recovery from trauma.

- Helping individuals, families and communities to discover and use the resources and tools within and around them[4]
- The goal of empowerment is to cultivate an individual's awareness of oppressive tensions and conflicts in their lives, to help them find ways to be free of these constraints[5]
- Psychological empowerment as a cognitive state characterised by a sense of perceived control and perceptions of competence[6]

Therapists focus on empowering clients to help them gain mastery and control over issues which are causing instability. Simon[7] suggests that empowerment is based on five important principles.

- Collaborating with clients
- Expanding clients' strengths and capacities
- Focusing on individuals in the context of their environment, family and community
- Assuming that clients are active agents
- Focus on the historically oppressed and disenfranchised

WGN Empowerment Model



Central to all therapeutic work is the client's activity and the aim is to provide clients with opportunities to develop and practise skills that allow control and increase competence. As a result, clients become more self-reliant and self-governing, and less reliant on and controlled by external forces. These goals are achieved by encouraging health, adaption, and competence rather than deficiency

[4] Kaplan, L., & Girard, J. *Strengthening high-risk families: A handbook for practitioners.*, New York: Lexington Books (1994)
[5] Pinderhughes, E., *Empowerment as an intervention goal: Early ideas*, in L.Guitérrez & P. Nurius (Eds.), *Education and research for empowerment practice* (pp. 17-30). Seattle, WA: Center for Policy and Practice Research (1994).
[6] Menon, Sanjay T, *Psychological empowerment: Definition, measurement, and validation*, Canadian Journal of Behavioural Science/Revue canadienne des sciences du comportement, Vol 31(3), Jul 1999, 161-164
[7] Simon, B., *The empowerment tradition in American social work: a history*, Columbia University Press (1994)

and by focusing on wellness rather than illness. Additionally, it is vital that therapists acknowledge the influence of oppression and the barriers that this creates [89]

- **Self –efficacy** is a belief in one's ability to successfully perform desired behaviours in specific contexts
- **Mastery** is the belief that one can act on one's environment and achieve a desired outcome
- When clients perceive themselves as capable of becoming **agents for change in charge of individual destiny**, then they can act upon the environment to achieve a realistic outcome
- **Control** allows the client to take actions that prevent potentially harmful situations and solve problems. It motivates the clients to gain knowledge about what limits and reduces their empowerment

By offering survivors choice, control, empathy and respect, therapy can repair and restore the negative aspect of the traumatic experience and facilitate healing and empowerment.

Working with the 4 S's

"Trauma cannot be destroyed but it can be dissolved in a sea of resourcefulness'"

1. Safety - the restoration of control

Abraham Maslow presented the following hierarchy of human needs:

1. physiological
2. safety
3. security
4. social
5. self esteem
6. self actualisation

See http://en.wikipedia.org/wiki/Maslow's_hierarchy_of_needs

The effect of violence is essentially the forced loss of control and power. It is vital that a woman reclaims a sense of control and power; this ideally should be begun as early on as possible in the healing process. Survivors usually feel unsafe about their emotions, perceptions of the world, their bodies or other people. When discussing issues related to safety with clients, it is important to identify potential threats and the differing levels of safety/danger associated with them. When first interacting with a client, the process should begin with taking time to:

- Orientate women to your work and role
- Introduce yourself and how you work
- Establish boundaries and create comfort zone

[8] Ibid
[9] Zimmerman, M. A. & Warschausky, S., *Empowerment theory for rehabilitation research: Conceptual and methodological issues*, Rehabilitation Psychology, 43 (1998), 3-16

- Explain the limitations of your role i.e. confidentiality
- Mobilise other support networks

The work should initially be directed at establishing internal safety (i.e. within the woman), and then extended to external safety (i.e. to include the environment). The work is difficult and stressful and we need to ensure that women are sufficiently safe and grounded in order to do the work and not to recreate devastation without any internal support.

