

WOMEN HEALING FROM TRAUMA: A FACILITATOR'S GUIDE

A Research Practicum Report

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Abstract

Women who have complex trauma often experience problems in acquiring necessary resources and supports needed to manage their symptoms. It is important that all women who are experiencing complex trauma be given the opportunity to acquire information and build skills to deal with the negative effects of trauma.

There is a lack of resources and community supports specifically developed for women experiencing complex trauma. Consequently, I created a group curriculum for the Provincial Association of Transition Houses and Services of Saskatchewan (PATHS) based on best practices that can be utilized to help women with complex trauma. After completing a literature review of research and programs on complex post-traumatic stress disorder, I developed a facilitator's guide entitled *Women Healing from Trauma: A Facilitator's Guide*. It is intended to be a user-friendly compilation of best practices in complex trauma. This guide contains clear and concise lesson plans for facilitators for each session of a 10-week group program.

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Introduction

The purpose of my research practicum was to develop best practice, trauma-informed group sessions for women with multifaceted problems and complex trauma. A traumatic response occurs when the protective survival instinct of fight, flight, or freeze is unsuccessful, leaving a person without the ability to resist or escape from the traumatic event (Courtois, 2004; Herman, 2015). The symptoms of post-traumatic stress disorder (PTSD) include re-experiencing, numbing and avoiding, and hyperarousal (Lonegan, 2014). When traumatic events occur repeatedly and over a long period of time, it is considered complex post-traumatic symptom disorder (CPTSD) (Courtois, 2004; Lonegan, 2014). Complex trauma is a result of traumatic events that occurred over a long period of time on a repeated basis and for women the effects are often compounded by the fact that the traumatic events are committed by people with whom the women have a close relationship. When the complex trauma is a result of domestic violence, sexual exploitation, childhood sexual abuse, or when the perpetrator has a close relationship with the victim, the trauma is considerably more complicated and requires a different therapeutic approach. Complex trauma occurring in the domestic domain can significantly affect an individual's worldview, emotional regulation, self-perception, and ability to experience healthy relationships (Courtois, 2004; Herman, 2015). Due to societal socialization patterns and deeply held belief systems, women are more likely than men to be the victims of violence in the domestic sphere and are more vulnerable to sexual exploitation (Brown, 1991; Russell & Radford, 1996). Therefore, women tend to experience complex trauma differently and more often than men (Herman, 2015). Therapeutic interventions that focus on complex trauma need to recognize the particular requirements of women (Courtois, 2004).

At present, there are limited resources available to marginalized women experiencing CPTSD as a result of relational violence. Marginalized women are those who are excluded from

conventional social, economic, cultural, and political life. Marginalized women who use homeless shelters have difficulty accessing services and supports because they are powerless and voiceless in society: whereas the needs of these women are immense and their demands for services great (Jenson, 2000). Unfortunately, this population often has access only to organizations with limited resources and are therefore unable to find adequate supports (Tseris, 2013). In Regina, such organizations are YWCA, North Central Family Centre, Street Worker's Advocacy Project, and Alcohol and Drug Services through Qu'Appelle Health Region. *Women Healing from Trauma: A Facilitator's Guide (The Guide)* was written to serve as an aid for professionals who work with women with CPTSD in the first phase of healing. This manual is a separate document from the research practicum report. It gathers best practice materials to develop a program that can support healing and empowerment.

Background

One of my current responsibilities at YWCA's My Aunt's Place, a women's homeless shelter, was to facilitate groups for women. During one group meeting, while the women were discussing self-soothing techniques, a woman recognized that she could utilize some of the skills taught when she experienced panic attacks. She proceeded to describe her experiences. Other women participating in the group became excited because they identified with her and had had similar experiences and symptoms of panic attacks. It became apparent from this discussion that the women were unaware of trauma and techniques that could be used to minimize their suffering. During the group sessions the women acknowledged that they felt alone and confused by their experiences. In response, we discussed panic attacks and some techniques that could be used to relieve symptoms, but more importantly, the women learned that they were not alone or abnormal. As a result of this experience, I determined that my master's research practicum would be to create a group for women struggling with complex trauma.

Many of the women accessing support from the YWCA's My Aunt's Place have been repeatedly victimized both as children and as adults. They have often been involved in a series of abusive relationships, addicted to alcohol or drugs, lived on the street, and had a history of child protection involvement both as children and as mothers. Many of the women have also experienced homelessness, poverty, and isolation from the community and others, which increased their trauma reactions. As a result of social exclusion, they suffer complex trauma alone, believing they are abnormal and less than other people.

This project is based on research completed on trauma and best practices in regards to group sessions for women. The foundation of the project is that women's experiences with complex trauma are significantly different than the experiences of men; therefore, therapeutic approaches need to reflect these differences. The foundation for this research practicum framework is based on academic research by Herman (2015), Courtois (2004), Courtois and Ford (2013), and Cloitre and Stolbach (2002). As already stated, the intent of my research practicum was to create a group program for women that was based on research and could be utilized by non-profit community organizations that work with abused and homeless women. Therefore, this guide was developed for the Provincial Association of Transition Houses Society (PATHS) for their distribution to shelters in the province (as requested) with the goal of supporting women with complex trauma in healing. I used the experiences of women accessing the YWCA's My Aunt's Place to inform aspects of the manual so that other women could gain strength and end their isolation.

