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SEEKING CONNECTION - A Relational Approach to Trauma-Informed Substance Abuse Intervention Treatment Manual

SEEKING CONNECTION

A Relational Approach to Trauma-Informed Substance Abuse Intervention

Treatment Manual

Timothy Lam, Psy.D.
Cora Lau, Psy.D.

About HKLSS

Hong Kong Lutheran Social Service was founded in 1977 by the Lutheran Church–Hong Kong Synod. Over 40 years of development, more than 50 service units are established to provide versatile services for people with different needs. Its missions are to:

(i) Provide innovative and holistic services.
(ii) Advocate the spirit of love our neighbour and justice.
(iii) Build a professional team caring for each other and the community.

Counselling Service Centre Division has been established to serve Psychotropic Substance Abusers and Problem and Pathological Gamblers respectively.

The Counselling and Treatment Centre for Gamblers with Gambling Disorder was set up in 2009 with the support from Ping Wo Fund. It provides counselling to people suffering from an addiction to gambling.

The first Counselling Centre for Psychotropic Substance Abusers (CCPSA) was setup in 1998, and was subsequently expanded to 3 centers in 2010. The service of CCPSAs includes individual and group counselling, anti-drug educational programs in schools, outreaching service, medical support, family support, professional training and community education. Upon our holistic service for the drug abusers and their families, together with the effort of different parties, we hope to build a caring, healthy and drug-free community.

FOREWORD

We are living in a traumatizing culture. Anthony Giddens, the premiere British sociologist, contends that the self in late modern society faces challenges of fragmentation, powerlessness, uncertainty and commodification. These are all phenomena associated with experiences of trauma. The experience of intrapsychic and interpersonal fragmentation and disconnection is particularly acute and overwhelming for persons wrestling with addictions. To address these phenomena, Dr. Timothy Lam and Dr. Cora Lau have created a relational approach to trauma informed substance abuse intervention in this one of a kind manual.

Tim and Cora have taken on seeking connection, the deepest most foundational human need, as the paradigmatic lens to understand the why humans would engage in addictive behaviors. To be exact, it is the failure or deficiency in human connection that we turn to substance or process addictions to sooth the emotional pain of relational alienation. The anterior cingulate cortex (ACC), the neurobiological structure that process physical pain, is also activated in psychic pain triggered by the experience of being excluded in social situation. This finding suggests that psychic pain and physical pain are experienced as identical by the ACC. As such, relational exile, alienation, exclusion or rejection is experienced as 'real' pain, compelling the experiencer to find ways for relief. In the case of addictions, the relief is temporary and short lived. Since the root issue of relational alienation was unaddressed, we seek relief again in our substances and processes of choice, further fuelling the addictive cycle.

Tim and Cora have brilliantly focused on the reconsolidation of implicit memory as paramount important in the relational approach in working with substance abuse. All depth oriented psychotherapy depends, arguably, on the effectiveness of reconsolidating implicit memory. Our core beliefs about ourselves, the world and our internal working model of self-other interactions, hence our Weltanschuaang or worldview, are stored unconsciously in our implicit memory. Unconscious does not mean we can never retrieve nor restructure the stored implicit memory, it simply cannot be restructured through 'talk'. Implicit memory is encoded through repeated self-other interactional experiences until the phenomenon becomes a representation of interactional experiences that has become generalized (RIG). As a result of the generalization of interactional experience in the past, we learn to anticipate these experiences, automatically, and by default, in the future. In the case of persons traumatized by repeated relational alienation and disconnection in the past, we learn to anticipate unconsciously, and automatically that this will be our future. We believe in the core, unconsciously and automatically, that this pattern of relational disconnection will be repeated over and over again, with no end in sight. As such, we are in a never ending loop of pain and suffering. Yet there is hope. We can change our future. We could access the internal working model stored in the implicit memory.

Accelerated Experiential Dynamic Psychotherapy (AEDP), cited in this volume, is precisely a model of psychotherapy that can restructure and reconsolidate implicit memory, and create a corrective emotional experience. The AEDP therapist works to catalyze in clients a cascade of psychobiological state transformation. This transformation is facilitated through the moment-to-moment tracking and optimal response to the body based affective experience. The affective experience is dyadically regulated and worked through to completion. The key mechanism of therapeutic change is: what was experienced by the client in the past, alone and disconnected, needing addictive substances or processes to defensively cope with the psychic pain, is re-experienced in the present moment with an emotionally engaged and connected attachment based therapist. The trauma that was experienced alone in the there-and-then, is reprocessed with the unwavering presence of a compassionate therapist in the here-and-now. This corrective emotional experience needs to be repeated, either with a compassionate therapist, or with a compassionate community, which will reduce and eventually release the person from the hook of the addictive cycle.

Tim and Cora have written a groundbreaking manual to unpack this corrective emotional experience and the necessary interventions to inform therapist and community caregivers how to facilitate such a healing process. It is my deep privilege to recommend this manual as an invaluable gem to all who may be working with persons with addictions.

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FOREWORD

Serving clients in a substance abuse counselling centre posts many challenges every day to all the professionals being involved. It is very common for us to meet people at the worst time of their life, when they are managing to cope with the many crises, being extremely distressed and depressed as they have lost all hope, and considering ending their life. It is also common for our clients to repeatedly relapse into the ditch of addiction again and again, after they have just freed themselves from it. Most professionals would agree that substance abuse counselling service is one of the toughest jobs among all treatment programs. It is one of the services that poses the highest risks of compassion fatigue and burnt out among service workers.

We have noted the trend of growing interests in trauma-informed therapy especially in western countries. The current project funded by the Beat Drugs Fund Association is a pioneer effort to develop an indigenous trauma-informed model in the treatment of substance abuse in Hong Kong. Research studies have consistently identified high comorbidity between trauma (especially trauma happens in childhood years) and the misuse of substances, indicating that a high proportion of our clients may have their problems rooted in experiences of trauma. Trauma-informed intervention has the advantages of reducing stigma to encourage clients to seek help, and targeting the source of the problem to increase treatment efficacy and reduce relapse.

This treatment manual is not only a clinical guide, but also a documentary of the pioneering endeavors of our project team in developing a comprehensive treatment model targeting the local Chinese population in Hong Kong. Over the years, we have been working hard both in increasing the effectiveness of our treatment program, and at the same time improving the caring for our service workers. The development of trauma-informed treatment in this project is a part of such endeavors.

The relational treatment approach introduced in this manual takes into consideration both the self-care of professionals and the care for the clients. I am delighted to see such efforts in the development of an ecological service model. The experience of the project team has shown that the two aims are mutually beneficial. The better the therapist cared for themselves, the better the outcome of treatment, and the longer lasting can the service be maintained. Care for our professionals is especially important in the field of substance abuse service as the phenomenon of compassion fatigue is very common.

The field of psychotherapy is undergoing a paradigm shift from cognition-based interventions to integrative bodily based emotion-focused approaches in recent years benefiting from the recent developments in neuroscience. Therapeutic work is more and more informed not only by psychology, but also biological science on the brain. The project team has made an innovative and ingenious effort in integrating these new developments, overseas and local experiences into a comprehensive relationship based trauma-informed treatment model.

I sincerely hope that our professional colleagues and experts in the field may provide valuable feedback and inputs to our project team, so that they may further refine and develop the current treatment model. In return, we hope that our work may benefit our professional colleagues and their services to clients.

Carol Ng
Service Director
Counselling Service Centre Division
Hong Kong Lutheran Social Service

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Chapter 1

Background and Theories - Why People Do What They Do?

As mental health professionals providing services to people who abuse substances, it often puzzles us why people do what they do. If the drugs are so harmful with so many negative consequences to the person, why are they continuing to abuse it? Most if not all professionals would agree that substance issue is one of the most difficult problems to tackle.

Assessment and conceptualization are usually the first step we use to understand the person and make sense of the problems, before we can provide helpful interventions. Having the correct understanding at the beginning can guide us in the right direction. Fortunately in modern times, the fast development of neuroscience has given us updated knowledge about the problem of substance abuse (SA), making it possible for us to have a more holistic and comprehensive understanding into the core of the puzzle. In this chapter, we would provide a narrative of the background and theories of these updated neuroscientific and neurobiological information, from which our treatment model is based and well informed.

Based on our studies, we have come to the conclusion that people do what they do because of relationships, with themselves, and with other people. Loving, compassionate, and caring relationship is a central theme binding all the theories and skills to be presented in this manual.

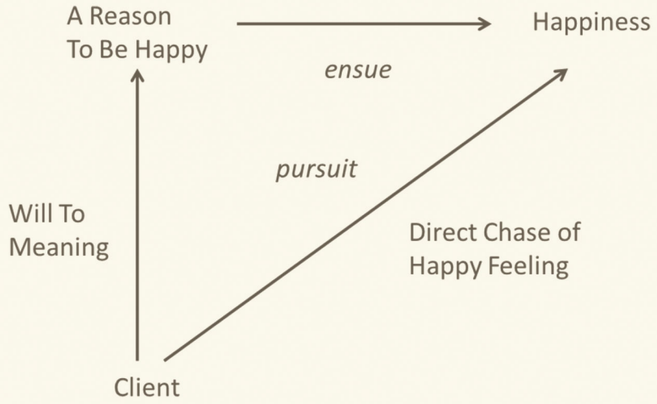
1.1 Enlightenments by Victor Frankl- Will to Meaning

Before touching on the modern findings of neurobiology, we would like to start with the philosophical and phenomenological attempts in the answer to the question of "why people do what they do". Our thoughts were influenced by Frankl's (1988) Will to Meaning in our conceptualization of the substance abuse problem. It helped to bridge us to the relational approach, though we started with the existential analytical approach.

Renowned neuropsychiatrist and Holocaust survivor, Victor Frankl (1988) asserts that human are beings of "meaning". Pleasure or positive affect are signals signifying meaning that are being fulfilled in one's life. On the contrary, suffering is the absence of meaning in one's life, creating an "inner emptiness or void", which Frankl termed as the "existential vacuum". From his personal experience of the Holocaust, Frankl hypothesized people are born with a "will to meaning", in other words, there is an innate drive inside each one of us engaging ourselves in constant search of meaning.

Frankl disagreed with Freud's pleasure principle, which suggests pleasure as the continuous pursuit of people. He illustrated his point with the following diagram (Figure 1) in his book (Frankl, 1988, p.21).

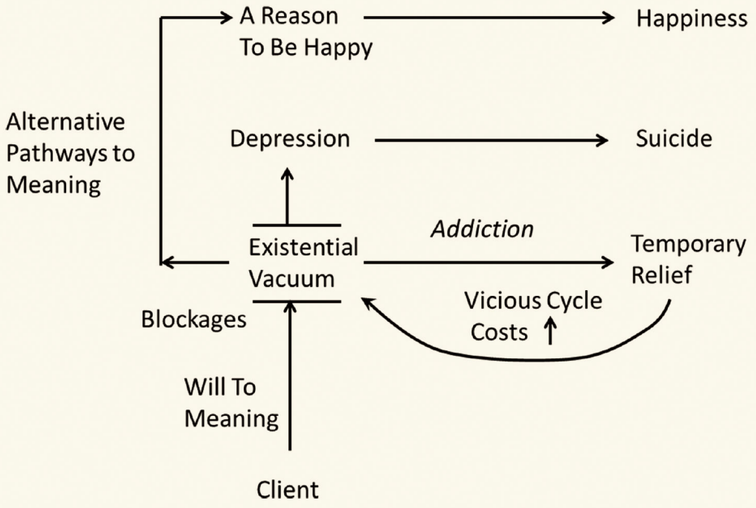
Figure 1 Victor Frankl's Notion of Will to Meaning (Adapted from Frankl, 1988, p.21)



Frankl asserts that if happiness is made as the immediate goal of pursuit, one would lose the reason for happiness and happiness would not last. Contemporary findings in neuroscience confirms that physiologically our body would release neurotransmitters giving passion (dopamine), focus (noradrenalin) and energy (acetylcholine), when we are owning and pursuing goals that are meaningful to us (Fabritius & Hagemann, 2018).

Drawing on the wisdom of Frankl, the cause of addiction can be conceptualized as blockages in the pathway for meaning. These blockages can be originated from unrealistic goals, expectations, maladaptive beliefs, coping or behaviors. These blockages would manifest in the forms of repeated failures, disappointments, and frustrations, leading to sufferings that are both psychological and psychosomatic. Such psychological symptoms or pathologies are simply the revelations of failure of reaching existential meaning, leaving an inner sense of meaninglessness, which was coined by Frankl as the "existential vacuum". If the person fails to find an alternative pathway to meaning when encountering a blockage in their life's quest, addiction would be a convenient way of temporary relief. The quick mood altering effect of drugs is a direct pursuit of happy feeling bypassing the need for a meaning or reason for the happy feeling. As we are all aware, such relief is short lived, and the deadly feature of addiction, is that the strength of stimulation needs to be continuously increased in order to maintain the happy feeling over time, due to tolerance. Subsequently, the person would go into a vicious cycle of paying higher and higher costs for the happy feeling, until it is not sustainable anymore. At last, the person may seriously consider ending their life, when they can no longer pay for the costs of the drugs. Figure 2 summarized the conceptualization of addiction based on the notion of Will to Meaning.

Figure 2 Existential Analytical Model for the Conceptualization of Addiction



Following this line of thought, the problem of substance abuse is not about the substance but the blockages of the quest for meaning. Paradoxically, the substance, which is harmful and costly, provides a temporary relief that gives more time and space for the person in successfully finding an alternative pathway or solution to life's goals and meanings, or at the least, making the existential vacuum more tolerable temporarily. Psychiatric medication is one of the good alternatives in providing such relief in the place of illicit drugs or avoidant behaviors without the heavy cost of addiction. Although the medication itself cannot be a replacement for existential meaning, it buys time and gives energy for finding one.

Conceptualization based on the existential analytical model cautions the danger in the simplistic intervention of stopping drug use without implementing alternative adaptive pathways to existential meaning.

1.2 Enlightenments by Neurobiology

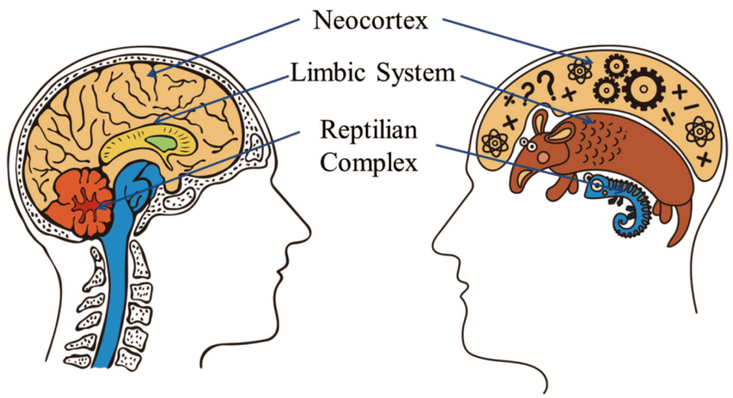
While Frankl's notion of the human will to meaning, is insightful in the nature and function of addiction, here comes a practical issue faced everyday by professionals working with people who abuse substances. Our clients, when they come to seek help, have lost their meaning or purpose for their life, and live in an existential vacuum, in which pain and sufferings are dependent on the relief by drugs. What would be an effective approach to enable their reconnection with the purpose that would be meaningful for their life? In the following sections, we are going to move one step further from Frankl. Evidence in neurobiology, especially the polyvagal theory, shows that love and compassionate relationship is the meaning that all human are pursuing.

In Frankl's time, there was no brain scanner, or neurofeedback devices that allow us to probe deeper into the physiological and the neurobiological processes underlining our affects and emotions. Neurobiological knowledge has showed a clearer picture of the hardware and software (our body and mind), and enhances the traditional wisdoms in psychology and psychotherapy with more solid evidence.