Internal Safety

- Basic health needs i.e. healthy patterns of sleeping, eating and exercise
- Management of PTSD symptoms i.e. grounding exercises
- Control of self-destructive behaviours
- Self care / self soothing strategies
- Re-establishing a safe living environment i.e. cleansing or other
- Self-protection plan / programme e.g. reporting to the police

External safety

- Creation of a safe refuge
- Support with the evaluation of relationships - assessing for potential source of protection, emotional support, practical help and also potential sources of danger
- Allowing people she can trust to come into her world
- Identification of what she needs from her support network
- Choices and sacrifices for freedom

This work will reassure and empower the woman about her ability to take care of herself. It will have ensured that she has a sense of control over the most disturbing symptoms and enabled her to identify who she can rely on for support. If this work has been successful, the woman will have reclaimed a sense of trust in both herself and others.

2. Stabilisation

A common reaction to PTSD and CTSD is deregulation of affect due to the brain operating from the limbic system and hotwired to only detect threat. The lack of influence and activity from the cerebral cortex means that women are unable to regulate the intensity of their feelings or implement adequate problem solving behaviour to manage emotions. Women can become trapped in a vicious cycle of hyper arousal involving flashbacks which in turn evokes self harming behaviour in an effort to override the intrusive thoughts.

The focus of the work needs to be the following:

- Psycho- educational work
- Establishment of a secure internal / external base
- Re-activation of the thalamus – 5,4,3,2,1 (see appendix) and creation of a comfort kit

- Grounding exercises – safe place (see appendix)
- Relaxation exercises – breathing techniques
- Development of dual awareness
- De – activation of the amygdala

3. Self-Soothing

Early childhood trauma changes the neurology of children and prolonged trauma decreases neurological ability to switch off hyper arousal. This means that for some clients, self-soothing capacities have either never been developed or have been lost and overwhelmed by trauma activation.

The innate healthy self-soothing capacity has to be re-learnt through the development of various techniques to ensure decreased arousal, pleasant sensations, to create a calming effect. Ideally, they should have the three following characteristics, slow, gentle, or rhythmical speed or movement, soft in texture, tone or hue, quiet in volume. Examples of self-soothing techniques include:

- guided visualisations
- meditation
- safe place (see appendix)
- breathing exercises
- calming self-talk
- positive sensations such as warm baths, showers, food, hot drinks
- gentle calming music
- yoga and stretching.

Resource Development: techniques that combine stabilisation and self-soothing

These are cognitive activities that have to be practised but are designed to have a calming effect.

- Positive self-imagery
- Resource person / guardian
- Rainy day letter (see appendix)
- Energy bubble/ shield

4. Self-care

Self-care activities tend to be more external and physical, they can test endurance and strength, offer a sense of accomplishment, and ultimately increase self-esteem. Many women benefit from activities that give them a break from their trauma requiring concentration and attention. For example, physical exercise, sports, dance, gardening, painting, music, computer games, solitaire.

Further Reading

Babette Rothschild: http://home.webuniverse.net/babette/

Bessel van der Kolk: http://www.traumacenter.org/about/about_bessel.php
Bruce Perry: http://en.wikipedia.org/wiki/Bruce_D._Perry
Judith Lewis Herman: http://en.wikipedia.org/wiki/Judith_Lewis_Herman
Pat Ogden: http://www.sensorimotorpsychotherapy.org/home/index.html

Post traumatic growth

The emergence of post traumatic growth (PTG) is connected to a much larger movement of positive psychology pioneered by the work of Martin Seligman. When addressing a psychiatrist's conference in 1999, Seligman challenged the established convention on psychiatric disorders in terms of the deficiency model which he suggested over emphasises psychopathology, focusing on what is wrong, as opposed to also considering what is healthy. Seligman concluded that normality, abnormality, sickness and health form part of a continuum of experience and are not the polarised dichotomies of wellness vs. illness of the traditionalist perspectives.

Seilgmans's conceptualisation was to provide a catalyst for a completely different perspective on the negative effects of trauma supported by a growing body of literature exploring growth following adversity.