In this research practicum paper, I describe the methods I used to create *The Guide*. I began with a literature review. Initially, my focus was a broad overview of trauma literature. I then narrowed the focus to complex trauma and the experiences of women and Aboriginal women in particular. I also reviewed the literature on existing programs and specific treatment

models. In this paper, I describe the outcomes of my literature review, as well as the structure of the group program I developed and the content for each session. Finally, I examine the methodology used to create group sessions that reflects the voices of participants. The intent of this paper is to examine the intellectual process that influenced the creation of *Women Healing from Trauma: A Facilitator's Guide*.

Literature Review

I began the research practicum with a literature review of trauma with the intention of developing a curriculum for a group that incorporates both academic research and best practices. Initially, I reviewed books and articles that focused on a universal understanding of trauma. This included articles written by Lonigan (2004), Rothaum and Foa (1996), Courtois (2004), Rothaum, Meadows, Resick, and Foy (2000), Turner, McFarlane, and Vander Kolk (1996). The focus of this research was on symptoms and treatment strategies used with individuals experiencing both trauma and complex trauma. During the initial examination of the literature on trauma, it became apparent that research has been completed on the experiences of women and complex trauma. I also ascertained that programs had been developed and implemented which incorporated and reflected research completed on women with CPTSD. After completing research, I concluded that all the programs incorporated the same essential themes in the healing process: skill building, building women's self-esteem and self-compassion, expanding their relational abilities, and maintaining safety.

Women and Complex Trauma

There has been significant research completed on the experiences of women with complex trauma. Scholars such as Herman (2015), Courtois and Ford (2013), Courtois (2004), and Russell and Radford (1992) have explored the unique experiences of women. They have

written groundbreaking work in the field of complex trauma and the complications of healing from abuse that occurs in the domestic sphere.

The feminist movement of the 1960s and 70s exposed and highlighted the extent of abuse that was experienced by women in the domestic sphere (Herman, 2015; Russell & Radford, 1992). As a result of this scholarship, academics began to focus on how interpersonal violence produces emotional damage and suffering that is unlike that of any other traumatic event (Courtois, 2004; Herman, 2015). At the present time, feminist researchers and academics recognize that women's trauma due to interpersonal violence is substantially different than the trauma experienced by men, specifically that of soldiers, whose PTSD has been researched (Courtois, 2004; Herman, 2015).

Research suggests that significant damage is caused when there is a close relationship between the victim and the perpetrator (Courtois & Ford, 2013). The violence and abuse that occurs in the domestic sphere substantially changes women's worldviews, feelings about self, and ability to trust (Courtois, 2004; Herman, 2015). Therefore, the needs of women experiencing complex trauma demand treatment models that recognize their unique needs.

I also investigated how feminist theories affected therapeutic treatment models by examining the works of Brown (1991), East and Roll (2015), Russell and Radford (1992), and Tservis (2013). Tservis (2013) wrote that there are several therapeutic approaches for trauma that should be adapted for marginalized women. Guided by feminist perspectives, the first belief that a psychiatric diagnosis and assessment is needed before effective treatment of trauma can occur in the therapeutic process has been reconsidered (Tservis, 2013). Psychiatric assessments are rarely available for underprivileged women and therefore psychiatric assessments should not be a requirement for women to participate in programming (Tservis, 2013).

Second, treatment needs to be holistic and not solely focused on a biological or pathological understanding of trauma. Although there is clearly a biological response to trauma, the solution is in building skills and strengths. Any form of treatment should consider the whole person, including their vulnerabilities and strengths.

Third, Tservis (2013) argues that trauma resulting from physical and emotional violence needs to be considered as a societal issue and not as an individual issue. As such, supports need to reflect larger societal factors that lead to abuse in order to help women understand their experiences of trauma in a broader context rather than as due to their individual failure.

Fourth, trauma treatment needs to examine themes of self-blame, power, shame, gender, and the stigma of abuse (Courtois, 2004; Herman, 2015; Tservis, 2013). Finally, interventions need to be strength-based and empowering to women. Therefore, groups should be facilitated in a manner that does not model the hierarchal and patriarchal power structures prevalent in society but facilitated in an egalitarian and empowering manner. In this environment, the facilitator is not the expert but an equal partner in the healing journey (Cloitre & Stolbach, 2009; Tservis, 2013).

In conclusion, because women experience trauma differently than men, they need different interventions than men. Therapeutic interventions need to take into account the role of trauma occurring in domestic spheres and the resulting social isolation, poverty, and societal power structures and inequalities (Courtois & Ford, 2013; Herman, 2015; Tservis, 2013). In addition, it is important that interventions are sensitive to societal power structures. Therefore, groups are most effective if the group structure is based on equality and a non-authoritarian approach. It is important for facilitators to treat women as authorities about their own experiences (Herman, 2015; Tservis, 2013).