1.2.1 The Triune Brain Theory

The concept of the brain being consisted of three parts was first coined by the neuroscientist, MacLean in 1990. As shown in Figure 3, these three parts are:

Figure 3 The Triune Brain



- Neocortex at the top

  This is the centre of higher level intelligent human functioning. The front part of the cortex is the Prefrontal Lobe (PFL), which is the "executive centre" governing all executive functions, mood management, and other cognitive functions. The other areas of the cortex are mainly composed of neurons for the sensorimotor functions, managing our body sensations and movements. This is the part that makes human different from other animals, gives us intelligence, logical thinking, various kinds of cognitive abilities, and higher level of self-awareness.

- Limbic System in the middle

  The limbic system is located in between the Neocortex and the lower Reptilian Complex. It is also called the mammalian brain. This part is commonly found in all mammal animals. This is the centre of our emotions. All our feelings like fear, pleasure, anger, sadness and love are raised from here. We would not have bonding or attachments with others if we do not have the limbic system. The emotions are signals for us to appreciate what is happening in our environment and relationships, helping us to connect with other people, knowing that we are all sharing similar experiences of emotions.

- Reptilian Complex at the bottom

  The Reptilian Complex is the part being formed the earliest among the three. It takes care of our basic survival functions, such as breathing, blood circulations, body temperatures, etc. It is also called the primitive brain, and is the main structure of the brain in reptiles. It consists of the brainstem and the cerebellum, and connects with the spinal cord. In general, the functions of this part of the brain take higher priority over other brain functions as they are primitive to sustain our survival.

1.2.2 Dualistic Framework of Brain Functioning

In the dualistic framework of brain functioning, we divide the brain into Cognitive and Instinctual Brain; Mind and Body; Left and Right Brain; or Conscious and Unconscious. These pairs of terms are used interchangeably in this manual.

The triune brain model has provided an overall framework on the function of our brain. The Neocortex (often times referred as the Cortex) can be heuristically considered as the source of our cognitive activities and therefore we used the term "Cognitive Brain" to refer to this "person" of the brain trinity. This is also where our "Mind" or "Consciousness" is located.

Both the Limbic System and the Reptilian Complex are often collectively referred as the Subcortical Brain, as they are just below the Cortex. This part of the brain functions like an auto-pilot system, collecting, processing and responding to signals/stimuli from the environment and our internal body, mostly all on its own without involvement of the Cognitive Brain, carrying out important functions of maintaining one's survival. The sub-cortical brain can heuristically be considered as the seat of the unconscious, whereas the Cortex is the seat of the conscious. In this manual, we used the term "Instinctual Brain" to refer to the Subcortical Brain consists of the Limbic System and Reptilian Complex. And in this manual, the term "Body" is also used to refer broadly to instinctual and bodily functions of the brain.

Modern brain scan technology showed that there are more connections from the Subcortical Brain to the right side of the Cortex, such that the right side of our brain is more associated with the autonomic, and survival-serving instinctual functions. The right brain is considered to be more instinctual, which is more related to the emotions, imagery and implicit memory. The left brain tends to be more associated with the cortical cognitive functions. It is therefore often in literatures, the Left Brain is being referred as the cognitive and conscious part of the brain, while the Right Brain more of the emotional, instinctual and unconscious part of the brain. In this manual, the terms "Left Brain" and "Right Brain", are used interchangeably with the terms of "Cognitive Brain" and "Instinctual Brain", respectively.

1.2.3 Polyvagal Theory

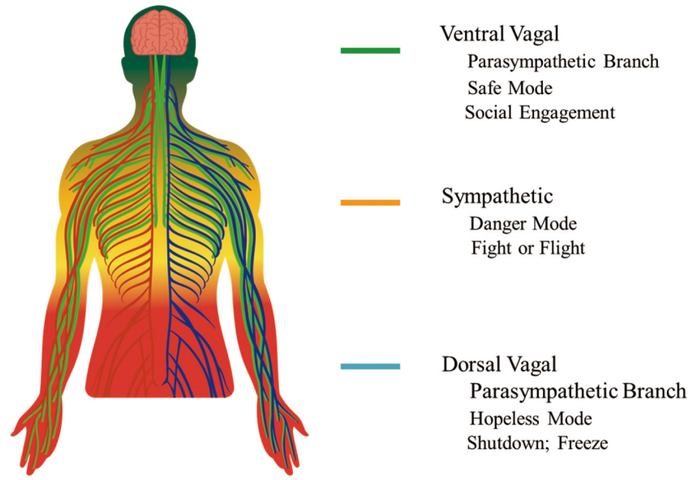
Stephen Porges (1995) published the landmark discovery of the polyvagal theory in the 1990s. It is then being widely applied in conceptualization and treatment of traumatic experiences. This is an important concept that helped to form the basis of the presuppositions we used in our treatment model. The followings are a list of the salient points of the theory related to our treatment model.

1.2.3.1 Neuroception

It is a term coined by Porges to signify our in-born mechanism of the Autonomic Nervous System (ANS), which acts like a guardian angel, to protect us from all threats to our survival, without much involvement from the Cognitive Brain. The ANS, connected with the Instinctual Brain, is continuously monitoring our internal and external conditions. It acts on its own to manage our physical resources in response to various situations inside and outside of us. Such intuitive and autonomic sensing and responding by our neural and instinctual systems, is named by Porges as the neuroception. In contrast to "perception", neuroception provides a much faster response as it bypasses the complicated and slow process of the Cognitive Brain. Such fast and reactive mechanism is to ensure our safety, which is the highest priority for our survival. However, it is not without trade-offs. False alarms may be easily triggered as the system would rather err on the safety side, instead of a careful examination of the situation by involving the slow process of the Cognitive Brain.

1.2.3.2 The Three Autonomic States

Figure 4 The Three Autonomic States According to the Polyvagal Theory



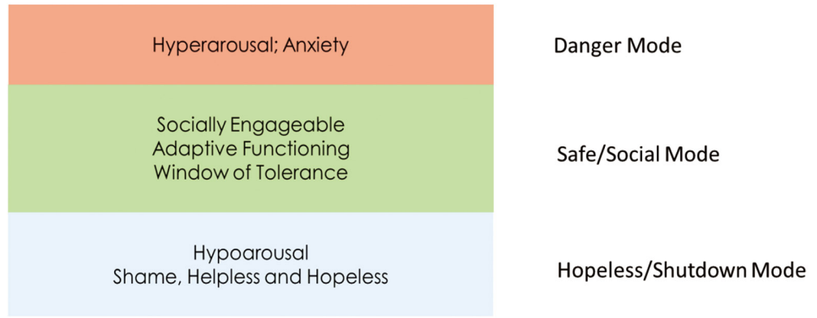
Our body is always in one of the three states determined by neuroception, which continuously monitors and manages our internal and external conditions, automatically changing our physiological states according to whether it is safe, dangerous or hopeless. As shown in figure 4, there are two branches of the autonomic nervous system, namely the sympathetic nerve and the parasympathetic nerve. The sympathetic nerve can be metaphorically considered as the accelerator while the parasympathetic nerve, the brake. There are also two branches in the parasympathetic nerve, the ventral vagal and the dorsal vagal. Porges discovered vast differences in these two branches of the parasympathetic nerve. When all is well and safe, the ventral vagal, also being called as the smart vagal, which connects all our facial, auditory and vocal muscles, ending at our heart, would be activated and we would be tuned into a condition for social engagements and relational connections. In the Safe mode, our Cognitive Brain is fully active, and works in good collaboration of the Instinctual Brain, supporting all the resources needed as we are making meaningful connections with ourselves and people around us.

When a threat is sensed, be it danger in the physical environment, physiological problem inside our body, or hostile cues from other people, the ANS through the process of neuroception, would enable the sympathetic nerve, mobilizing our body resources to provide more energy for a fight or flight response. The body is geared toward a battle, breathing will become short and fast, heart rate increases, transferring more oxygen to the muscles and tensing them up in preparation to deal with the danger. The amygdala, which is the fear centre in our limbic system, would generate a fear signal and the Instinctual Brain would hijack the control of the body from our executive centre in the prefronal cortex. Just like the Chinese saying of "no processing through your large brain" (不經大腦), our instinct takes full control of the body and acts like an auto-pilot to protect us, until all the threats are perceived to be eliminated.

If the person is trapped and they perceived no way to eliminate the threats, the Instinctual Brain would turn the fight or flight mode into the shutdown mode, by enabling the more primitive branch of the parasympathetic nervous system, the dorsal vagal, sending signals to the visceral organs and immobilizes our body to preserve energy and numbing our senses from the predicted pains and hurts. This is a state often being named as "feigned death", a basic instinct of all animals in dealing with trapped and inescapable dangers, prolonging their life through energy preservation and reducing pain through numbing and dissociating. It can also have the effect of fooling the predators in believing the animal is dead and stop further attacks.

1.2.4 Window of Tolerance

Figure 5 Window of Tolerance and the Autonomic States



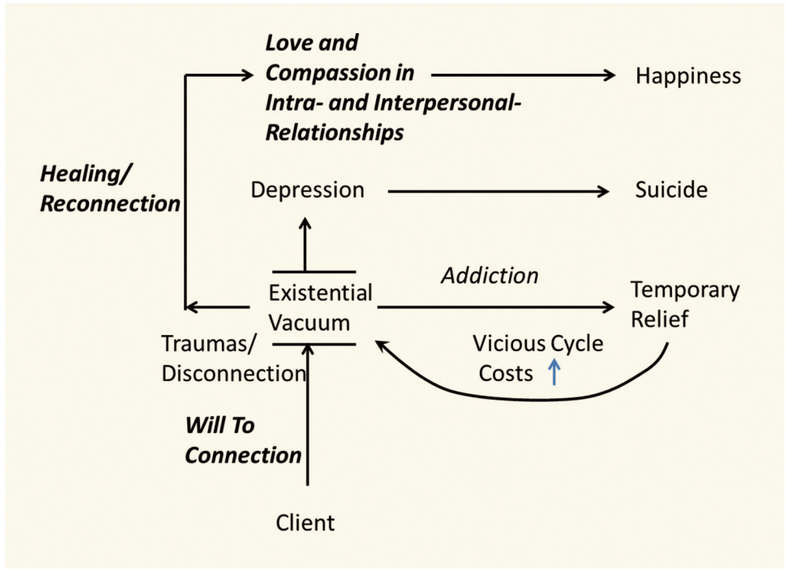
Window of tolerance, is a term coined by Dan Siegel (2010) to signify the upper and lower boundaries of our emotional states, beyond which, we may run into hyperarousal or hypoarousal. Integrating the concept with the polyvagal theory, the upper and lower boundaries are the edges, determined by internal and external conditions, that our neruroception mechanism would throw us out of the feeling safe zone, and run into the Danger zone (hyperarousal), or the Hopeless zone (hypoarousal).

1.3 Will to Connection: Relationship at the Core of Human Needs

The above is a brief introduction to the polyvagal theory. Taking a closer look at such remarkable discovery of ourselves, and combining Frankl's notion of Will to Meaning, we are gaining a better picture of ourselves. The Danger and Hopeless states are just our natural defense mechanisms against threats to ensure our survival. The meaning of our life should be found in the Safe state, this is the state in which our whole body works in unison, and all our resources are geared toward relational connections. Neuroscience has also discovered that our brain releases the most pleasurable chemicals, oxytocin and dopamine, when one is in love or in strong relational bonding with others (Fabritius & Hagemann, 2018). Oxytocin is often referred to be the love or cuddle hormone, which gives satisfying and pleasurable feelings. Dopamine is released when we are in touch with something that is beneficial to our survival.

Integrating Frankl's model and neurobiological findings, love, connection and relation can be considered as the meaning and the cause, while oxytocin and dopamine, signifying pleasure and motivation, the effects. In our opinion, Frankl's "Will to Meaning" needs to be revised as "Will to Connection", in the light of modern neuroscientific findings. We have observed the trend of such a paradigm shift as more concrete evidence in how our brain works are being uncovered. We have modified the earlier figure on the existential analytical model of addiction to Figure 6, the relational model of addiction conceptualization. Our treatment model adopted this renewed conceptualization model.

Figure 6 Relational Model of Addiction Conceptualization



1.4 Understanding Suicide and Substance Abuse

Our physical body has an overall program to protect us. Ensuring our survival is by default the task and goal with the highest priority for human. However, survival alone cannot be a lasting goal. If one is constantly in the Danger mode, keep fighting and defending without any hope that they can move into the Safe/Social mode. The Hopeless/Shutdown mode will then be activated if one finds it hopeless and helpless with the situation. It is another extreme to the "fight or flight mode". In Shutdown mode, one would give up all endeavors, shift into a very passive state akin to what Frankl described as living in the existential vacuum. People in this condition usually would suffer from various degrees of depressive symptoms, losing interests in all activities and motivation. If the situation continues, the pain and suffering would continue to increase, to a point the person would start to consider ending their life together with the pain and sufferings that appear to be meaningless for the person.

By the notion of Will to Connection, we do what we do in order to search for meaningful connections and relationship with ourselves and others. What if someone is continuously trapped in the "fight or flight mode" or the "shutdown mode"? In such situations, substance abuse, or other forms of addiction, like gambling, is often used as an escape or compensation for the pain of being trapped in the space of existential vacuum.

Therapists working with people having the substance abuse issue need to have good awareness of the function of the drugs in the person's life. It is dangerous for the client if they are asked to quit the drugs without an alternative way of coping. Drugs are used as a way of coping by the client, the core of the problem is isolation from self-connection and others connection. Though drugs are harmful, it may have been the only support for the client. Working on removing the drugs without providing alternative support, like psychotropic medications or a relational bonding that is perceived as supportive and reliable for the client, may have put the client in a dangerous crisis situation of suicide, or non-compliance to therapy due to the avoidance to the shameful feeling of failing to meet the demand of the therapist. Our model of therapy encourages multidisciplinary and relational interventions, such that clients may develop alternative coping mechanism in the quickest possible way to the drugs they have been addicted to.

1.5 Memory, Trauma and Substance Abuse

Dan Siegel described people suffering from traumatic experiences as "prisoners of the past" (Siegel, 2010). We would try to summarize his wonderful narration of the phenomenon of trauma in his landmark "Mindsight" book (Siegel, 2010) in the following sections.

1.5.1 Implicit and Explicit Memory

Understanding how our brain stores information is important in understanding trauma. One way to classify our memory is to divide them into implicit and explicit memory. While I am typing away on the keyboard of my computer, I am using the implicit memory in my brain. Implicit memory records six domains of information in our brain: perceptions, emotions, bodily sensations, mental models, and anticipations. The recording and processing of this memory are mainly handled by our Instinctual Brain or mostly on the right side of our brain. In our early years of life, implicit memory plays a dominant role before we can speak around 18 months after birth. It provides us with mental models that govern our behaviour without our awareness. For example, you do not need to think when you are typing or riding a bicycle, unless you are at the stage of learning, which needs to involve your active attention and your Cognitive Brain.

In contrast, our explicit memory records factual and autobiographical information that our Cognitive Brain is aware of, and is mostly associated with the left side of our brain. Autobiographical means that we are aware of the time together with the content of the events, able to know whether it is happening now or in the past. Whereas for implicit-only memory, all the experiences appear to be happening at the moment, even though it is triggered by something in the distant past. If you ask me to recall the time when I was learning keyboard typing, I will have the image of looking at the book trying to locate the keys and try to move the right fingers onto the key, some years ago in my study room. I would be using my explicit memory to recall this experience in the past.

Implicit memory is the first layer of our memory and is recorded whenever we have an experience, whether it is further encoded into the explicit memory, depends on whether we pay attention using our Cognitive Brain at the time of the experience. Our focus and attention will enable the hippocampus, a sea-horse like structure in our limbic, is responsible to record our experience from the implicit to the explicit memory.