The seminal research was provided by Tedischi & Calhouns[10] and resulted in the development of the following PTG model; the initial response to trauma is characterised by unmanageable distress and this triggers a rumination process leading to an initial stage of growth. There is a final stage of further growth accumulating in the development of wisdom. As a concept, PTG is regarded as a process and an outcome which means that people are not only able to bounce back but also grow.

Tedeschi, Park & Calhoun[11] describe this process as not merely surviving but rather transforming the traumatic experience so that in some ways it becomes beneficial. McMillen, Rideout & Zuravin[12] reveal that 49% of women who suffered child sexual abuse (CSA) reported positive outcomes (although 88% of them also reported a negative impact on their lives). Frazier, Conlon & Glaser [13], in a longitudinal study of rape survivors, found that 80% of women reported empathy for other victims of rape, an improvement in family relations, a greater appreciation of life and an ability to recognise their strengths. Frazier & Berman[14] discovered that 3 days post rape 57% of women reported positive change. Further, 91% reported at least one positive change two weeks post assault. The

[10] Tedeschi, R.G., & Calhoun, L.G., *Trauma and transformation: Growing in the aftermath of suffering*. Thousand Oaks, CA: Sage (1995)
[11] Tedeschi, R.G., Park, C.L., & Calhoun L.G., *Posttraumatic growth; Conceptual issues*, in R.G. Tedeschi, C.L. Park, & L.G. Calhoun (Eds.), *Posttraumatic growth: Positive changes in the aftermath of crisis* (pp. 1-22). Mahwah, NJ: Lawrence Erlbaum Associates, Publishers (1998)
[12] McMillen, J.C., Zuravin, S., & Rideout, G., *Perceived benefit from child abuse*, Journal of Consulting and Clinical Psychology, 63 (1995), 1037-1043
[13] Frazier, P., Conlon, A., & Glaser, T. (2001), *Positive and negative life changes following sexual assault,* Journal of Consulting and Clinical Psychology, 69, 1048–1055
[14] Frazier PA, Berman MI. *Posttraumatic growth following sexual assault*, in Joseph, Stephen; Linley, P. Alex, (Eds.) *Trauma Recovery and Growth. Positive Psychological Perspectives on Posttraumatic Stress* (2008), pp 161- 181

most common reaction reported was an improvement in relationships and an appreciation for life post trauma recovery.

The following are some of the positive changes reported:

- Increased perception of competence and self-reliance
- Greater acceptance of one's vulnerability and negative emotional experiences
- Improved relationships with significant others
- More compassion and empathy for others
- Increased effort to improve relationships
- Greater appreciation of own existence
- Greater appreciation for life
- Positive changes in one's priorities
- Increased religious/spiritual beliefs

Resilience

Resilience is a universal concept and it describes the positive capacity of people to cope with stress, trauma and catastrophes. It is a dynamic process whereby individuals adapt and respond positively to adverse conditions. The following are a number of the key factors that promote resilience:

- The ability to cope with stress effectively and in a healthy manner
- Good problem-solving skills
- Patience and optimism
- Seeking help
- Belief that there is something one can do to manage feelings and cope
- Social support
- Connection with others e.g. family or friends
- Self-disclosure of trauma to loved ones
- Spirituality
- Positive identity as a survivor as opposed to a victim
- Helping others
- Finding positive meaning in the trauma
- Self-efficacy
- Sense of honour
- Strong self esteem
- Action orientated approach
- Ability to perceive the strengthening effects of stress
- Ability to adapt to change
- Ability to use past success to confront current challenge

Triumph over trauma

- Resourcing enables someone to overcome crisis
- Acceptance
- Affirming actions
- Reestablishment of community

- Creating new beliefs
- Understanding of the wider life picture and appreciation of ebbs and flows of life
- Restoration of normality
- Sense of hope
- Future focused
- PTSD growth and new sense of purpose

Signature Strengths

Seligman has interviewed people from around the world and identified the universal personality traits (virtues and signature strengths).