Stages of Healing

Academics such as Herman (2015), Ford and Courtois (2013), and Van de Hart (2012) argue that healing can be broken down into three distinctive phases. Some women go through the phases sequentially, completing all three phases in order (Courtois & Ford, 2013; Herman, 2015), while others move in and out of each phase numerous times. Some women may choose to only focus on the first phase of healing and not complete the other two phases (Herman, 2015; Van de Hart, 2012). In order to be successful, therapeutic approaches need to incorporate the requirements necessary in each phase.

The Guide is intended to support women in the first phase of healing. There are four key aspects of the first phase of healing. First, it is important for women to focus on their personal safety as a means of curtailing retraumatization (Courtois & Ford, 2013; Herman, 2015). Women who experience complex trauma often continue to put themselves in unsafe environments, thus causing retraumatization. They also choose to act or make decisions in a manner that leads to further victimization (Herman, 2015; Van de Hart, 2012). For example, individuals may decide to use alcohol or drugs as a means of numbing emotions and suppressing thoughts, thereby placing themselves in unsafe places and with unsafe people. Women may also, consciously or unconsciously, endeavor to recreate the traumatic event with the hopes of changing the outcome (Herman, 2015). An illustration of this is when a woman unconsciously and repeatedly seeks out relationships with men who are abusive, with the unconscious intent of having a different outcome to the relationship. Women may also believe that the world is unsafe and therefore danger is inevitable (Courtois, 2004; Herman, 2015). Consequently, survivors may believe there is no value in making decisions to create safety. Exploring the reasons women continue to place themselves in unsafe environments or together with abusive people is essential in creating a safety plan that can be utilized to end retraumatization (Herman, 2015; Van de Hart, 2012).

A person struggling with complex trauma often experiences emotional dysregulation (Van de Hart, 2013). Emotional dysregulation results in outbursts of extreme anger, anxiety, frustration, and depression. Survivors are unable to regulate or manage these intense emotional reactions, causing problems in their personal lives and in their relationships with people (Courtois, 2004). Learning how to manage emotional dysregulation will lead to an improvement in their quality of life and in their ability to achieve personal goals (Courtois, 2004; Van de Hart, 2012). Building competency in emotional management includes specific skills such as self-soothing and relaxation techniques (Courtois, 2004). Therefore, the second focus for women in the first phase of healing should be on emotional regulation.

Women who have complex trauma often feel like they are abnormal or “crazy.” They tend to perceive themselves as weak, failures, or social misfits (Courtois & Ford, 2013). Victims internalize negative and destructive beliefs often acquired from their perpetrators, and as a result they have low self-esteem, self-worth, and self-confidence (Courtois & Ford, 2013; Herman, 2015). Rather than perceiving these symptoms as normal reactions to abnormal situations, the survivor views herself as a failure in being able to fit in or experience a normal life (Herman, 2015; Van de Hart, 2012). During this first phase of healing, it is important to promote self-compassion, acceptance, and the building of self-esteem (Courtois, 2004).

Women who have complex trauma are often isolated and alone. They have trouble trusting, feeling close to, or communicating with others (Courtois & Ford, 2013). They have difficulty establishing healthy boundaries in relationships or assertively communicating their needs and wants (Najavits, 2009). As a result of relational trauma, these women have a limited ability to trust and develop lasting and fulfilling relationships with others (Courtois & Ford, 2013; Herman, 2015; Van de Hart, 2012). As a result, they do not have social supports that can be used as a foundation for healing (Herman, 2015; Van de Hart, 2012). Developing the skills

and capacity to connect with others decreases isolation and helps women rebuild their lives (Herman, 2015).

The second phase of healing focuses on undoing psychological conditioning, mourning loss, altering perceptions and behaviors, and integrating skills (Courtois, 2004). In this phase of healing, an individual focuses on building life stability. Attention is focused on telling their own life story and recreating and reclaiming their narrative (Herman, 2015). The narrative may include events, individuals, and particulars of their traumatization with the intention of integrating this experience into their lives. The focus is also on disconnecting from the emotional aspects of their experiences (Courtois, 2004). In the second phase, women continue to build on their skills by participating in role plays, gaining more information, and integrating what has been learned into their lives (Monson & Shnaider, 2014). During this phase of healing, it is beneficial to utilize exposure and narrative therapies, to create meaning, and to detach from the traumatic events (Courtois, 2004). This phase can also focus on mourning and accepting the long-term aftereffects of the trauma (Courtois, 2004). Women may also increase their skills to regulate emotions and behaviour.

The third phase of healing is a continuation of the first two phases, focusing on developing a new, stronger self. This state centers on empowering the survivor and building psychological and physiological mastery (Courtois & Ford, 2013; Herman, 2015). Survivors concentrate on living the new narrative that was developed in earlier phases, strengthening skills, and maintaining safety (Herman, 2015). The third phase centers on continuing the journey by reconnecting with others, learning to trust, and seeking friendships (Courtois & Ford, 2013).