1.5.2 Trauma

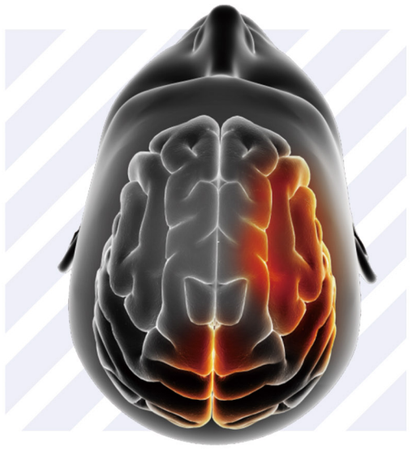


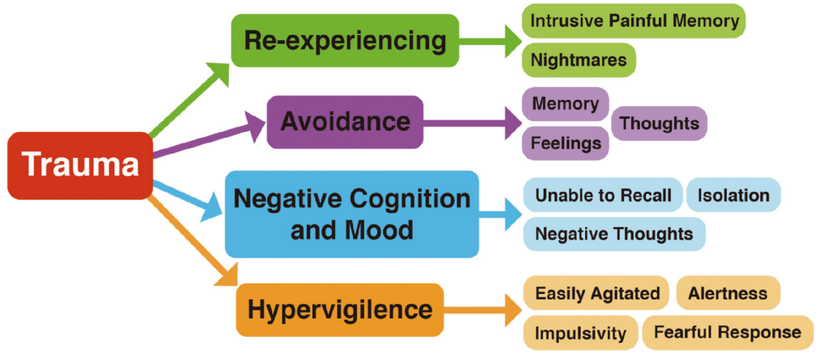
Figure 7 Scan of the Brain in Traumatic Reaction (Adapted from Van der Kolk, 2014)

When one experiences a life threatening event, that is, a traumatic experience, our implicit memory will record the experience, our body will be set into the Danger mode by neuroception (according to the polyvagal theory), releasing large amount of stress hormone like adrenalin and cortisol, preparing our body for fight, flight or freeze actions. In stress situations well beyond the limit of our window of tolerance, our Instinctual Brain takes charge, while our Cognitive Brain recedes to the backstage, and the hippocampus would be inhibited, and stop recording implicit memory onto the explicit. Therefore memories of trauma are stored in the implicit-only memory with no encoding on the explicit part. We are not able to make sense or auto-biograph the experience using our Cognitive Brain with traumatic experiences. They are lying in the emotional brain, waiting to be triggered by internal or external cues. Figure 7 shows the scan of our brain when undergoing a traumatic reaction or a flashback (Van de Kolk, 2014). The right side of the brain, which associates with our implicit memory, and the back of the brain, the location of our visual cortex, shows a lot of activities. On the other hand, the left side of the brain, which associates with explicit memory and cognitive processes, is quiet and can hardly see any activities. It indicates that the person in the flashback is re-experiencing the traumatic event in the past, with vivid images, strong feelings of fear and bodily sensations, all seem to be happening in the current moment. Without the involvement of the Cognitive Brain, the person loses track of the time of the event and re-experienced the painful past event just like at the current moment.

The fearful reaction in the flashback would once again shutdown the hippocampus, failing again to make sense of this experience, until the triggers are passed, or the person dissociates himself from the stimuli and traumatic memory. The traumatic memory remains only in the implicit part of the memory, waiting for the trigger next time.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5; American Psychiatric Association, 2013), is the gold standard for diagnosing psychological problems including posttraumatic stress disorder (PTSD). Figure 8 shows the symptoms indicating PTSD base on the criteria given by DSM 5. The symptoms can be understood from the perspective of a fearful experience being stored in the implicit-only memory. Among the four major groups of symptoms, the re-experiencing is the flashback from past experience triggered in the implicit memory; the numbing and avoidance of the triggers are our attempts to avoid re-experiencing the flashbacks; the hypervigilance is due to anticipatory function of the implicit memory, putting ourselves always on guard for dangers; and cognitively and emotionally, we are confused and not able to make sense of our feelings and behaviors as the connection between the implicit and explicit memory is not made.

Figure 8 Summary of PTSD Symptoms According to DSM 5



1.5.3 Substance Abuse

Substances would be a quick fix for someone who has experienced trauma. As the drug acts directly to alter our feelings, that is, on the experience of the implicit memory in the Instinctual Brain, they will remove all painful feelings and experiences for the person suffering from PTSD. Research consistently shows high comorbidity rates between PTSD and substance abuse problems (Cottler, Compton, Mager, Spitznage, & Janca, 1992; Najavits, Weiss, Shaw, & Muenz, 1998; Schäfer & Najavits, 2007). It was the main motivating factor for this project leading to the publication of this manual.

Our clients who experienced trauma, being a prisoner of the past, are trapped in painful and fearful feelings that they are not able to make sense, nor able to verbalize. What is worst, as we understood from polyvagal theory, people in such a state are hard to engage in social relationship with others, as the body is continuously going between the Danger and Hopeless state due to the unresolved past memory. PTSD experience renders the client to remain in the state of the existential vacuum as depicted by Frankl (1988). It is natural that one would want to come out of this condition at all costs, even though it would be just a temporary short relief by drugs.

Illicit drugs such as Cocaine, Ice, Cough Medicine, Ecstacy, and Tranqulizers act directly on our emotional brain in altering our mood quickly. The short lived positive experience induced by the drugs acts on the pleasure centre, the Nucleus Accumben (NA), inside our limbic system, fooling the Instinctual Brain to believe that the drug is essential for our survival. Once the brain has registered such positive impression of the drug, strong feelings of craving in seeking relief by the drug will emerge when the traumatic memory is triggered. In this case, the Cognitive Brain may have the awareness that the drug is not beneficial in the long term, however, the priority for attention of the Cognitive Brain is much less than the emotional Instinctual Brain, as the Instinctual Brain is responsible for our survival and is given a much higher priority, especially the person now is in the Danger state (feeling desperate in need of relieve from the negative mood). As a result, the person would submit in taking the drug, and repeat the cycle again and again. Due to the tolerance of our body to the effect of the drug, the dosage keeps increasing each time in order to achieve the same level of relief. A vicious addiction cycle is formed and the costs of the coping, including both financial and physical harmfulness, would keep increasing, until it is too high to bear.

The effect of drug addiction, is similar to the effect of trauma, in that the implicit memory, or the instinctual part of the brain is in control, instead of the cognitive part of the brain. The Cognitive Brain in no way can compete with the Instinctual Brain due to our in-born program for the higher priority for survival and preservation of life. Drugs, which act on our pleasure centre, and trauma, which acts on our fear centre, are all located in the limbic system, works in pair to form a maladaptive cycle of addiction.

1.6 Memory Reconsolidation

How to heal trauma? Can prisoners of the past be freed?

Memory reconsolidation was discovered in year 2000. The discovery provided hopeful answers to healing the wounds of traumatic memories. Before this, the traditional belief was that memory consolidated into the long term memory cannot be altered. Nader, Schafe, and LeDoux (2000) discovered that changing the consolidated memory is possible under special conditions. They named such memory changing process as memory reconsolidation and the theory has been gaining more and more attention, and being applied in psychotherapy and the treatment of trauma (Ecker, Ticic, & Hulley, 2012).

The process of memory reconsolidation starts with memory reactivation. After the memory is recalled, the neural network associated with the memory becomes malleable within a period of around 5 hours. During this period, a new experience being very different to the original experience is applied, the neural circuitry can then be rewired according to the new experience, forming a new version of memory that is stored back into the long term memory. This new version of reconsolidated memory integrates both the positive new experience with the negative past experience, and would be free of the traumatic reactions when being recalled again.

When we apply memory reconsolidation in healing traumatic experience, the key is in the moment when the client reactivates their traumatic memory, which is implicit only and would throw the client into the "fight or flight" or "freeze" mode, that is, either the Danger or Hopeless states. Once the client is in these modes crossing the boundaries of the window of tolerance of mood, they would feel very uncomfortable and would naturally want to quit and sabotage any further efforts to reconsolidate the memory. Therefore, it is important to engage the client in a good therapeutic relationship as an important cushion and resource for the client before exposing the client to past traumatic experiences. It is also important to track client's condition moment to moment to see any signs of hyperarousal or hypoarousal, and help regulate client's mood to keep them inside the window of tolerance. Titration is also an important skill to limit the exposure to traumatic materials to help affect regulation for the clients.

Therefore the key in the success of memory reconsolidation is to keep the client in the Safe State of their ANS inside the window of tolerance, while the past experience is gradually reactivated. The therapist acts as a transitional attachment figure for the client, such that they feel the support, care and understanding while the past is reactivated again. In such condition, client will stay in the Safe mode and their hippocampus will be enabled, while they are paying attention to the past memory, in the presence and support of the therapist, and register the new corrective integrated experience onto the explicit memory. The traumatic experience would no longer be an implicit only memory and the Cognitive Brain can recognize that it is just an event, miserable though it was, it is already in the past, and there is no need for the body to turn into defense mode again.

In essence, the process of memory reconsolidation has been named as the "corrective experiences" in psychotherapy (Alexander, 1980). The neuroscientists have found concrete evidence to support this therapeutic wisdom long discovered.

Illicit drugs are used to numb and avoid feeling the pain of hurts and trauma as in the case of substance abuse. Successfully healing the trauma by registering onto the Cognitive Brain a peaceful version of the memory through corrective emotional experiences in therapy, would naturally remove the need to use the drugs for medicating the pain of trauma. The risk of relapse would be significantly diminished.

Chapter 2

Development of the Treatment Model - From Seeking Safety to Seeking Connection

Our therapy model has gone through the following stages of development:
1. "Seeking Safety" Stage
2. Neurobiological Study Stage
3. Relational "Seeking Connection" Stage

2.1 "Seeking Safety" Stage

At the initial stage of the project, we were influenced by a well-established evidence-based model of intervention in Trauma-informed Substance Abuse Treatment called "Seeking Safety" (Najavits, 2002). The model focused on the stabilization of clients' physical and mental conditions. It shifted the traditional prioritized focus on "quitting the drugs" or "resolving the trauma" in therapy, to the establishment of a sense of security in the clients. The author believed that stabilization and affect regulation are the central tasks in trauma-informed treatments. The model was met with great success and has been considered to be one of the best practices in trauma-informed substance abuse treatment.

While we appreciate the advantages of the "seeking safety" model, this is a model developed back in the 1990s. We considered that it captured an important part of the therapeutic process, but there is still room for improvement with the new findings in neurobiology.

2.2 Neurobiology Study Stage

We expanded the "seeking safety" concepts with neurobiological findings from:

- The Polyvagal Theory

As we have illustrated in Chapter 1, the polyvagal theory provided a sound scientific basis on why stabilization and affect regulation are so important in therapy for trauma. People's functions are limited if they do not feel safe. Trauma renders one to be locked in the fight or flight (anxiety) and shutdown (dissociation) mode. As such, "safety first" can be generalized to almost all situations of psychotherapy, helping clients to leave the Danger and Hopeless modes.

What was more enlightened by the theory is the relational need at the core of each of us. Safety is the means rather than the ends. Based on the support of such important discovery by Porges (1995), we may conclude that the meanings by which we as human beings are all seeking, exist mainly in the relational context to self and others. This is consistent with the view of the founder of Interpersonal Neurobiology, the renowned neuropsychiatrist, Dan Siegel (2010).

- Cognitive and Instinctual Functions of the Brain

By reviewing current literatures in neurobiology, and taking into consideration of the application in psychotherapy, we divided brain functions grossly into Cognitive and Instinctual. We have heuristically associated these functions physically with the left and right sides, or upper cortical and lower subcortical areas of the brain. Since the right brain is heavily connected neurologically with the subcortical area of the brain, we named this part as the Instinctual Brain, and the left side and cortical part of the brain, the Cognitive Brain. We used these terms interchangeably, between Left Brain and Cognitive Brain, Right Brain and Instinctual Brain. The classification of brain functions by left and right sides of the brain is commonly adopted by current literatures on neurobiology and related psychotherapy. It helps our conceptualization of brain function and its application in therapeutic work.

Under such dualistic framework of the brain, we would be able to better appreciate and explain the phenomenon of trauma, mood disorders, and psychopathologies, as well as devising suitable intervention strategies, to facilitate the changes needed to make clients healthy again.

• Conscious and Unconscious; Implicit and Explicit Memory

In fact, modern cognitive neuroscience has confirmed the existence of the "conscious" and "unconscious", and they are being called "explicit memory" and "implicit memory" (Anderson, 2000). Such classification of memory functions is consistent with our dualistic brain model, with the Left Brain mostly associated with the "explicit" processes, while the "implicit" mostly with the Right Brain.

The explicit is familiar to us as it is the cognitive part of our being. It tends to focus on one thing at a time, associates with factual and autobiographical information, like numbers, logic, event chronology, planning and organizing. It is our conscious awareness and is the "what we are aware of" in the here and now.

The implicit is related to our physiological functions, body sensations, emotions and even the skills we have mastered and our habits. After we have mastered a skill, e.g. typing, our brain will use the "implicit" (right brain) to process it. While you are typing, you have no awareness of your fingers as they are under the control of the "instinctual" brain. If you try to use the cognitive brain by remembering the location of the keys and the movement of your fingers, the operations will become very slow and clumsy, just like at the time when you first learn typing.

Apart from this, our breathing, heart beats, physiological operations of our internal organs are all implicit unconscious operations managed by the Instinctual Brain. When a habit is formed, it will be managed by the Instinctual Brain and the implicit memory. Addiction can be considered as a persistent habit, which is hard to change as it is associated with the unconscious instinctual part of the brain.

The advantage of the "implicit" and "unconscious" is that it is fast in operation and saves energy. Cognitive processes in the brain consumes lots of resources and energy. However the "implicit" has the disadvantage of being automatic, difficult to tolerate changes and exceptions, and leave the person very few options (e.g. either fight or flight). For the "explicit" and "conscious" part, it is slow but more flexible, provides many more adaptive choices for the person.

Most of the mind-body practices (e.g. mindfulness; focusing) are voluntary communications between the cognitive and instinctual brains (Pavuluri, 2015; Gendlin, 1982), connecting the conscious with unconscious functions. For example, when one observes their breathing, the observing part is managed by the Left Brain and the being observed "breathing" part is the Right Brain function.

Such mental process (integration between the cognitive and instinctual) is mediated by a subcortical structure called the "insula" in the limbic area. The insula integrates cognitive, sensory and emotional information and conducts regulation for the whole body, achieving affect regulation and maintain the body in an optimal homeostasis condition (Pavuluri, 2015).

Brain scans of traumatic reaction revealed that the Right Brain is very active during flashbacks, and there is almost no activity on the Left Brain and the language area (Van der Kolk, 2014). It is a condition of "fear without words". This explains why many trauma survivors abuse substances as drugs can directly alter the feelings (act on the Right Brain). It also indicates that cognitive intervention alone may not be effective as the Left Brain is idled during the recall of trauma memory.

• Neuroplasticity and Memory Reconsolidation

Neuroplasticity is a well-known concept which posits that our neural network is changeable and adaptable to improve its functions. Memory reconsolidation sheds light on the process of change, which needs a corrective experience that the person feels safe, such that new learning is possible to be recorded on both the implicit and the explicit memory, thereby healing the person from the effect of the traumatic experience.

• Neurotransmitters and Drugs

Drugs can directly act on our subcortical part of the brain and activate the secretion of neurotransmitters like dopamine, oxytocin and GABA. It makes the drugs very convenient in directly altering our Right Brain processes, and easily creating a false perception that these drugs are vital to our survival.

To counter the effect of drugs, a relational approach in therapy is warranted as it directs us to the core need of the person. The experience of a positive relational connection with another human being, gives the client the hope that they can cope without drugs, their needs can be met by making it right their relationship with themself, and thereby with others.