Seligman's universal 6 virtues and 24 signature strengths

1. Wisdom

- Curiosity in the world
- Love of learning
- Creativity
- Judgement, critical thinking and open-mindedness
- Ingenuity, originality, practical intelligence
- Social intelligence, personal intelligence, emotional intelligence
- Perspective

2. Courage

- Valour and bravery
- Perseverance, industry and diligence
- Integrity, genuineness, honesty

3. Humanity and Love

- Kindness and generosity
- Loving and allowing oneself to be loved

4. Justice

- Fairness and equity
- Leadership
- Teamwork

5. Temperance

- Self-control
- Prudence, discretion, caution
- Humility and modesty

6. Transcendence

- Appreciation of beauty and excellence
- Gratitude
- Hope, optimism and future-mindedness
- Spirituality, sense of purpose, faith, religiousness
- Forgiveness and mercy
- Playfulness and humour

- Zest, passion and enthusiasm

How to work with signature strengths

1. Identify strengths
2. Acknowledge and practise strengths – this naturally lifts moods
3. Ask - what do you do that enables you to be more courageous?
4. Ask - how do you demonstrate this?
5. Focus on these strengths

Appendix

Glossary

Amygdala: a part of the brain which performs a primary role in the processing and memory of emotional reactions. It is part of the limbic system.

Limbic system: a set of brain structures including the hippocampus, amygdala, limbic cortex and fornix, which seemingly support a variety of functions including emotion, behaviour and long term memory.

Broca's area: a region of the brain with functions linked to speech production.

Thalamus : a portion of the brain relating to relaying sensation, spatial sense, and motor signals to the cerebral cortex, along with the regulation of consciousness, sleep, and alertness.

Hippocampus: part of the brain which belongs to the limbic system and plays important roles in the consolidation of information from short-term memory to long-term memory and spatial navigation.

Specific Techniques

Safe Place

The purpose of this exercise is for a client to be able to go to this place automatically when they are feeling less able to cope. Ask a client to think of things that comfort them; things that make them feel good and to form a picture in their mind of these things. They can also think of a place where you can go to get away – for example, a desert island, the top of a mountain with a panoramic view or a forest glade. The idea is for a client to get so familiar with this place that they can get there easily. Ask them to imagine smells, noises, everything and get it cemented in their mind so that they can go there often to remain calm and relaxed.

5, 4, 3, 2, 1

If a client is experiencing flashbacks, it is important to try and ground them in the present where possible. This exercise can help to ground the client.

Ask the client to focus on an object in front of them and to say "I see" and name the object. Ask the client to do this until they have named five things that they can see.

Ask the client to focus on the sounds around them and to say the words "I hear" and name something they hear. Ask the client to do this until they have named five things that they can hear.

Ask the client to focus on what they can touch and to say the words "I feel" and name something they can touch and feel. Ask the client to do this until they have named five things that they can feel.

This completes one cycle. You can then ask the client to make one change: instead of doing five statements again, do four statements relating to each sense. Then, in the next cycle, do three statements. Then, in the next cycle, do two statements. Then, in the final cycle, do one statement.

Rainy Day Letter

Some people find it helpful, when they're feeling well and able to cope with daily life, to write a letter to themselves, which they can read when they're not feeling good, or are struggling to cope. The well, stable and strong person, writes a letter to the more vulnerable person. Encourage your clients to write such a letter to themselves when they are in a good place and at the same time encourage them to read the letter when things are more difficult.

Examples of what to include in the letter:

- What helps the client feel better during difficult times
- What the client has found helpful in the past
- Guidance on what the client needs to do (e.g. talk to someone, do something, be with others)
- Advice on what not to do (from experience)
- Reinforce personal strengths and resources
- What you need to know at that time

Overall, encourage your client to be compassionate, caring, supportive, understanding and encouraging to their vulnerable self.