Aboriginal Perspectives

As a result of my experiences in the field, I know that it is important to acknowledge and create programs that integrate Aboriginal cultures and perspectives. Aboriginal peoples continue

to struggle with the “destructive legacy of colonization” (Truth and Reconciliation Commission, 2015). Sexual and physical abuse, separation from families and communities, the loss of parenting skills, and the destruction of a cultural identity occurred during colonization, residential schools, and the 1960s scoop, causing significant damage to the Aboriginal population (Truth and Reconciliation Commission, 2015). The lasting effect of residential schools has led to extensive trauma for all people within the Aboriginal community.

The Truth and Reconciliation Commission of Canada (2015) calls for programs and organizations to recognize Aboriginal healing practices and to work in collaboration with First Nations healers and elders. Therefore, it is important to recognize the needs of Aboriginal women in all treatment services. Integrating traditional healing methods and western therapeutic models is important to meet the needs of First Nation’s women (Heibron & Guttman, 2000). My literature review included Aboriginal researchers’ and academics’ perspectives such as Ferrara (2004), Heibron and Guttman (2000), and Isaak, Stewart, and Mota (2015).

When offering group treatment, it is important to recognize the needs of Aboriginal women. Integrating traditional healing with western therapeutic models is important to meet their needs (Heibron & Guttman, 2000). First, it is important to create an atmosphere and use a leadership model that is comfortable for all participants in order for the group to be successful. Leadership should not be hierarchical, rather, it should be a group of equal participants consistent with feminist approaches (Heibron & Guttman, 2000). The facilitator should guide the conversation but not control the group (Heibron & Guttman, 2000). Second, communication styles vary within many Aboriginal groups and this needs to be respected when working in a group setting. Direct questioning can be interpreted as an attempt to control behaviours or feelings (Ferrara, 2004). Therefore, it is important to ensure the women feel safe before asking questions and to allow time for their response. Groups will benefit if women have control over

the pace and tone of the conversation (Ferrara, 2004). Finally, it is also important to note positions of privilege. Group facilitators need to be aware of their positions of privilege and how this may affect participants' interpretation of the leaders' behaviours in regards to power, leadership, and communication styles (Ferrara, 2004).

Culture and cultural identity is a source of healing, strength, and resilience and needs to be integrated into the group format (Isaak, Stewart, & Mota, 2015). In communities involved in healing, recovery may be a group process and not an individual endeavour. Therefore, services should be offered with the support of the individual, family, and community (Ferrara, 2004). Because healing is a community experience for many First Nations populations, group interventions are often preferred rather than one-on-one counselling (Isaak et al., 2015).

There are three main subthemes in Aboriginal healing: turning points, connections and reconnections, and moving forward (Isaak et al., 2015). It is important that these three subthemes are recognized and integrated when designing interventions. A turning point is when the participant wants to move on from the current situation and seek aid from others. In many cases, this is the time when people reach out for support from groups or agencies. They are ready to focus on changing their future by healing from the past.

The second subtheme is connections and reconnections with culture, traditional teachings, or spirituality. Connections to community and spiritual traditions are central to healing and need to be regularly included in interventions (Isaak et al., 2015).

The third theme is moving forward, which includes acceptance of the past, recognizing strengths, and communicating dreams for the future. Interventions at this phase need to focus on goal setting and supporting individuals who communicate hope, self-compassion, and self-acceptance (Isaak et al., 2015).

Traditional healing circles, led by an elder who can conduct a healing circle and a purification ceremony, should be utilized for in-group programs whenever possible. A plant (sage, sweet grass, cedar, or tobacco) is burnt at the beginning of the ceremony (Heibron & Guttman, 2000). Each person participating in the circle removes jewellery and glasses and then proceeds to place the smoke over their head, face, shoulder, and then entire body in prayer (Heibron & Guttman, 2000; L. Tanner, personal communication, January 16, 2016). Members come together to give thanks for the opportunity to speak honestly about their concerns and feelings (Heibron & Guttman, 2000; L. Tanner, personal communication, January 16, 2016). Women participating in the circle will then pass a sacred object, often a stone, to another member to start the talking circle when the group is having a check in. In Cree traditions, the circle should progress in a clockwise fashion, representing the cycle of life (L. Tanner, personal communication, January 16, 2016). When passing the sacred object around the circle, only the person holding it is allowed to speak. After everyone has been given an opportunity to speak, the sacred object or stone is placed in the middle of the circle. The talking circle can build an environment of respectful dialogue, creating a bond of trust and a safe place for honest discussion (Heibron & Guttman, 2000; L. Tanner, personal communication, January 16, 2016). The circle is a unifying symbol in Aboriginal culture representing connectedness, equality, balance, and the cycle of life (Heibron & Guttman, 2000). If it is not possible to include an elder in the group, incorporating aspects of the talking circle is an important means of showing respect to both the traditions and teachings of Aboriginal participants (L. Tanner, personal communication, January 16, 2016).

The concept of balance is important to First Nations culture; therefore, healing should focus on including the spiritual, emotional, physical, and mental aspects of self in each session (L. Tanner, personal communication, January 16, 2016). If only one facet is being focused on in

treatment while ignoring the others, services will not support healing and strength because there will not be a balance (Heibron & Guttman, 2000). Therefore, in order to encourage balance in the healing process group sessions need to include all four aspects of the individual (Heibron & Guttman, 2000).