2.3 The Relational "Seeking Connection" Stage

The concept of "seeking connection" was inspired by Anita Fok, a well-respected scholar and clinician in family therapy. She is invited to provide regular clinical supervision to services of our organization. In one of her demonstrations, she brilliantly showed the vast difference between the interventions of a relational approach to that of an individualistic approach (A. Fok, personal communication, August 9, 2019). We were able to experientially appreciate the power of relationship working in therapy.

At the same time, we have also learned from renowned supervisors and therapists in the Accelerated Experiential Dynamic Psychotherapy (AEDP), Danny Yeung, Kwok Wing Wu and Cammy Cheung. Danny inspired us about the importance of therapeutic presence and the concept of the internal human tuner, the insula (D. Yeung, personal communication, May 6, 2019). We are grateful for Wu and Cammy, who agreed to support the project in providing the part of trainings on clinical skills. From their wonderful teaching, mentoring and modeling, we came to appreciate the many relational strategies and skills being brilliantly integrated in the AEDP therapy process.

These amazing encounters and influences have opened our eyes and reminded us of all the evidence in neuroscience indicating that we as human are born for relationship and connection with self and others.

- In the polyvagal theory, people can only engage in social connection in the safe mode, when the smart vagal is being enabled. When we are in danger, we need to use the right brain functions to keep us alive and not able to make relationship with others. However, love and relation is a core need for human, if we stuck in the stress mode for too long without the nourishment of relationship, we develop all kinds of psychopathologies and even suicidal ideations to end the pain of loneliness and meaninglessness. Loving relationship is the most important source of meaning for human life.

- Oxytocin is an important neurotransmitter, as it is related to love and relationship. When we are in love, not only oxytocin is released, but also dopamine, giving us motivation and energy, to go for what is good for our survival (Fabritius & Hagemann, 2018). This clearly shows that love and relationship is good and needed for our survival. To heal trauma and quit drugs, oxytocin and dopamine released due to therapeutic connection and relationship are the first step in giving a corrective experience to clients that they can see hope apart from drugs and addiction.

- For the part on intrapersonal relationship, we observed that skills like mindfulness and focusing can have such effect. Based on the practice of focusing and neurobiological concepts, we constructed the Self-Compassionate Communication (SCC) exercise, aiming for the development for a compassionate self-connection and relationship. The practice is beneficial for self-care, helping therapist to be more present in therapy and can be taught to clients.

- Connection with the therapist and compassionate self-relationship are important in helping the client to heal from the trauma and relieve themselves from the dependence on drugs. The work does not stop here, we need to support client to proceed with making meaningful interpersonal relationships outside of therapy, connecting with healthy communities. This is the important final part of treatment, and important work for relapse prevention.

At this stage, we adapted and integrated skills from various well-established treatment modalities, like AEDP (Fosha, 2000), Focusing (Gendlin, 1982; K. Whalen, Personal Communication, October 28, 2015), Psychosensory and attachment based treatments (K. Barthel, personal communication, July 29, 2019). The integration is built upon the principles and processes we have identified in our relational approach to trauma-informed treatment. We have designed the model in a way that it can be easily integrated with other treatment modalities, strategies and skills, targeting the goals and principles in each stage of the treatment.

2.4 Toward a Relationship-Based Therapy Model

Relational connection is at the core of our therapy model, and there are two types of relational connection: intrapersonal and interpersonal. The first step of therapy is to build up a therapeutic relationship with the client as the first agent of change. Base on the therapeutic bond with the client, the therapist then support the client to resolve the trauma and past memories that are hindering the client's functioning and their ability to have love and compassion for themselves. Often times, the clients are still in an insecure physical condition or environment when initially entering therapy. Case management work to build up security in the physical aspects, should be given priority to therapeutic intervention. After these physical and mental barriers are removed, clients would be guided in the process and taught skills to nurture a compassionate relationship with themselves, and be able to effectively regulate their affects and manage their life. The final stage of therapy would support the client to develop meaningful relationships with others and connect them with healthy communities. Therefore, the stages of therapy go in the following flow:

i. Interpersonal: Therapeutic relationship between therapist and client
ii. Intrapersonal: Client's self-compassionate connection
iii. Interpersonal: Client's connection with others and healthy communities

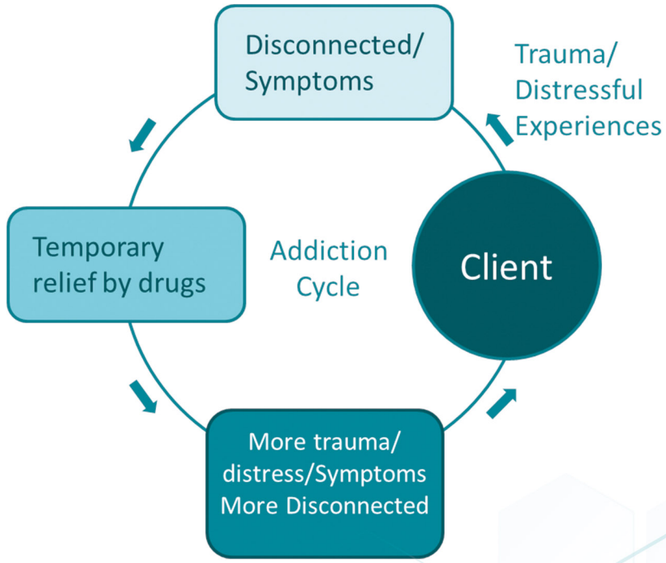
Interestingly, we noted the above key elements in our treatment model, though originated from a very different theoretical background, are actually in resonance with the meditation of Virginia Satir (Banmen, 2003): peace within, peace between, and peace among.

2.5 Presupposition of the Treatment Model

The Polyvagal Theory provided a sound base for our assessment and conceptualization framework. Our presupposition for our clients is that everyone lives in a relational context, and seeks to connect with ourselves, and others, in a loving and caring way.

Following this line of thought, psychopathologies, like substance abuse, depression, anxiety, are the outcome of failing to connect meaningfully in the relational context, and are maladaptive coping mechanisms to sustain our survival in a less than ideal form. The Safe mode of the polyvagal state is what we aim for, while the Danger and Hopeless modes are the coping and defensive mechanisms to protect us, so that the Safe mode may be restored later. Trauma is a tragic experience that locks our body in the defensive mode, stopping us from restoring the relational mode. Figure 9 shows the overall conceptualization of the clients' issue.

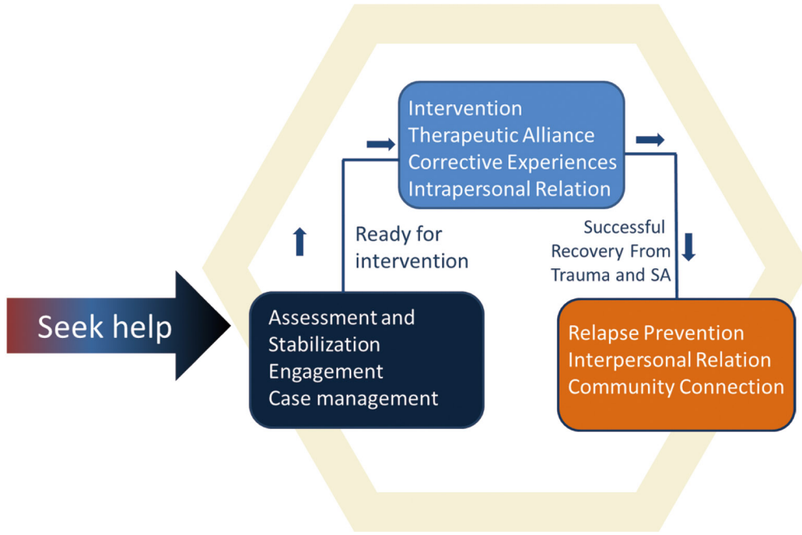
Figure 9 Addiction Cycle in Trauma-Informed Substance Abuse Conceptulization



2.6 Overview of the Treatment Model

Based on the above conceptualization of the clinical issues, our treatment model follows a staged approach, aiming to suit different needs of clients, integrating theories and concepts of addiction, trauma and therapy, basing on the goal of facilitating and enhancing intrapersonal and interpersonal relationships.

Figure 10 Overview of the Staged Treatment Model of Trauma-Informed Substance Abuse Intervention.



The following is a brief introduction to the three stages of the treatment program.

Stage 1: Assessment and Stabilization

The goal of this stage is to know and understand the client, and build a therapeutic relationship with the client. Assessment is conducted with a high priority for relational engagement with the client in mind. Therefore the assessment process is not mechanically going through a list of questions but a process of engagement and developing empathic connection with the client. Assessment for the level of functioning of the client, and the presence of crisis is important as we need to make a decision whether the client's condition is suitable to move onto the next stage, which is the intervention stage. If the client's condition is unstable and functioning is low, they would need to enter the process of case management, which aims to ensure safety and stability in the client's physical condition and living environment.

Stage 2: Intervention

The core principles in the treatment model are safety, compassion, collaboration, and embodied emotional focus. These are consistent with the principles as illustrated by the theories of polyvagal and memory reconsolidation. An integrative experiential approach is taken by integrating skills from different therapy models with the aims of: maintaining the therapist in optimal condition for therapy; establishing secure, engaging and nurturing therapeutic relationship; and corrective emotional experience for the healing of trauma and substance abuse. After mastering the essential principles and skills with the treatment model, practitioners may integrate their familiar therapy approaches into the treatment to better achieve similar outcomes.

Psychoeducation to clients about trauma and substance abuse would be provided when the need is indicated in the course of intervention. Helping client to make sense of their addiction problem in the light of non-pathologizing underlying causes can significantly reduce stigma, enhance trust and therapeutic alliances. As it is important for practitioners to be "trauma-informed" and "trauma-knowledgeable", it is also helpful for clients to have such understanding.

The important concept and approach we adopted in preparing the therapist in an optimal condition for effective therapy is Therapeutic Presence (TP; Geller, 2017). It is based on polyvagal theory and neurobiological knowledge. TP posits that the therapist needs to feel safe and grounded before they can effectively engage and develop therapeutic relationship with client that is conductive to effective outcome of treatment. The aim of

TP is to maintain a compassionate, intimate and nurturing relational connection with the client, by paying attention and working on the condition of the self and presence in the moment of the therapist. Practicing therapeutic presence can improve therapist self-care, increase their resilience when exposed to distressing and traumatic information, and reduce the incidents of compassion fatigue.

Following the principle and practice of TP, we proposed the dual tuning process to facilitate and enhance the self-care of the therapist and their presence in the therapeutic process. We would depict the skill in details in the chapter for Intervention Strategies and Skills.

For the purpose of mood regulation and the stabilization of hyper-activation and anxiety, we utilize mind body integration skills like mindfulness, grounding and focusing, providing clients with easy to use and structured skills that can effectively soothe mood disturbances, and enhance a sense of safety and self-connection.

We also draw on concepts and strategies in the Accelerated Experiential Dynamic Psychotherapy (AEDP) model (Fosha, 2000), which is an affect focused experiential short term dynamic therapy approach. The advantage of the approach is that it helps to give corrective emotional experience for the clients in attachment, affect transformation and resilience. AEDP pays due attention to the core emotional experiences. It is based on neuroscientific evidence, and resolves the problem of trauma and substance abuse by targeting the root causes of emotional dysregulation and maladaptive coping.

Safety and close therapeutic relational bonding are emphasized especially at the initial stage of intervention. Drug abuse is conceptualized as a coping or defense mechanism to avoid feeling the underlying psychological pains, and therefore not the cause of the problem, but a maladaptive "solution" to mood dysregulation and life stress. Stopping drug use before healing the hurts and pains of trauma or having a healthy alternative coping, would make clients feeling like taking away their lifeline, consequently their anxiety and resistance to treatment would understandably be heightened. In the language of AEDP, substance abuse is a defense that is best to be "melted", not challenged or antagonized. It means that showing empathy, understanding and compassion to clients' maladaptive coping can give them a safe feeling, and enable them to have a clearer picture about the harmful habits. These would prepare the suitable conditions for melting the habit of substance abuse. It aligns the therapists and clients on the same front working collaboratively for life-changing and long lasting healing.

Stage 3: Relapse Prevention

At this final stage, client would have resolved most of their issues in drugs and trauma. A solid foundation of compassionate relationship with self is developed. This final stage aims to reconnect clients with the community and their social networks with the personal transformation they have achieved; and support clients to deal with new stressors and triggers as they come up in their new life. The process of treatment is completed when clients can make use of the skills learnt in making healthy connections with both self and others.

In the following chapters, we would illustrate the treatment model in more details according to the stages of treatment.

Chapter 3

Assessment and Stabilization

3.1 Accept, Attune, Affirm Principle (AAA or Triple A principle)

Before going into the contents of the assessment tasks, we believe a treatment on the proper attitudes in the provision of service is crucial for the success of therapy. As relational connection is at the core of our treatment model, we developed the Triple A principle to facilitate such connection, from our clinical experiences. AAA stands for Accept, Attune and Affirm. These are the attitudes we as therapists hold in the whole process working with our clients.

3.1.1 Accept

All therapeutic connections start with acceptance. It is important to be aware of what we are accepting that can have a therapeutic effect. We are accepting the client as another human being the same as us, who have senses, feelings, thoughts, personal agencies, and in need of meaningful connection with self and others. In the process of assessment and intervention, it can be very easy for us to run into the trap of treating our clients as objects, which are our targets to label and to manipulate. Diagnostic labels are useful means to understand the transitional state of the client and for professional communication, however, they can easily be misused as rigid frames to define the client, who then becomes objects for us to make changes and manipulate. We support the use of diagnostic labels, which are very useful in understanding the clients, professional communications and psychoeducation. However, they need to be used properly and wisely. We may easily objectify or dehumanize the client depends on whether we are embracing their humanity, or just consider them as "objects" of our work. One may easily unconsciously objectify clients in the process of therapy. We need to be constantly mindful of our own feelings and behaviors toward the client. When we notice our impatience and frustrations toward the client, or being actively involved in problem solving without attending to understand the person, we may have already fallen into the trap of objectification. Soon we would experience a disconnection with the client, and losing the client, regardless how learned we may be, or how wonderful the skills we have.

Chapter 3

Let us illustrate this with a case example (with identifying information modified and masked to protect client's confidentiality). Peter is a 55 years old male, unemployed for 5 years, living with his wife and 26 years old son in a public housing. He has been abusing cough medicines for over 20 years. He used to work as a chef. His father left the family when he was 8 years old, leaving him with his mother and 4 other siblings younger than him. He needed to take care of his younger brothers and sisters, since mother needed to work to provide for the family. He suffered from a lack of care from others, and had to work to provide for the family at a very young age. After the first drink of the cough medicine, he felt very good and energized. Since then he became more and more addicted and could not work without it. After some time, his physical health deteriorated and the cost of drug abuse became higher and higher. To a point he used all his salary in the drug and cannot provide for his family. His son found him being distant and rejected him. His wife lost her patience with him.

A simplistic view about the client's condition may be that drug abuse is at the core of the problem. If the client quits drugs, then he can be healthy again, he can have a job, provide for his family, and live a happy life, ever after. Holding such a view, we may start to actively work on helping the client to stop using drugs. As we commonly experience in our therapy work, such efforts may work well at the beginning, but does not last long. For some reasons, the client seems to have such a firm attachment with the drugs, that despite how much he knows about the harm of the drug, he keeps falling back into taking it. There starts to be tension between the therapist and the client, and resistance to therapy increases as the therapist blames the client for not following what is agreed in therapy, and not doing his homework, etc. There is no doubt the therapist holds a genuine care for the client, but was not accepting the neurobiology of the client. If the source of human problem is in the breakdown in relationship as indicated by strong evidence in neuroscience, we first need to accept that the client's behaviours are outcomes of disconnection with self and others. Seeking to change the behaviour, but neglecting such core issue, does not help a long term change to healthy life.