In summary, if interventions are to be sensitive to Aboriginal cultures, communication styles, the role of the leader, the importance of the circle, the three themes of healing, and the significance of balance need to be considered (Heibron & Guttman, 2000). It is important to show respect for Aboriginal culture and community in order to create a curriculum that benefits, accepts, and includes participants (Heibron & Guttman, 2000).

Groups

I next researched the structuring of groups for women with complex trauma. Some of the information is found in the research conducted by Herman (2015), Courtois (2004), Courtois and Ford (2013), and Ford and Russo (2006). I also examined articles written by Najavits, Weiss, and Liese (1996), Van der Kolk, McFarlane, and Van der Kolk (1996), and Cloitre and Stolbach (2009) These authors examined the specific needs of women with complex trauma and best practices for both content and group structure.

During the first phase of healing, it is important that women are safe, create community, gain skills, and identify their strengths (Herman, 2015; Van de Hart, 2012). Groups can be particularly successful at this stage of healing. Group work can focus on the psychoeducational needs of survivors by making trauma information available to participants (Cloitre & Stolbach, 2009). Groups can also help women who have similar problems to learn social skills, which will strengthen their ability to participate in healthy relationships (Herman, 2015; Van de Hart, 2012). Finally, groups that emphasize individual women's strength will empower and bolster participants' confidence (Cloitre, Koenen, & Cohen, 2002). Group work dynamics need to

encourage self-compassion and build self-esteem, which in turn will increase the women's autonomy and resilience (Courtois, 2004; Herman, 2015).

In my literature review, I also came across information on how to develop and run groups for women with complex trauma. Due to the complexity of trauma, it is essential to establish structures and boundaries that will create and maintain emotional safety, including rules and the expectations of the group (Najavits, Riggs, & Roth, 1997).

Treatment Models

The next step in my research was to examine other programs that have been developed, implemented, and researched. These included *Skills and Training Affective and Interpersonal Regulation* (STAIR; Levitt & Cloitre, 2005), *Trauma Recovery and Empowerment Model* (TREM; Fallot & Harris, 2002), *Trauma Affect Regulation: Guide for Education and Therapy* (TARGET; Ford & Russo, 2006), and *Seeking Safety* (Najavits, Weiss & Liese, 1996). These programs had similar structures, themes, and objectives, but subtle differences in the use and emphases of particular therapies. I examined academic work that was used to create these programs including Levitt and Cloitre (2005), Najavits, Weiss, and Liese (1996), Ford and Russo (2006), and Fallot and Harris (2002), as well as research completed in regards to the outcome of these programs.

STAIR is based on cognitive behavioural therapy (CBT) and dialectical behavioural therapy (DBT). This program addresses three core issues that are experienced by women with complex trauma. These core problems are emotional regulation, PTSD and CPTSD symptoms, and interpersonal problems. This program is based on providing emotional stabilization, building relationship skills, and addressing everyday functioning (Levitt & Cloitre, 2005).

TREM is a group program that focuses on reducing the symptoms of PTSD and increasing recovery skills. TREM is founded on four core beliefs: dysfunctional behaviours were

developed to cope with abnormal circumstances; long term abuse affects the development of coping strategies; sexual and physical abuse fundamentally affects relationships with family, community, and self; and women who have experienced complex trauma feel powerless (Fallot & Harris, 2002). There are 11 areas of skill development: self-awareness, self-protection, self-soothing, emotional modulation, building relationships, labeling of self and others, gaining a sense of agency, problem solving, parenting, finding purpose and meaning, judgement, and decision making (Fallot & Harris, 2002).

TARGET is founded on the participants' desire for safety, hope, and community (Ford & Russo, 2006). It is structured around the acronym FREEDOM.

Focus through the use of the acronym SOS: (S)low down—pause and take a breath, clearing

brain and controlling impulses; (O)rient yourself—pay attention to the five senses,

including the environment, thoughts, and feelings; (S)elf-check—what is the body

feeling? what are your stress levels? your cognitive responses and reactions? (first phase);

Recognize triggers and reactions to the environment (second phase);

Emotional regulation;

Evaluate circumstances and reactions;

Definitions of goals, which include plans for the future or intentions;

Options;

Meaning making (Ford & Russo, 2006, p. 343).

TARGET also contains a psychoeducational component, mindfulness, grounding, and emotional management.

The third phase of TARGET is founded on lifestyle choices, values, goals, and identifying future plans to manage emotions (Ford & Russo, 2006). The aim is to create plans and learn

techniques that can be used to prevent dysfunctional reactions in harmless situations (Ford & Russo, 2006).

Seeking Safety is a program designed for women who have experienced interpersonal violence, complex trauma, and substance abuse (Najavits, Weiss, & Liese, 1996). This program is designed to support women in their recovery from both the trauma and their addictions (Najavits, 2009). It is based on CBT but also includes a psychoeducational component. The CBT aspects of *Seeking Safety* include impulse control, grounding, problem solving, anger management, cognitive restructuring, relaxation, active listening, assertiveness, and rehearsing coping strategies (Najavits, Weiss, & Liese, 1996). In this program, four spheres are explored: cognitive, behavioural, interpersonal, and case management (Najavits, 2009). Topics covered in the groups are honesty, asking for help, compassion, healthy relationships, self-care, creating meaning, healing from anger, and grounding (Najavits, 2009).

Underlying Therapies

After completing a review of programs, I determined that it was valuable to consider different therapies in order to determine the strengths and weaknesses of each one. The intent was to create a program that I believed would best meet the needs of women participating in a group. Therefore, I examined narrative therapy, acceptance and commitment therapy (ACT), art therapy, drama therapy, mindfulness, CBT, including stress inoculation training (SIT), progressive exposure therapy (PE), cognitive processing (CP) and eye movement desensitization and reprogramming (EMDR). After examining academic perspectives on therapies, I reviewed workbooks and self-help sheets that were utilized as homework or for group activities. I found workbooks on specific topics such as anger (McKay & Rogers, 2000), panic attacks and disassociation (Monson & Schaider, 2014), communication (Paterson, 2000), fighting fair

(Schmidt & Friedman, 1998), meditation (Metta Institute, 2015) and mindfulness (Flowers, Kabat-Zinn, Santorelli, & Kornfield, 2016).

To summarize, I started my literature review by doing a general overview of trauma and then allowed my research to progress to specific material. I noted a number of academics who were widely deemed as experts in the field of women's trauma and their research was extensively used by others, this included Herman (2015), Courtois and Ford (2004), Cloitre and Stolbach (2009), Najavits (2009), and Van der Kolk, McFarlane, and Van der Kolk (1996). Based on these works, I set the direction for my research practicum, and by narrowing my review of the research, I was able to develop a strong academic foundation for the therapies and activities in *The Guide*.

Outcomes

The outcomes segment of my research practicum report encompasses the content of *Women Healing from Trauma: A Facilitator's Guide*, which I developed and is based on both academic literature and lived experiences of women who have been marginalized. This section will outline the specifics of *The Guide*, including an overview of the intent and content of all ten sessions. I will also examine information gained by completing an environmental scan, consultation with a Cree elder, and open dialogues with women who used the services at My Aunt's Place.

As previously stated, the aim of my research practicum was to design an easy to use, clear, and concise facilitator's guide. *The Guide* includes a section that explains complex trauma, its symptoms, phases of healing, and the connection between the mind and body. It also examines the particular needs of women experiencing complex trauma and the inclusion of Aboriginal perspectives. *The Guide* consists of an outline for ten group sessions. Each of the ten sessions has a clearly defined rationale, weekly objective, activity sheets, learning opportunities, and homework. The sessions are not to be used in individual counselling sessions but rather in a

group that is focused on helping women gain the skills and information necessary during the first phase of healing.

There are a number of objectives set out for each session of *The Guide*. The overall objectives of the group sessions include supporting women's development of healthy relationships and social skills and sharing information about trauma and inclusion in a community. Group activities include teaching specific skills such as assertiveness, safety planning, breathing techniques, healthy communication, and mindfulness. *The Guide* also includes opportunities for role-plays, practicing skills, and completing homework.

Considerations

I am a white, middle-class, social worker and I have not been a victim of violence nor have I been homeless, and I am not Aboriginal. Therefore, it was necessary for me to educate myself on how to incorporate the voices of Aboriginal women participants in *The Guide*. I knew from experience that it would be essential for the group process to reflect the perspectives of Aboriginal participants. To inform myself, I examined the literature written by Aboriginal academics on best practices and therapeutic approaches. In addition, I worked with a female Cree elder for additional advice and aid. She was extremely supportive and open to discussing and critiquing the cultural components of *The Guide*.

It is easy to become swamped with research and information found in books and scholarly papers and in doing so to ignore the voices and needs of individuals who will utilize the program. Therefore, *The Guide* focuses on hands-on techniques that can be easily used by a wide variety of participants. The activities and topics were developed with the intent of supporting the particular needs of marginalized women. I integrated the information acquired by speaking with women who will eventually utilize the program. In this way, women with lived experience became a

fundamental instrument in building a guide that can be utilized by women struggling with complex trauma.

I wanted to ensure that the voices of experience were included in the formation of sessions for the group. To this end, I included my own experiences of working with women at My Aunt's Place and the knowledge I gained while working there. I also utilized the advice, input, stories, and lived experiences of women who had been in the shelter to inform *The Guide*. By including their voices and experiences of the group work, I was able to ensure that participants and their experiences would give meaning and depth to *The Guide*. Finally, *The Guide* includes ample opportunities for discussions so that group participants can share their perspectives, skills, and strengths.

Outline of *Women Healing from Trauma: A Facilitator's Guide*

The **first session** sets the tone and intentions for the entire group program. In the first meeting, group rules and expectations will be established. Predictability and clear guidelines are especially important for people struggling with complex trauma and are important means of establishing healthy boundaries and safety within the group (Courtois, 2004). Once the basic structure of the group is determined, the discussion will center on goal setting and the importance of creating a plan of action.