Acceptance in this sense means that we accept there is a deep rooted issue that contributes to the problematic behaviours on the surface, and not jumping to fix the problem on the surface. In this case, the childhood experience of the client rendered him an avoidant attachment tendency in his relational style. He tended to disconnect with himself and had been motivated by an external locus of control. Once he was in contact with illicit drug, it gave him a wonderful feeling about himself. Seemingly first time in his life, he was able to feel good about himself. He was using the drug to escape from the anxious and painful feelings. We can accept the person as we know from our neurobiology that we are all relational beings, and if there is a way out, we would not want to stay in a disconnected state. By accepting Peter as a person, who was seeking for health, wellbeing and meaningful connections, despite how futile his past attempts were, we would start the valuable life-saving connection with him, and in turn, it would enable his connection with himself, eventually remove the need for the drug.

3.1.2 Attune

To understand the process of Attuning, we may use the metaphor of a radio tuner. It is also called a radio receiver, which can scan and tune-in to the carrier frequency of a radio channel, so that we may listen to the programs of the radio channel. In the client-therapist relationship, we need to tune-in to the inner world of the client, in order to fully connect with the client, and fully understand the client. We may imagine that each person's inner world has a specific frequency band that we as therapists need to tune-in to, so that we may hear the correct messages about the client. Otherwise what we hear may just be distorted sounds or noise. Attuning refers to such a process of achieving a deep understanding with the client.

3.1.3 Mirror Neuron

Do we all have a device like the radio tuner that can tune-in with others' inner world? The answer is the mirror neuron (Riess, 2018). Mirror neuron was discovered by accident by a group of Italian biologist in the 1990s, when they conducted experiments on chimpanzees. They obtained the brain scan of the chimpanzees when they were eating nuts to understand the parts of their brain responsible for such activities. During the break time, one of the biologists enjoyed the nuts. To his surprise, he noted that a chimpanzee was watching him eating with the sensor devices still on its head, and the researcher noted almost the same pattern of brain activity in the chimpanzee on the screen, as if it was eating the nuts. The event led to the discovery of the mirror neuron in the brain of human, as well as mammals, located in our parietal lobe (top middle part of the brain), that can simulate the internal process of another person, if and only if, we pay attention to the other person.

Mirror neuron enables us to be able to empathize with high accuracy of what is happening in the brain of the other person. There is one important condition, that is, we need to be interested, and pay close attention to the other person, in order to enable the mirror neuron, which we would name as the interpersonal tuner. The mirror neuron would not be enabled in the chimpanzee if it was watching the researcher recording the experimental data, because it was absolutely of no interests to the animal. However, the behaviour of human eating aroused an intense interest in the animal, and subsequently enabled its mirror neuron in its brain.

In other words, in order for us to attune with another person, we need to have a genuine acceptance of our clients as we have mentioned before, and need to be curious and interested in the clients' experiences and inner world, no matter how shattered their life appear to be.

3.1.4 Compassion Fatigue

Working with substance abuse issues poses a high risk for compassion fatigue. It is not uncommon seeing workers and therapists burnt out after working in the field for some time. A good awareness of the risks and causes of such issue can help with the wellbeing of our colleagues, and support the service to go well and go long.

Compassion Fatigue is closely related to the interpersonal tuner, the mirror neuron. When we are constantly in touch with people who suffered from anxiety, depression and traumatic experiences, and if we hold genuine care and empathize with the clients' painful experiences, our brain will constantly simulate such experiences and if we do not know how to care for ourselves, we would be traumatized by the experiences of the clients, resulting in compassion fatigue, burnt out and secondary trauma.

3.1.5 Prevention of Compassion Fatigue

To understand the principle in the prevention of compassion fatigue, let us review what trauma does to our brain. When trauma happens, our cognitive brain is cut off from the instinctual brain, our experience in the implicit memory cannot be registered to the explicit memory, subsequently disabling the autobiographical function of the brain. The trauma event leaves only a trace in the implicit memory in the instinctual brain, in forms of sensations, emotions, tragic images and sounds, without time or words about the event. Therefore, preventing us from going beyond the window of tolerance and running into the cut-off mode of the Cognitive Brain, is important in the prevention of compassion fatigue, or secondary trauma by caring for our clients.

In the next chapter, we will illustrate the self-care skills that can effectively prevent compassion fatigue. We would like to provide the basic principle here, that is, to constantly maintain connections between our Cognitive Brain and Instinctual Brain, or always have our Left and Right Brain integrated with each other, such that we may keep reasonably calm, while being able to be in touch with the emotional experiences of the clients. In such way, our Cognitive Brain can always inform us that this is not our own current experience, it is something terrible happened with the client, sometime in the past. While we are able to empathize such experience, we do not need to re-experience such tragic events again. It would be like observing and sensing the events from a distance, with good awareness of our body's reactions to clients' accounts of the event.

3.1.6 Successful Attuning Process

In Peter's case, the therapist may be seriously affected by Peter's helpless and hopeless state, and sensed helplessness and hopelessness in herself too. She may run into the Danger mode and unconsciously pushing to stop Peter's drug use behaviours, seems that fixing Peter's problem would be like a relief for herself too, as her inner world is meshed with Peter's through the unregulated tuning process of the mirror neurons.

On the other hand, if the therapist is able to ground herself, and maintain a mental distance from Peter's experiences, while still in connection with him, she is able to calmly understand what is going on with Peter, and at the same time, be able to make clear sense of his experiences, and seamlessly receive the signals from her Instinctual Brain about Peter's condition, forming sound insights in her Cognitive Brain. Such Mind Body integration inside the therapist, is mediated by an important subcortical structure called the insula, which we name as the intrapersonal tuner. We would illustrate the function of insula and the dual tuning process (insula and mirror neuron) in more details in later sections.

3.1.7 Affirmation

Affirmation is the last "A" of the AAA principle of therapeutic connection. It is the expression of what we have obtained from the first two As. It is not enough if our deep understanding and care for the client stays with ourselves and client is not aware of our understanding of them. Feeling being understood and being cared for, would enable the neuroception mechanism to switch to the Safe mode, opening our internal channels and resources for social connection and engagements.

In Peter's case, the therapist felt the loneliness and the deep self-rejection in Peter. She expressed her understanding of such loneliness and how difficult it was for Peter if he was not on the drugs. And how painful it was for Peter to have to rely on the drug, while watching it gradually ruining his life and the connection he longed for with his wife and his son. The expression of such deep understanding affirmed the experience of Peter, paradoxically helping to undo the loneliness experienced by him, without any suggestions or push for change in Peter's behaviour. What is important is how we make the clients feel, not what we do to them. In this process, we communicated to the Right Brain of the client, helping the client to feel safe, then he would be able to open the Left Brain as well, and the whole process of corrective experience could give him new positive connections in his neural network, which would then be reconsolidated into his explicit memory, giving an adaptive responses in his future copings.

3.2 Orienting Client to Therapy

We start to orient clients to therapy the moment we get in touch with them. It can be the first phone conversation, or the first face to face meeting.

We need to orient the client to the structure and boundaries of therapy, things like confidentiality, exceptions, and service agreements are the basics in creating a safe structure and environment for therapy. Since there is already an abundance of text and literatures on this topic, and most service providers would have developed comprehensive policy and procedures for such functions, we would not repeat this part here in this manual.

What we would like to point out in this section is to suggest the importance of holding and practicing the AAA principle with the clients, from the start to the end of therapy. This is the key feature that makes our model a relational model. AAA is the principle and the process of therapy that strings the whole treatment together from beginning to end.

The first thing we need to accept, attune and affirm (AAA) with the client, in our orientation for client to therapy, is the reason that leads client coming to therapy with us. This is the very important first thread of connection between us and the client. Following this lead, can effectively guide us into the deeper inner world of the client.

Often times, client does not come voluntarily into therapy with us. They may have a probation order, or they may be aiming for secondary financial gains that the family may give them more support, if they can show to the family that they are seeking professional help. There are, of course, many cases, that the client goes to their rock bottom and desperately wants to seek help for a long term change.

No matter what causes the client to be shown up in front of us in the therapy room, the AAA principle comes into play even before we see them. If the client comes involuntarily, we would be interested to know how showing up in therapy would impact their relational connection. The core of the issue is not about whether the client has insight about their problem or not, it is about whether we have insight about the client's relational context. If we lose track of the relational context of the client, even if the client comes with motivation, it will drop over time as we would not be able to track and catch that core thing keeping the client motivated. That core thing is, the Will to Connection, as we have illustrated in an earlier Chapter.

On the other hand, if we are able to track and catch the relational context surrounding the client, fully accept the client's experiences, attune to the whole of their experiences, and express how deep we understand their pain, struggle, and tears, as well as joy and love, we may connect with the client therapeutically and inspire their motivation to keep the connection with us, such that one life may impact another life, and vice versa. In the process, not only the client can be positively changed by us, we are open to be changed, and learn from the client too.

3.3 Intrapersonal Assessment

Assessment is the process for us to have an overall understanding of the client. In our relational approach, there are two parts in the contents of the assessment, namely intrapersonal and interpersonal. There is no clear demarcation on doing which part first. Their contents can be intertwined between each other, depending on the best way to achieve a therapeutic connection with the client, and the process of understanding the client. Diving it into parts is for the purpose of systematically illustration in the manual.

If you have worked in the field for some time, some of these assessment contents would look familiar with you. We are just reorganizing them to fit into the context of a relational approach.

The following is a list of the contents of intrapersonal assessment:

3.3.1 Autonomic States (Polyvagal Theory)

This can give us an idea on whether the client is feeling safe, or being anxious in the Danger mode, or depressed, dissociated and shutdown in the Hopeless mode. And if they are in a certain mode, what are the internal and environmental factors that are contributing to the maintenance of such mode, and what may be helpful in moving towards the Safe mode.

3.3.2 Physical Health History and Living Condition

An account of the client's health from their birth to the current time, would provide us with a comprehensive understanding of the client's physical condition. We like to spend some time with the client in the initial contacts to focus on this part. We would usually start by asking if there is anything special at the birth of the client. By the time a baby is born, most of the development of the Instinctual Brain is completed and implicit memory is in place. However, most of the Cognitive Brain is not formed yet, and explicit or autobiographical memory is virtually not present. Any traumatic events happened at this time, or any time in the first 18 months after birth, may become a deep traumatic experience as the baby is at a vulnerable stage of life. It is often misunderstood that since the baby has no language, they have no awareness of what happened. To the opposite, the Instinctual Brain and the implicit memory would have a record of what happened and if the record indicates that the world and the people are dangerous, the impact on the attachment relational style, and the mental health in later life of the person, can be very profoundly negative.

A brief medical history on the person would be helpful. Were there any surgeries, hospitalizations, chronic conditions or long term medications the client is taking? These are good information reflecting the overall physical health of the person.

Living condition concerns whether the client has a proper and safe sheltering place. If a safe and stable sheltering is not available, it would be hard to engage the client further in therapy as their basic living condition is unsafe. The same applies when the client is suffering from a serious medical condition, it would be hard to start and continue therapy. Case management should be the priority in these cases to restore physical stability before further intervention can be implemented.

3.3.3 Mental Health and Family History

Has the client experienced any mood or mental health problems before? Such a history would be very helpful to give us a three dimensional picture of the client's mental condition and better understand the current condition.
The genetic factor is an important factor in mental health problems, having a history of the mental health issues of family members can be very helpful to make sense of client's mental health conditions.

3.3.4 Life History including Traumatic Experiences

Having a timeline of the client's life from birth to now can be a systematic way of a full understanding of the client's intrapersonal and interpersonal development. As a trauma-informed practice, we pay attention to potential traumatic events in the client's life, for example, accidents, serious neglect of care or abuse, life threatening events experienced by self or witnessed others' experiences.

3.3.5 Symptoms and Functioning

Checking the sleep of the client is the best indicator for client's current mental health condition and functioning. Most mood and mental disorders associate with sleep problems, either over-sleep or difficulties in sleep. And the disruption of sleep, would in turn contributes to worsen mood conditions.

Another good indicator of client's current condition and function, is the high time and low time of the day. Ask the client, "When is the worst time of the day?", "When is the best time of the day? And what makes it best and worst?" Such enquiries may usually reflect the things that the client concerns most, the underlying causes of the mood disruption, and the protective factors.

3.3.6 Risks of Self-Harm and Harm to Others

If we sense that the client is lack of hope in life, appears to be very depressed. We need to assess the risk of self-harm, suicide or harming others. As there is an abundance of text addressing this issue, we would leave the details of this part out of this manual.

3.3.7 Function of Drugs

The function of the drugs shows how the drugs are playing a role in the client's life. Therapeutic skills like motivational interviewing can help to reveal what the drugs are doing for the client and may provide more options for the client, other than drugs, to achieve the same goal. Drug is only one of the means to the ends. The ends, that being, what the client ultimately aimed at, is more important.

3.3.8 Screen for Special Issues:

There are many special issues that warrant our attention as well, as specialized treatment may be indicated to effectively treat these conditions.

- Attention Deficit and Hyperactivity Disorder (ADHD)

  ADHD is a very common comorbidity with substance abuse. People with ADHD have problems in concentration, hyperactivity, and may develop all kinds of interpersonal problems since childhood due to their impatience and impulsivity. They are the group of clients, who often self-medicate their attention and hyperactivity problems with illicit drugs.

  The book written by Hallowell and Ratey (2005), "Delivered from Distraction", is a very good reference on the identification and helpful strategies for ADHD.

- Cognitive Impairments and Dementia

  Drug abuse may lead to cognitive impairments. Elderly people may have the condition of dementia. Assessing this level of impairments would be helpful in shedding light on how well the client may receive various kinds of intervention and the related functioning level.

  The Montreal Cognitive Assessment (MoCA; Nasreddine, 2005), is a well-established tool for the assessment of cognitive ability and dementia.

- Intellectual Disability

  Some clients come to therapy may have problems in their intellectual ability. Usually these are marginal cases, as most of the obvious cases would have been identified and are cared by appropriate services. Our experiences show that these clients often times may cause frustrations for the therapist, if we are not aware of their condition and expect them to have normal intelligence. As they may not tell you if they do not understand what you mean. They are usually anxious and want to hide their deficits in their cognitive abilities. If you notice the client is simple and concrete in their thinking, often misunderstands you, and stops school early, it would be helpful to assess their intellectual ability. People poor in their cognitive ability may need guidance and supervisions from their family or they may need to be referred to appropriate services.

- Autistic Spectrum Disorders (ASD)

  People having ASD needs specialized treatment and services. They are usually very sensitive in their sensory receptions, highly anxious and having serious problems in language expressions and social interactions.

- Specific Learning Difficulties (SpLD)

  Similar to ASD, SpLD needs specialized treatment and services. Multidisciplinary collaboration is crucial for the success of treatment.

3.4 Interpersonal Assessment

The pattern and style of our relationship with others are heavily molded by the first relationship in our life. Our first relationship in life is usually the one with our caregivers when we were a child. Such basic pattern or style of our relating to others and the world, formed in our early years, is called attachment styles.

3.4.1 Attachment Theory

The attachment theory was first proposed by John Bowlby in the 1960s (Bowlby, 2008), and was further developed by Mary Ainsworth based on her keen observations with the interactions between children and their caregivers, a standardized assessment procedures named as the strange situations (Ainsworth, Blehar, Waters, & Wall, 2015). Following Ainsworth's efforts, there appeared two main lines of development of the attachment theory. One being led by Mary Main, she proposed the 4th attachment style, Insecure-Disorganized Attachment (Main & Solomon, 1986), on top of Ainsworth's three basic attachment styles, namely the Secure, Anxious-Avoidant and Anxious-Ambivalent.

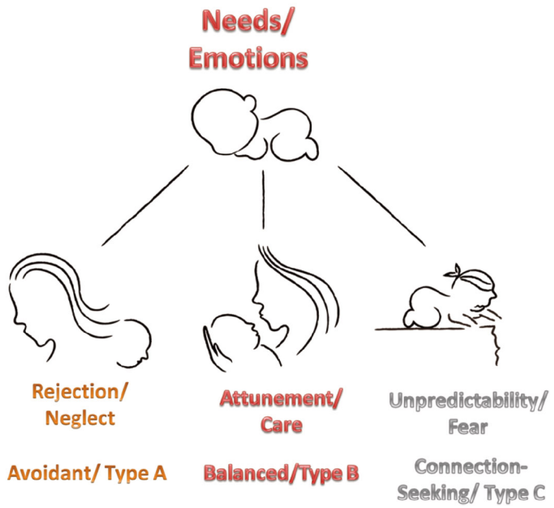
The other line is led by Ainsworth's other student Patricia Crittenden, who proposed and developed the Dynamic Maturation Model (DMM; Crittenden, & Landini, 2011). While Ainsworth's work mainly focused on children, Crittenden further developed the three basic styles discovered by her teacher, from their studies with the adolescent and adult populations. Instead of adding an additional style, Crittenden expanded the three basic styles with more sub-types, resulting in 5 sub-types in the Secure Attachment style, which is known as the Balanced Type (or Type B); 8 sub-types for the Anxious-Avoidant style, known as the Avoidant Type (or Type A), and 8 sub-types for the Anxious-Ambivalent style, known as the Connection-seeking Type (or Type C).

3.4.2 Basic Attachment Styles Based on the DMM

This section intends to provide a basic understanding about the three main attachment styles based on the DMM framework, according to the materials presented by Kim Barthel (K. Barthel, personal communication, July 29, 2019). We do not intend to provide a detailed treatment of the topic, which can be further pursued directly from the training courses and publications from the Family Relations Institute (https://familyrelationsinstitute.org/).

Figure 11 shows the influence of childhood experiences on the choice of the three attachment styles by individuals.

Figure 11 Attachment Styles and Childhood Experiences



- Attachment styles can be conceptualized as a pattern of strategies in response to early relationships with others in order to feel safe.

- Caregiver's response to the needs of the child, influences the attachment strategies adopted by the child, and tends to continue into adulthood.

- For Type B attachment, children's needs are being attuned to and cared for properly. The child's limitations are fully understood and accepted. Children growing in such an environment tends to grow with more self-acceptance and confidence, as well as more understanding and realistic acceptance for other's limitations. They tend to have a balanced relationship between themselves and others.

- For Type A attachment, the needs of the child are being rejected or neglected. As it was a time when the child was operating mainly with implicit memory, the experience of rejection and neglect works like a traumatic experience, being stored in the implicit memory with no record in the explicit memory. The child would form a persistent avoidance of being in touch with their own needs, and seeks comfort from external stimulations, the responses of others to their actions and performance. The cause is due to the painful experiences stored in the implicit memory about the rejections of their needs. People with Type A attachment tends to focus on external affirmations on their performance, and neglect their own needs and limits. They have very low self-esteem and tend to drive themselves very hard in order to achieve the praise and credits from others. On the other hand, they are afraid of intimacy and deeper connections with others, as they feel unsafe about themselves and are afraid of expressing their needs and vulnerabilities to others. They tend to put up a tough or "everything is ok" image in front of others. The form of maladaptation is increased in Type A when the person is having a decreasing sense of self-importance.

- For Type C attachment, the needs of the child were being responded to inconsistently. The traumatic experience for the child would be that the world is uncertain. The child is not sure if the caregiver loves them until they respond in a positive way. They are fearful of being disconnected from others and being left on their own. In an attempt to cope, they would actively seek for connection with others, and they are sensitive and being anxious of any signs that people are going to ignore them or leave them alone. The form of maladaptation is increased in Type C when the person is having an increasing sense of self-importance.

- At the extreme end of both Type A and Type C, is the A+C+ type, which has features similar to the disorganized type in Main's model (Main & Solomon, 1986). This type is signified by highly unstable mood and strategies used to cope. They may have experienced serious abuse in their childhood.

3.4.3 The Process of Interpersonal Assessment

The goal of interpersonal assessment is to have a comprehensive understanding of the person's relational patterns and attachment strategies. As you may have experienced from your practice and service, most if not all of our clients, come with an insecure attachment. We conceptualize insecure attachment as relational traumas experienced before the explicit memory was fully in operation (around 18 months after birth). As a trauma informed model and practice, we have observed that most if not all of our clients have experienced some kind of trauma, especially in their relationship with others in their early years. The assessment of the relational style of our clients, therefore, is a core component in the assessment phase of our treatment model. The following are the important points summarized for the process of relational assessment:

- While we are seeing the client in therapy, we pay attention to the client so that our interpersonal tuner, the mirror neurons are enabled; we observe our interactions with the client and track the moment to moment states of the client.

- After we pay attention to the client, we would start to have a sense of the attachment styles of the client by being present with the person. Our mirror neurons will give us an impression whether the client is avoiding deeper connection (Type A), anxiously groping for connections (Type C), or balanced between Type A and Type C (Type B).

- The life timeline we obtained from the client, is a helpful tool for both intrapersonal and interpersonal assessment. Client's family relationship in their childhood provides useful information on their attachment style.

- What is the current state of client's social relationship? Does the client have any social support network? How about their relationship in the workplace or school?

3.5 Crisis Intervention

It is very common in substance abuse works that the client coming to therapy is contemplating suicide or has already made attempts of suicide. There are already good references and practice guidelines available in treating the topic of suicide assessment and crisis intervention. We would like to supplement in this section with the principle of our relational approach in crisis intervention.

As we have illustrated in earlier chapters, ending one's life is an extreme choice when one is at their wit's end to make meaningful connections, or the costs for temporary relief becomes too high to continue. It is important for therapist to assess the relational condition of the client, both in the intrapersonal and interpersonal area. Hope is better to be instilled in the direction of rebuilding connections and relationships, directly or indirectly. Often times, these clients have no other people to connect to except the therapist. It is important for the therapist to provide a corrective positive relational experience early in therapy such that they can become a relational anchor for the client. At the same time, connecting the client to more professional support forming a multidisciplinary care network may be necessary to help restore the client's physical and mental wellbeing in the quickest possible way. Psychiatric services and medications can be very effective in quickly improving the mood condition of the client and may serve as good substitutes to the illicit drugs. Though not always possible at the beginning, the therapist needs to seek every means to reconnect the client with their family and support networks. Hospitalization and rehabilitation needs to be considered if the client is in danger and is not likely to be able to support themself on their own.

3.6 Case Management

Case management involves multidisciplinary collaboration to support the treatment for the client. We would not go into details in this manual about case management, as there are other references and practice guidelines available for a proper treatment of the subject. In general, seeking support from other services or professionals may be indicated for the following conditions:

- Client's mental condition being unstable and disorganized
- Psychosis; serious depression; delirium; dementia
- High suicidal risk
- Serious health problems
- Lack of a safe shelter
- Difficulty in maintaining minimal self-care
- Special issues as mentioned in last section, like ADHD, intellectual disability, cognitive impairments; ASD or SpLD.

It is worth mentioning that we have close collaboration with medical and psychiatric services in the Substance Abuse Clinics in many of our cases. Psychotropic medication is a very good alternative to illicit drugs in helping clients to cope with the painful symptoms of trauma and mood disorders. Often times, it provides fast relief that can help stabilize the condition of the clients. Researches consistently showed that combined medical and psychological interventions are more effective than single modality treatments, especially in cases with serious mental issues. Medications may help to reduce the need in clients for illicit drug uses, and improve their functioning, thereby prepare them for a better condition for psychotherapy.

Chapter 4

Intervention Strategies and Skills

4.1 Introduction to the Intervention Process

At the core of our treatment model, it is the dualistic functional structure of our brain, and the in-born human Will to Connection or, Relationship. As we have illustrated in previous chapters, we named the two functional parts of the brain as the Cognitive Brain, and the Instinctual Brain. Often times, they are being heuristically referred to be the Left and Right Brain, Conscious and Unconscious, or Mind and Body.

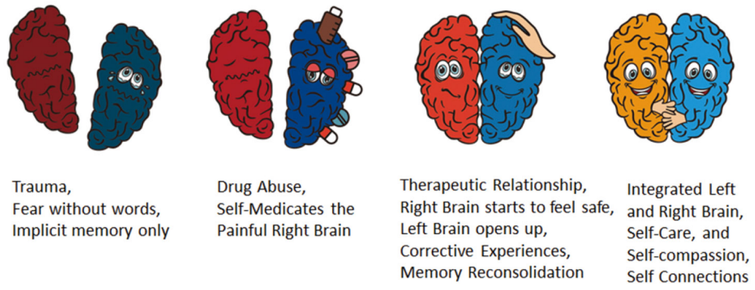
We have stressed much about the importance of relational connections in the core of our treatment model. And in an earlier chapter, we have presented the AAA principle and process, applied throughout the whole process of therapy from beginning to the end, in order to facilitate such a therapeutic relational connection, intrapersonally with oneself, and interpersonally with others.

In this chapter, we are going to illustrate how we may integrate the theories and skills together, to bring healing in client's life, and to support them to develop loving and caring relationship with themselves and others.

We have divided the treatment strategies in 4 parts. The first part is on the skills in developing and nurturing self-care and presence with the client. The second part is on the strategies for the therapist to reach out to develop therapeutic connection with the client. The third part is on the strategies in supporting the client to develop and nurture a loving intrapersonal relationship; and the fourth part is on how to support the client, with a renewed life, being fully in touch with himself, to reach out and form healthy relationship with others, and reconnect with the larger community.

In an earlier chapter, we tackled Stage 1 of the treatment process, Assessment and Stabilization. Intervention starts as stage 2 of the treatment process if the client is assessed to be ready after stage 1. Figure 12 depicts the overall process in Stage 2, helping a client to be healed from the trauma and the drug abuse, and finally be able to have a self-compassionate relationship with himself.

Figure 12 Overview of Stage 2 Intervention: Achieving a Self-Compassionate Intrapersonal Relationship.



As shown in the first image in the figure, we posit that our clients come with unresolved issues or traumatic experiences that isolate the Left from the Right brain. The disconnection within the client rendered him short of the relational connections they need in order to have a sense of meaning in this world. They live in an existential vacuum, as described by Frankl.

In the second image, the client copes the pain of existential vacuum with substances, which can directly alter the mood and provide the pleasure that a meaningful relationship may give, but only last for a short time, and needs a high cost to maintain.

In the third image, the client enters therapy and their Right Brain starts to experience the care and acceptance from the therapist. A healthy alternative to drugs starts to emerge and attract the client's attention. Feeling safe and connected with the therapist, the client starts to open up their Left Brain and ready for reconsolidating the corrective experiences onto their explicit memory, and subsequently resolving the effects of the trauma.

In the last image, the client is compassionately intrapersonally connected. It provides resilience to prevent future trauma, and enabling the client's readiness for healthy interpersonal connection, which would complete the whole treatment process.

4.2 Therapist's Self-Care – Intrapersonal Techniques

We believe in that healing starts from the self of the therapist. We do not need to be free of all problem, nor become a master in therapeutic skills, before we can be effective in helping a client to resolve the substance abuse issues. At the same time, it is very true that it would be difficult for us to do to our clients something that we cannot do to ourselves.

Being aware of, and be able to appreciate, our own strengths and weakness, to be able to have compassion on ourselves, and manage our own emotions well, in our opinion, is the very important first step toward building a solid therapeutic relationship with our clients. We need to apply the AAA principle on ourselves before we can apply it to our clients.

Therefore, the simple fact is that we need to develop a healthy relationship with ourselves, before we can have a healthy connection with our clients. It applies to both the therapist and the client. In this section, we would like to introduce a skill we named as the "Self-Compassionate Communication" (SCC). It is a skill aiming to nurture a compassionate relationship with ourselves. We have integrated our skills from Interpersonal Neurobiology concept (Siegel, 2010) and the Focusing practice (Gendlin, 1982; K. Whalen, Personal Communication, October 28, 2015).

In a nutshell, the concept of intrapersonal relationship refers to the interaction between our Cognitive Brain and our Instinctual Brain, or using more common terms, between our Mind and our Body.

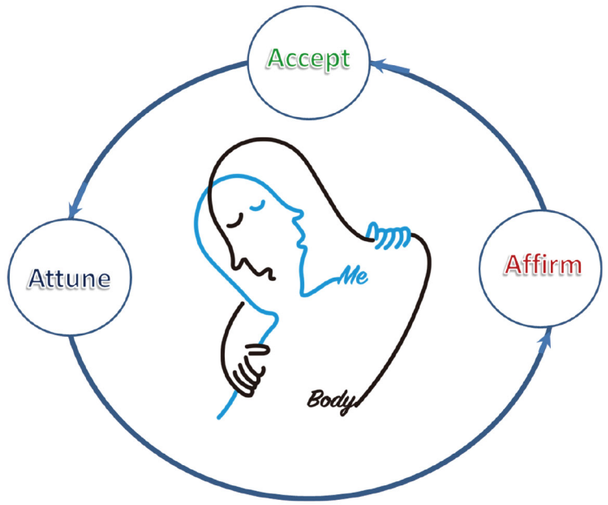
The concept of Mind and Body requires some clarification. The concept of "Mind" has been puzzling the minds of many scientists and philosophers over the centuries. To come up with a proper definition, Siegel gather a remarkable group of 40 scientists, from a wide range of fields, including linguistics, computer science, genetics, mathematics, neuroscience, and psychology. After some serious arguments and discussions, all the professionals involved agreed on the following comprehensive final version (Siegel, 2010, Chapter 3):

> *The human mind is a relational and embodied process that regulates the flow of energy and information.*

According to Siegel, our mind is a dynamic process and it is closely associated with the prefrontal cortex, our executive centre in the Cognitive Brain. It is the seat of our "sense of self" and the "conscious awareness". We may direct the attention and focus of our mind. The awareness of our mind can expand or concentrate depending on how we choose to direct its focus.

We use the term "Body" to refer to our Instinctual Brain and all the processes involved with this part of the brain. Figure 8 is an imagery representation of the SCC skill, in which, the Mind and the Body are like two close friends in the same person. The sense of self, or the "Me" is in the conscious Mind, having the AAA communication process with the Body.

Figure 13 Self-Compassionate Communication (SCC)



We would illustrate this self-compassion exercise in the following steps:

4.2.1 Grounding – Having a Sense of "Me Here"

When we are stressed and are outside the window of tolerance of our mood, our mind goes to the backstage and let the Instinctual Brain to take charge. The key to put our Mind or the Cognitive Brain back onto the driver's seat is important for our affect regulation. Having a sense of our mind, in other words, a sense of "me here", is an important step before we can have a self-compassionate connection.

Connection between our Mind and Body starts when the Mind starts to pay attention to bodily signals, including our sensory information (the five senses), emotions, signals from inside our body (interoceptive signals like pain, softness, etc…), body movements and functions (like breathing, or walking).

You may sit with a comfortable position on the chair, either close your eyes or leave them open, depending on what feels comfortable for you. Start to pay attention to your breathing, notice the speed, the warmth of your breath, then try to gradually slow down your breathing, just like comforting a baby. You may gently repeat these words to yourself in your heart, "Slow down, it is ok, I am here, let's take a rest." Continue for a few times. Do this as if you are communicating with a close friend, this close friend is your Body. You may consider your friend as your brother or sister.

Treating your body as your close friend is to establish a relational framework for self-connection. Your body is continuously working hard to ensure your safety and survival, and keeps acting like an intelligence agent to feed you information about conditions internal and external to your Body. It is in fact, like your best partner/friend together with you since you were born.