Session two examines the reasons safety is an issue for survivors, ways women re-create the trauma, and how to regain a sense of safety. This session will also examine safety planning because once a woman chooses to focus on safety, her feelings of powerlessness, vulnerability, and isolation decrease. In this session, the group will discuss what women can do to regain a sense of safety, including becoming mindful of the environment, changing self-destructive thoughts, and finding and maintaining sobriety. The activity in this session is to create safety plans that will assist the women as they consider situations, people, or behaviours that are risky.

Numbing, hyperarousal, hypervigilance and intrusive thoughts are constant symptoms for women with complex trauma (Herman, 2015; Loneyan, 2014). Therefore, the intention of the **third session** is to recognize emotional dysregulation and develop skills necessary to manage emotions. Failure to manage intense emotions is the prime reason some women become emotionally flat and disconnected, that is, avoiding their feelings (Herman, 2015; Van de Hart, 2012), and participants will be asked to consider this in terms of their own experiences. The unconscious consequence of disengagement is somatization (medical issues that are a result of trauma), affective destabilization (emotional instability), and relationship difficulties (Courtois & Ford, 2013). This session ends with a *Safe Place Meditation*, which connects the mind and body. There are two benefits to meditation. First, the mind unwinds and centers on a safe place, the breath slows down and deepens, and the body relaxes. (Birnie, Speca, & Carlson, 2010). Second, participants gain control over their physical reactions, which is empowering and strengthens their beliefs in their own abilities (Birnie et al., 2010).

The objective of the **fourth session** is to help the participants become cognizant of their personal triggers and to learn how to use skills that minimize negative reactions. The rationale of these objectives is that women with complex trauma become overwhelmed when triggered, feeling intense fight, flight, and freeze responses (Courtois & Ford, 2013; Herman, 2015). Triggers, such as events, objects, smells, places, or sounds, elicit feelings of anxiety, fear, anger, or frustration even when the triggers themselves are harmless (Boon, Steele, & Van der Hart, 2011; Ford & Russo, 2006). However, the individual's response to the experience of being triggered can be traumatizing (Courtois, 2004). In this session, helping women to recognize triggers and how they affect thoughts, emotional responses, physical symptoms, and behavioural reactions is the key to helping them learn how to manage inappropriate actions or feelings.

Emotional regulation becomes impaired when individuals experience trauma and respond with anger, which is an adaptive reaction to dangerous environments (Chemtob, Novaco, & Hamada, 1997), therefore, the **fifth session** will focus on helping participants monitor their thoughts, recognize signs of arousal, and implement productive coping strategies. Anger is activated when an individual feels threatened and once triggered, anger impairs their ability to self-monitor and process complex information (Chemtob et al., 1997). Anger can impede a woman's ability to participate in healthy relationships, express emotions appropriately, and make rational or safe decisions (Newman, Riggs, & Roth, 1997).

The **sixth session** will deal with how emotional regulation leads to a healthier lifestyle and the attainment of personal goals. It focuses on how anxiety and panic attacks interfere with ordinary life experiences. This session teaches techniques that can help women manage symptoms rather than avoiding situations or circumstances that trigger anxiety and panic attacks. As Courtois (2004) has shown, acceptance of their emotions and building skills tends to decrease the intensity and regularity of anxiety and panic attacks.

The **seventh session** will focus on building self-compassion, empathy, and self-esteem and includes a number of activities that help with this. Women who have survived abuse and neglect often experience profound low self-esteem, self-hatred, and a lack of confidence (Herman, 2015). They also feel betrayed, rejected, and abandoned by others (Cloitre & Stolbach, 2009). Many women who have experienced complex trauma adopt feelings of shame, guilt, and humiliation because of their experiences (Banks, Newman, & Saleem, 2015). These emotions lead to harsh judgement on oneself and self-criticism. Women also internalize statements learned from the abuser, including that they are responsible for the abuse and that they are worthless (Birnie et al., 2010).

Women who have experienced abuse and trauma often struggle with creating and maintaining healthy relationships (Courtois, 2004; Herman, 2015; Levitt & Cloitre, 2005). The ability to connect with others in a healthy manner is disrupted as a result of abuse, neglect, or trauma. Therefore, survivors often struggle with the ability to trust others, becoming intimate, and maintaining healthy emotional connections (Courtois, 2004; Herman, 2015). Given these realities, the intention of **session eight** is to discuss abusive personalities and why individuals stay with abusive partners. The session will focus on boundaries, what are healthy relationships, and how to become mindful in relationships.

Session 9 focuses on building skills necessary for healthy communication. Individuals who have experienced trauma often have unhealthy communication patterns in their relationships and do not possess the confidence to successfully assert their needs and wants (Paterson, 2000). Survivors can sometimes surrender to the demands of others but then become resentful or angry. Developing the skills to communicate personal needs and wants in an assertive manner will support healthy relationships and help the women develop self-confidence.

The **final session** will focus on creating a relapse management plan that can be utilized by participants. Relapse is when a woman experiences a deterioration or decline after a period of recovery (Courtois, 2004; Herman, 2015; Levitt & Cloitre, 2005; Najavits, 2009). Therefore, when discussing relapse management plans these discussions often include specifics such as substance abuse, depression, anger, isolation, returning to an abusive partner, and anxiety. An effective relapse plan examines signs of a relapse such as altered sleep patterns, anger, and craving for or use of substances (Najavits, 2009). Relapse management plans also include an examination of actions, thoughts, and feelings that lead to setbacks. The intent of the final session is to draw attention to the strengths of participants and the relationships that have been built.