Continue to notice your breathing just like being with your best friend. Expand the awareness of your body by noticing your body weight when you breath out, the parts of your body in contact with the chair, the surface of your foot in touch with the ground. On every breath out, notice the weight of your body, sitting on the chair and supported by the ground. Continue the grounding breathing for a while, just paying attention, noticing that you are firmly sitting on the chair. Your awareness of "me being here" is strengthen more, as your attention is more and more connected with your bodily sensations and breathing.

Grounding is the first step in having our Mind back online, to be on the driver seat again, if we are stressed and outside the window of tolerance. We may not notice our anxiety if we do not slow down and connect our Mind with the Body.

4.2.2 Insula – Internal State Tuner and Integrator

The grounding exercise described above is a basic skill common to mindfulness and focusing practice. Mindfulness has fast becoming one of the most popular application for affect regulation and stress reduction, with strong evidence for its efficacy (Kabat-Zinn, 2005). This section attempts to explain from a neurobiological perspective the mechanism behind mindfulness and focusing.

Pavuluri (2015) reviewed literatures on an important part in the centre of our brain, called the insula. It is an island like structure located in between the cortex and the limbic system, connecting the cognitive, sensorimotor and emotional brain systems. It was found that the insula is instrumental in the integration of the cognitive, sensorimotor, and emotional functions in the brain. In other words, it is the important central processor that supports the integration between the functions of the Mind and Body. When the Mind is paying attention to the signals from the Body, large amount of neural information are passed between the Cortex and the Limbic System and to the lower layer of the brain, through the insula.

While the mirror neuron can be viewed as an external tuner for our interpersonal connection with others, the insula can be considered as an internal tuner for our intrapersonal connection between the Mind and the Body. Through the processing and integration of the cognitive and instinctual information by the insula, our Mind is attuned with the Body, having a full picture of what is happening inside and outside of our Body; enabling the Mind to make adaptive decisions and action tendencies.

4.2.3 Self-Compassionate Communication (SCC)

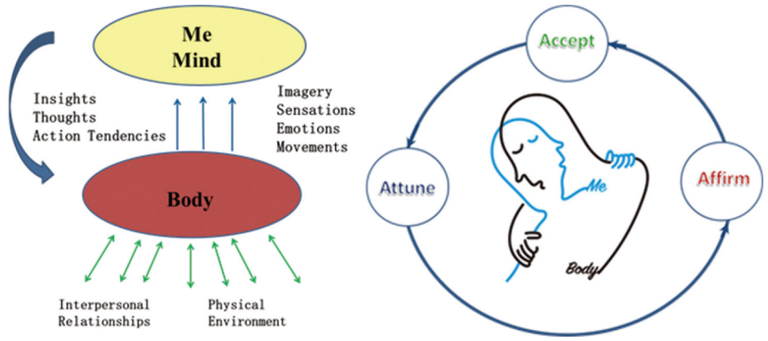
It takes two to communicate. How can we communicate with ourselves? The two entities in a self-communication as we have presented in earlier sections, is the Mind and the Body. The Focusing practice (Gendlin, 1982; K. Whalen, Personal Communication, October 28, 2015), makes use of the self-communication process, to facilitate insights and self-awareness.

In our model, we consider the Body as an intelligence centre with many sensors. There are external sensors, that is, our sensory systems like our vision, hearing, smell, taste, touch and balance; and internal sensors, neural networks monitoring the internal state of our body.

We can think of our Body as a separate "person" to our Mind, having its own processes that are mostly associated with the functions important to our survival. Our Body is like a loyal friend and a servant to us. It works 24 hours round the clock to keep us alive. It keeps our breathing so that we can have a continuous supply of oxygen; it monitors the environment and our internal temperature and keeps our body temperature at an optimal degree; it pumps the heart around 70 times every minutes, to supply nutrients to all the cells in our body; when we need water or food, it will remind us by sending signals of thirst and hunger to our Mind, so we can take action to take care of ourselves; when we face danger, it will send emotional signals of fear to our Mind, and neuroceptively put us in the appropriate states, so we may protect ourselves from the harms; when others love and care for us, it will send signals of affection and happiness to the Mind, so that we know this is beneficial for our survival and is something we pursue; even when we are sleeping, our Body keeps working to maintain many physiological functions to keep us alive.

The languages used by our Body are the sensations, emotions, and movements. The Body needs to communicate with the Mind, so that the Mind is aware of what is happening surrounding us and inside of us, and make the appropriate decisions and take proper actions for an adaptive and healthy life. This is what we meant by thinking of the "Body" as an intelligence agent, collecting information from inside and outside the body, then communicate to our Mind through sensation, emotions and body movements. Figure 14 shows a conceptual diagram of the Self-Compassionate communication process.

Figure 14 Conceptual diagram of the Self-Compassionate communication Process



As shown in the diagram, the "Me" in the "Mind" keeps observing and empathizing with the messages and signals from the Body. With the integrational processes of the insula, our awareness of "what is happening in the here and now" keeps increasing. The Mind would just observe and track the messages from the Body, keep expanding its awareness from the body signals. More and more insights would gradually emerge inside the Mind, which would communicate these insights and thoughts back to body, the body would give another wave of sensations, emotions or movements back to the Mind, feeding back how adaptive these insights are matching with the reality that the Body sensed. The Mind then becomes mindful on this new wave of message feedback from the Body again. Gradually when the Mind has collected and integrated enough information, it starts to come up with decisions about the situation and forming action tendencies. The body would then feedback about these new thoughts with another wave of body signals. A sign of the completion of the integration is a resonant feeling from the body in response to the thoughts and insights from the Mind (Gendlin, 1982)

Integrating the AAA process into the above process, the Mind is open to all the signals (be it positive or negative) from the body, accepts and welcomes all these signals, because it knows that these are useful information to facilitate good insights and decisions. The Mind keeps attuning to the current situation through interaction with the body, and keeps affirming and acknowledging signals from the Body.

An open, compassionate and accepting attitude of the Mind towards the signals of the Body is the most important element in the whole process. Applying polyvagal theory, it helps the whole person to be in the Safe mode, such that the Mind can engage in a relational interaction with the body.

The process of SCC can be illustrated with the following example.

> I sit down and prepare myself for the SCC exercise. After grounding myself with an awareness of "me here" and my Body, I turn my focus to the signals from the Body. In my Mind, I imagine myself sitting with my Body, who is the closest "person" to myself. I am used to call my Body as my brother.
>
> I start to feel a tight and uneasy sensation on my chest. As I notice the tightness, I gently say to the chest part of my "brother" with a compassionate attitude, "Hey you are tight here, it is ok, I am here. What do you want to tell me?" Then I just wait and go back to the observer mode. Keep tracking the response from the body.
>
> Then I notice my shoulder and neck are actually quite tense, as I am aware of the tension, they relax with my out-breath, and I realize that I have been very stressed mentally, trying to meet the many deadlines of work. Having this new insight, I started to have images of my hard work over the past few weeks, and I reflect genuinely to my brother, "You are stressed. I can sense your stress. It has been a difficult time for you. Thank you for standing with me and working hard for me!" Then I sense a stream of gratitude starting from the bottom of my trunk, extending to the top of my head. I say to my brother, "It feels so good, thank you! Yes, thanks for being a loyal supporter of me." The sense of gratitude turn stronger and then ease off, changing into a calm and pleasant feeling, filling my whole self. The tight feeling on the chest disappeared. I can feel my Body totally relaxed and light.

> I go back to the observer mode. Staying with and being mindful of the peaceful feeling and sensation. I then feel impulses on my hands. There are little movements on my fingers. It is a joyful feeling. I sense an urge to place my right hand on my heart. As I place my hand on heart, I sense a warm feeling in that part, emanating throughout the trunk of my body.
>
> Then I sensed an uneasy sensation around the diaphragm area. I turn my attention to that part and the uneasy feeling becomes more solid. I welcome this new uneasy feeling, which is in stark contrast to the warm and happy feeling on the chest. I hold my attention to both. Then the images of those works waiting to be finished emerged, and my chest started to become tight again. I sense the warm feeling is still present, mixing with the tightness and the uneasiness. I welcome these mixed feelings and sensation, as they are familiar to me at other times when I am doing the exercise. I keep myself in the loop of Accept, Attune and Affirm. I say to my brother, "Yes, there are still hurdles to overcome, hard works to be done and uncertainties." These are the insights that come up in my Mind and I reflect them to my Body. I continue to say, "It is ok, I am here with you. No matter what happens, we are together."
>
> In this situation, I am used not trying to actively change the feelings and sensations by my Mind, saying things like, "Do not worry, we will get things done. It is not difficult for you." These words may come out if I am not comfortable with the mixed uneasy feeling and try to make it go. So holding a fully acceptant attitude is important, let the body signals to facilitate insights and action tendencies, instead of reactive responses due to an urge to escape from the difficult feelings. When our Mind works too hard, it would come out of the fully acceptant mode, and try to intervene before fully attuning to the Body, and is prone to act immaturely and make wrong decisions or choices.
>
> It is a good practice to always "Welcome all the body signals, stay and be compassionate with them." I learnt this attitude of "welcoming all bodily feelings and sensations" from my Whole Body Focusing (WBF) teacher, Karen Whalen. And from my own practice, I adapted her focusing practice to the current SCC exercise presented here.

It is only when we are loyally following the AAA principle with a compassionate attitude to our Body, we can be fully in tune with all the useful information sensed by our Body, after fully integrating with our cognitive Mind, to form useful insights and adaptive action tendencies.

Back to my SCC practice, after I accept and stay with the mixed feelings and sensations, warmth and tenseness, joy and stress, and affirm these with compassionate words to my Body, the tense and uneasy feeling gradually ease off. The mixed feeling is replaced by a steady calmness and solid feeling. I notice my whole Body is sitting comfortably on the chair, I notice my body parts touching the chair and the ground. My Body turns my attention back to grounding state. I feel calm, stable and solid. Gradually I sense a new insight in my Mind, "You are more important than the works." Followed by a sense of touching feeling, starting from my chest, emanate throughout my body. I stayed with the touching feeling and it gradually turns into a sense of confidence, that I will be able to complete my work. I reflect my insight to my body, "You are confident now to complete the works on time." And I sensed a resonant feeling from the Body to my words.

Now I have a sense of completion to the SCC process. I thank my Body and turn my attention to the surrounding environment, the sounds in the room, then I open my eyes and look around, take note of the room, and bring myself back to the room.

The above is one example of the SCC exercise. The experience may vary from person to person and be different each time. Nonetheless, the following principles and processes are common in practicing the exercise:

i. Start with the Grounding exercise;

   Through grounding, we gain an awareness of our Mind and a sense of "me being here", and differentiated our Mind (the observer self) from the Body (sensations, emotions and movements). It prepares us for further compassionate communications.

ii. Fully accept/welcome all signals (sensations, emotions and movements) from the Body; Keep holding a compassionate and acceptant attitude to all the signals, images, memories, insights and thoughts that emerged.

   This is a very important attitude throughout the exercise. Often times the negative signals (e.g. anger, stress, pain) are perceived to be avoided and changed. Yet these are useful information from our Body, waiting to be integrated and processed, to increase our awareness of the situation. These signals becomes regulated when they are being attended to, and integrated, at the same time, our awareness and insights increased.

iii. Keep engaging the Mind (our attention) on the bodily signals, tracking the signals and observing the changes, wait for images, memories or new insights and thoughts come up to our Mind. Observe and be with the images and memories that come up, and track further signals from the Body in responses to these information; Reflect new insights/thoughts back to the Body compassionately, then track further signals from the Body in response to your empathic reflection. Keep in the cycle of: bodily signals ---> images, memories, insights/thoughts ---> bodily signals.

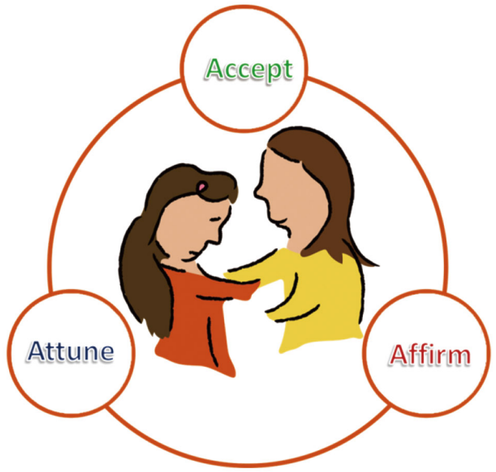
iv. End the exercise when a resonant (agreeing) feeling is sensed between the Mind and the Body just like in the above example. Or if it is about the scheduled time for ending, tell your Body it is time to end, "We have about one minute before ending, thanks for being with me and all the useful information. Please prepare to come back to the room." Then you may gradually notice the sounds in the room, look around and notice the surrounding environment and end the exercise.

We recommend you to try this exercise after some basic training in mindfulness and focusing, and with guidance from people familiar with the practice. It takes some guided practice to be able to master the skills in the exercise.

4.3 Building Therapist and Client Relationship – Interpersonal Techniques

The same principle of a compassionate attitude applies not only in the intrapersonal relational building process as described above, but also in the interpersonal relationship between the therapist and the client. In this case, the therapist needs to always hold a compassionate and acceptant attitude toward the client. As one of the AEDP therapists (B. Yip, personal communication, November 7, 2019) once metaphorically reflected, you need to see your client as someone you really care for, almost like holding your children in your arms. It is this level of compassion and acceptance that helps to activate the Safe mode in client, enabling them to wake up from the automatic defensive modes of Danger and Hopelessness. Figure 15 is a conceptual diagram of the therapist client relationship building process. The AAA process is followed in the therapist and client relational connection.

Figure 15 Therapist and Client Relationship Building Process.



4.3.1 Being Present in the Therapeutic Process – The Dual Tuning Process

Recent literatures have placed emphasis on the need for the therapist being present in the therapeutic process and with the client (Geller, 2017). We would illustrate such process from the perspective of a dual tuning process. We conceptualize therapist's presence in the therapeutic process as a state of being that is compassionately connected both intrapersonally within the therapist and interpersonally with the client.

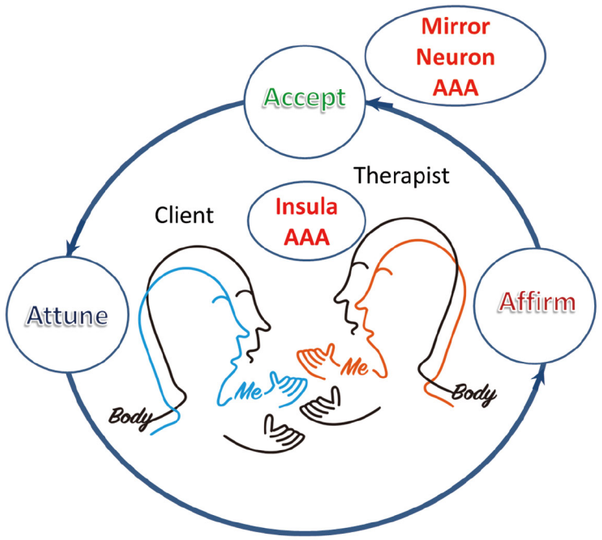
As we have illustrated in earlier section on the mirror neuron, it acts like a tuner for us to enter into others' internal world. To be present in the therapeutic process, we need to have this tuner on in order for us to attune into the client's world. This is the crucial element to enable us to be present with the client. In order to effectively enable the mirror neuron, we need to be curious and paying due attention to client's conditions and body languages. However, as we have illustrated earlier, such practice may render us susceptible to the negative mood condition of the client and being dragged into the black hole together with the client, a phenomenon called compassion fatigue that may lead to secondary trauma.

Therefore the therapist needs to first have an AAA connection with themself, as we have illustrated in the earlier section, before they connect with the client with their mirror neuron tuner turned on. The purpose of such intrapersonal connection is to enable the self-regulation process of our insula, to ensure the continual integration between the Left and Right brains, the implicit and explicit memories, helping us to keep regulating our internal conditions while being with the client, protecting us from being traumatized by the traumatic experience of the client.