Design

As stated earlier in the report, I facilitate an informal group for women who stay at My Aunt's Place. The women who utilize the shelter have often experienced considerable trauma, including intergenerational trauma, domestic violence, mental health, addictions, exploitation on the streets, and childhood abuse. They also manage problems that arise because of poverty, homelessness, and involvement in a complexity of government agencies such as social assistance and child protection. Most women do not reside at my My Aunt's House for more than a month and often return to dangerous and unstable situations. Therefore, for these women, I used selected sections of the material that I developed for *The Guide* in-group session, including safety planning, domestic violence and panic attacks. The group participants were encouraged to critique the content and how the information was presented. They were also urged to share their knowledge and skills in regards to these topics. Through the generosity and kindness of the women at the shelter, I was able to deepen and strengthen *The Guide* based on their experiences and thoughts.

At the beginning of the research practicum, I had a clear sense of the target population and the subject matter. As a result of my experience, I determined that many women needed information, skills, and group support in order to manage the symptoms of trauma. After I completed the literature review, I completed an environmental scan, examining both the programs available in Regina and gaps in available resources and programming for marginalized women in non-profit agencies and government agencies in regards to trauma. The available programs are Four Directions Community Health Centre, Street Worker's Advocacy Project, Addictions Services, North Central Family Centre, Regina Immigrant Women Centre, Family Service Regina, Catholic Family Services, The Circle Project, and Prairie Spirits Connections. These agencies all have group programs dealing with specific issues such as addictions, anger

management, positive life choices, communication, and domestic violence. However, no organization offers group sessions or counselling that focus on trauma and its consequences.

I also worked with a female Cree elder to gather information on cultural aspects of healing and how to support Aboriginal women through the therapeutic process in a culturally sensitive manner. She was generous with her time, suggestions, and perspectives. We discussed therapeutic approaches and cultural content. The elder then reviewed each session contained in *The Guide* to ensure that it was accurate. Through her guidance, I was able to understand the importance of the spiritual aspects of healing and balancing all aspects of self in the recovery process. She also aided in my understanding of talking circles and how they could be utilized in groups.

Once *The Guide* was completed, my professional associate agreed that it was to be presented at the PATHS 2016 conference in May 2016. At the conference, I met with other professionals who worked with women with complex trauma who wanted to use *The Guide* to develop group work in their organizations. I have agreed to facilitate a group for the Immigrant Women Center on trauma, with the intent of incorporating the voices of immigrant women into the sessions. I have also been given the opportunity through my current employer at YWCA to facilitate a group using *The Guide* in its entirety. Through this experience, I am hoping to strengthen and modify the curriculum, where needed.

Discussion and Reflections

Women who live with complex trauma experience a fundamental alteration to their worldview, the capacity to trust, to connect to others, and to self-regulate (Courtois 2004; Herman, 2015) Therefore, their ability to have the life that they dream of is substantially damaged. *Women Healing from Trauma: A Facilitator's Guide* is meant to be used in the first phase of services. It is intended to end the isolation of women with complex trauma and to help

them develop the skills necessary to manage symptoms of complex trauma. With support, understanding, and evidence-based services, women can escape the confines of domestic violence, childhood abuse, sexual abuse, and exploitation. The intent of my research practicum was to develop a curriculum that could be used for in-group work to support women through the complexities of dealing with multiple traumas.

I hope that all 10 sessions of *The Guide* will be used and then modified or adjusted to meet the particular needs of participants. As previously mentioned, I intend to use *The Guide* to run a group with the objective of evaluating both the content and how to implement the group sessions. The intent is to make improvements based on participant feedback. After an entire 10 sessions have been facilitated, I can make adjustments before sharing it with other agencies. It is my intent not only to provide services based on *The Guide*, but in my role at the YWCA, to support other agencies in the creation of programs for women that focus on trauma. These services may include using *The Guide* in its entirety or in parts based on the particular needs of the women using those services and the financial limitations of organizations.

The Guide is intended for the beginning of a healing journey. Unfortunately, due to the lack of resources, its group sessions may be the only support some woman will ever receive. There are few group or counselling services that can be used by marginalized women that are free, easily accessible, culturally relevant, and comfortable for them. There are a number of groups in the community that focus on addictions or anger management but nothing that examines the complications of complex trauma in a holistic manner. Therefore, women may complete these group sessions and have nowhere else to go for ongoing services. Ideally, there need to be services for phases two and three of the healing process. Services in the second and third phases would aid women through support groups, individual one-on-one counselling, and alternative therapies, such as art or drama therapy. A group based on *The Guide* would be a good

beginning, but more resources need to be added to the spectrum of programs that provide ongoing support for women with complex trauma. In conclusion, women need supports that can aid in their healing from complex trauma. Without supports women will continue to have multiple needs and repeatedly end up in homeless shelters.

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