If the mirror neuron is considered as the interpersonal tuner between us and the client, then the insula can be considered as an intrapersonal tuner for our Mind and Body. To be fully present in the therapeutic process requires both tuners to be on at the same time. Such that both our Left and Right brains are turned on, and continuously integrates the signals from the client and ourselves, informing us the most adaptive decisions and actions for the therapeutic process.

Figure 16 is a conceptual diagram showing the dual tuning process of presence in the therapeutic process.

Figure 16 The Dual Tuning Process for Being Present in the Therapeutic Process.



After having the right attitude and condition, we would present the skills and strategies that we often adopt for the interpersonal connection part for the clients in the following sections. There are three types of interpersonal strategies in this manual: 1) relational strategies based on attachment theory, 2) relational strategies from AEDP, and 3) integrational strategies from AEDP. These skills and strategies are presented in the following sections. The skills presented in this manual are served as examples to illustrate the application of the principles. In addition to these skills and strategies, readers may integrate and adapt the therapy skills that they are familiar with into our treatment model base on the treatment principles.

4.3.2 Relational Strategies Based on Attachment Styles

The skills and strategies presented in this section are adapted from the materials presented by Kim Barthel in the workshop she provided in Hong Kong (K. Barthel, personal communication, July 29, 2019).

As we have illustrated in the Assessment chapter on the attachment styles base on the DMM model, there are three basic types of attachment: 1) Type A: avoidant, 2) Type B: balanced, and 3) Type C: connection seeking. We would present strategies for relating to the insecure types (Type A and Type C) in this section, as they are most commonly found among our clients.

- Strategies for Type A

  Clients used to Type A style of coping learn from their childhood experiences that their feelings and needs make others feel uncomfortable. They were the children who are being rejected or neglected by their caregivers. The more they feel anxious and insecure, the more they are disconnected with the needs of themselves and are more separated from themselves. They tend to cope by pleasing others, being compliant and provide self-sacrificing care. They are used to suppress their emotions and try every means to avoid conflicts with others. They feel insecure with people and sensitive to rejection from others. Therefore, they tend to be self-reliant and are difficult to delegate or trust others. These clients when being seen in therapy, are often withdrawn, avoid eye contact, and sit in a flexion posture. You may find these clients very pleasant and compliant in therapy, but emotionally distant from you. If we cannot effectively engage them in session, they are prone to leave therapy after some time without any signs of difficulty. They may tell you their problems are solved but being vague in how they are solved, or they would just say that they are too busy to come.

In relating to clients of the Type A style, the aim is to increase their connection to feelings and body sensations, through compassionate acceptance. They will not open until they can sense full acceptance from the therapist and feel safe. We need to be sensitive and be aware of their body language, as they seldom expressed discontent. It would be helpful to slow down, observe and carefully track the communication process with the client. Giving permission and helping the client to speak the unspoken is important to facilitate a sense of understanding and acceptance. Avoid asking too many questions, as they are sensitive to rejection and fearful of exposing too much of their inner world. Seek opportunities to genuinely affirm their strengths and help them feel being understood and accepted. More skills of affect regulation can be provided to clients only after a trustworthy relational connection is established.

- Strategies for Type C

Clients used to the Type C coping experienced inconsistencies and uncertainties from their caregivers in childhood. Opposite to Type A coping, Type C clients tend to seek connection with others in order to feel safe. They would maintain eye contacts with you. You may find them being clinging, demanding and attention seeking. They are highly emotional and are anxious. They tend to have challenging behaviors when there is no connection with others and feel isolated and abandoned. They are overly focused on self needs and fulfill them through reliance on others. As their insecure feeling increases, they may display more aggression or feigned helplessness.

In relating to clients with the Type C behaviors, it is important to maintain consistency in our relationship with them. Expectation management is important to ensure a realistic expectation on what the therapist may comfortably deliver. It is helpful to maintain eye contact and connection. Their challenging behavior can be considered as cries for help, and can be reduced by setting realistic expectations. They seek all kinds of attention, positive or negative. Therefore it is helpful to minimize your negative reaction to their challenging behaviors, as they may be rewarded by being able to trigger your reactions. Seek every opportunity to help clients to increase self-regulation and self-awareness, and empower their independence in coping and regulating their affects.

4.3.3 Relational Strategies from AEDP

In this and the next section we would present the skills adapted from AEDP for building good interpersonal relationship between the therapist and the client. We find that the skills in AEDP are very suited for this purpose. Please refer to the related AEDP literatures for details of the skills (Fosha, 2000). Since our theoretical conceptualization is slightly different from AEDP, the categorization of the skills is slightly different from the original AEDP approach after our adaptation.

The purpose of relational strategies is to help making a therapeutic connection with clients through corrective relational experiences. In the process, we are able to track client's condition from moment to moment using our mirror neuron, and decode the information collected using our internal tuner, the insula, and decide on the best way to give a sense of safety and meaningful relational connection for the client. As the saying goes, it does not matter what you do to the client, it matters how you make them feel. Follow the AAA principle in your communication with the client, so that they may have positive relational experience first on their Right Brain, and subsequently opens up their Left Brain after feeling safe and gaining trust in the therapeutic process.

The followings are some of the micro-skills that we adapted from AEDP. Sample scripts are provided in each skill, however, these examples are just given for illustration, and not expected to be followed strictly by the therapist. As we are in tune with both the client and ourselves, we would be able to give the most adaptive intervention and responses as a result of the integration of our Left and Right brain.

- Dyadic affect regulation

Through this skill, the therapist helps the client to regulate their affects by paying attention to client's body, their strengths, or any experiences the client is going through. It provides a good modelling for client to also pay attention to their body and experiences.

Examples:

- Empathize and validate client's experience
  "I can sense your difficulties and your hard work."
  "I am very touched by your hard efforts!"

- Helping client to ground and stabilize
  "Let's slow down, have a feel of ourselves and take care of ourselves.
  "Let's slow down, notice our breathing and notice our body sensations.

- Undoing aloneness

The therapist actively relates to the client and supports the client, to help the client feeling a compassionate connection with another person, and thereby relieving them from their aloneness. Facilitating a sense of togetherness and the "we here".

"Yes I am listening, you may take your time to tell me about your experiences"
"Thank you for sharing these experiences with me. Can you feel that I am experiencing these together with you?"
"Can you feel my presence while you are recalling those painful memories?"
"Can we go back in time together to revisit those experiences in the past?"

- Explicit support

"How would you feel if I support you in this issue?"
"How do you feel being supported by me?"
"If all those who love you are here, what are they going to say about you?"

- Validate Defense

When we sense client is not feeling safe and tries to defend, we show our empathy to the defense. This can help to connect with the client, enabling a safe feeling, and raise client's awareness of the defense they has just raised.

"You were angry, because you want to protect yourself"
"Keep silent was the only choice you have according to the situation at that time."
"It is natural to feel nervous and unnatural at your first therapy session."

4.3.4 Integrational Strategies from AEDP

The integrational strategies help to register the corrective experience on the Right Brain to the Left Brain of the client. This is an important set of strategies to help client to resolve their trauma. While the relational strategies may also open up the Left Brain of the client by giving a safe feeling to the Right Brain, the focus of relational strategies is not on integration. Integration is a deeper level of work after the client has gained some positive relational experiences and developed trust with the therapist. Therefore these strategies are often used after successful relational connection with the client.

In the language of Danny Yeung (Personal Communication, November 12, 2016), a well-known AEDP therapist and trainer, the relational strategies are the horizontal intervention; and the somatic and affective strategies are the vertical intervention(十六個縱橫轉進; The 16 horizontal and vertical intervention strategies). In our model, the vertical strategies are similar but slightly different to the transformational strategies in Yeung's conceptualization. We named the vertical strategies as the integrational strategies, which deepens the experience and insights of the client by integrating client's cognition with the experiences.

If we sensed client is not ready for integrational strategies, we would always fall back to the relational strategies to build up the ground work.

The following are some of the integrational strategies we adapted from AEDP. For details of the skills, readers are encouraged to consult the AEDP literatures (Fosha, 2000). It should also be noted that these skills are not exclusive to AEDP. They are commonly shared among other well established therapy models.

- Meta-processing

  Meta-processing can be considered as a way of debriefing by guiding the client to take a look back on the emotional experience that they have just gone through, to facilitate and register the insights gained through the experience onto the Left Brain.

  The process is similar to the Self-Compassionate Communication as described in the earlier section, with the difference being that the therapist is now guiding the client going through the AAA processes in the exploration of the experiences.

  In the process, the therapist would direct client's attention to the important experience just gone through, standing together with the client to look at the piece of work that has just been done. The following is an example of a meta-processing work.

  The client has just recalled her experience with a failure in a public examination. After being in touch with the shame and guilt feelings associated with the event, the therapist helped the client to be in touch with her sadness associated with the event at a deeper level. The client cried in session expressing her grief over the loss as a result of the event. And she was joined by the therapist showing compassionate acceptance of her emotions and her experiences, tracking and being present with her processes moment to moment. The client was able to feel a relief about the negative event out of the relational intervention of the therapist.

  The therapist then started a meta-processing work with client by inviting the client to look back on what just happened when they were talking about the public exam experience, and ask how she felt when reflected on the whole conversation just happened. Client reflected that she had never gone through the event in such way with another person. She was impressed and appreciative of the feeling of support and understanding from the therapist. It helped her to look at the event from a different perspective.

Just like what happened with the AAA process in the SCC, the therapist summarized and reflected the client's insight back to the client, "It seems that you are more supportive of yourself and be able to arrive at a better place, if you can be accepted and supported by an understanding person."

The client replied, "Yes, I never had this experience before and in my mind, I believed that everyone will laugh at me or criticize me if they know what happened. I never thought that someone may understand me and comfort me."

The therapist then turned the client's attention to her Body signals again base on the new insight, "While you are saying this to me, how is your body responding to what you just said?"

Client (C): I feel my body is relaxed and there is a sense of lightness.
Therapist (T): Great, just pay attention to the relaxed and light feeling, and stay with it, see if anything comes up as you are paying attention."

C: I realize that it is a common experience to have failure in all of us. I deserve to be cared for and be comforted. My heart feels for others who have a similar experience like me, and we can support each other in our weakness.

T: Cool. How is your body feeling now as you are having this insight?

C: I feel a resonant feeling in my body with this thought, and I feel warm in my heart.

As we can see from the above example, the client's corrective experience is deepened with the meta-processing, such that she is likely to respond differently the next time when she experienced a similar negative experience.

- Portrayal

Portrayal is a technique consistent with the memory reconsolidation theory. This is an important and effective skill in treating the traumatic experience. We classified it as the integrational skill as it integrates the implicit memory (Right Brain) with the explicit memory in the Left Brain. Similar to the 3 elements in memory reconsolidation, there are three steps of Portrayal.

i. Reactivation

The traumatic memory needs to be reactivated in the first step of portrayal. It is important to note that the client needs to be well prepared before this, as the recall of the traumatic memory may immediately throw the person out of balance outside the window of tolerance of their emotion. A solid and trustworthy relationship should have been developed before applying the portrayal technique. In the reactivation, the client is guided in recalling the imagery, feelings and experience of the painful past event, in the presence of warm support of the therapist.

ii. Corrective Experience

This step may sometimes be called as mismatched experience. It would be best if the client has already mastered some affect regulation skills like breathing relaxation, mindfulness and focusing. But it is not a must. The therapist may guide the client to regulate their affect while the client is exposing to the painful memory. All the relational strategies may be used, such that the client may feel the warm support from the therapist, facing the painful past together. The main corrective experience happens in the relational realm. The therapist, in the dual tuning mode, keeps to accept, attune and affirm (AAA) the experience of the client. The key is for the client to feel safe and support when they are recalling the experience, such that their Left Brain (i.e. the explicit memory) may open up and register the new corrective experience.

iii. Reconsolidation

Reconsolidation or transformation is completed after the therapist being through with the client in the whole recall, and the client is able to feel safe and supported in the whole process. Their Left brain would have insights and autobiographical memory of the corrective experience now. When they recall such event in future, both their implicit and explicit memories about the event may be recalled, and they would still have some uncomfortable feelings and negative impression on the event. At the same time, these feelings are regulated, far less strong, and within the window of tolerance of emotion. They would also have the clear awareness that the event happened in the past. They no longer need to medicate the pain using drugs and they are ready to make compassionate connection with themselves and others.

4.4 Helping Client to develop Compassionate Intrapersonal Relationship.

By this time, most of the client's traumatic experiences are resolved through memory reconsolidation and corrective experiences in the therapy. The client is ready for self-connection and develop skills to build a compassionate intrapersonal relationship.

As the condition and educational level of clients are varied, readers are encouraged to review the skills presented in the earlier sections on "Grounding" and the "Self-Compassion Communication" techniques. The techniques for therapist's self-care can be used for clients to develop their compassionate intrapersonal relationship. Readers may tailor the techniques to suit the needs of their clients. The key for this part is to increase the resilience and ability to independently regulate affect for the client.

4.5 Integration with other Therapy Modalities

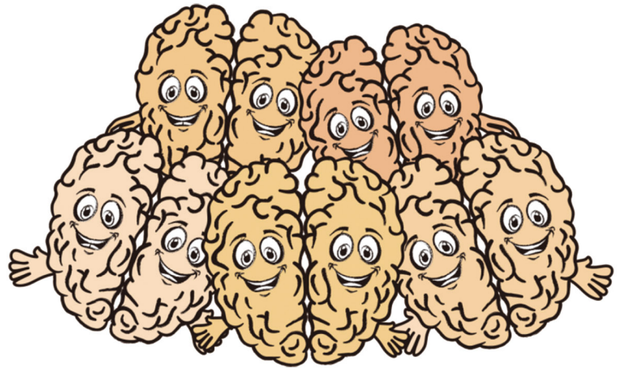
David Grand (2013), who authored Brain Spotting once said, "There is no turf when it comes to healing." It is our aim in this manual to present the principles of effective treatment so that readers may integrate the therapeutic skills that they have already mastered into the treatment model. In our development of the model, we are guided by the principles gleaned from the neurobiological theories, systemic, short term dynamic, attachment based and focusing oriented therapeutic models, and our practice experiences. We then integrate skills and techniques from different therapy modalities to form our treatment model. The advantage of the current treatment model is that you may apply the same principles into your work, and integrate your therapy skills and strategies to fit in the treatment principles of this model. It would require some adaptation and integration. And we hope that by going through the process, you may gain more wisdom for the therapy process and share with us in future.

Chapter 5

Interpersonal Connection and Relapse Prevention

At the conclusion of the intervention phase as depicted in the previous chapter, the client would have resolved most of the issues in trauma and substance abuse. And the important marker for the completion of stage 2 (the intervention stage) for a client, is a compassionate relationship with themself. Based on the relational model, therapy work is not completed until the client is able to make meaningful connections with others in the community. Clients with substance abuse are usually connected with their peers who also abuses substances and rely on drugs to medicate the pains of the past. If clients recovered from the drug abuse go back to their original community, they may be dragged back into the black holes again. Therefore it is an important step to connect the client with a healthy community before the termination of therapy, if possible at all means.

Figure 17 Developing healthy interpersonal connections helps relapse prevention.



We are not going to give a detailed treatment for this part as from our understanding, many service providers have already established various services to support clients connecting with health community. Clients may join support groups with guidance on developing interpersonal communication skills; joining community service programs, church or other religious groups; or helping in programs of substance treatment.

After successfully connecting with themselves compassionately, the clients would naturally be starting to connect with others. The therapist can act as a coach in providing support and guidance at this final stage, and moving towards completing service as clients are more and more empowered to be independent on their own.

Completing the part of interpersonal relational connection is also the key to bullet proof the prevention of relapse.

Chapter 6

Case Vignette
第六章 案例剖析

來到最後一章，我們希望能通過描述其中一個個案的治療過程來闡述Seeking Connection「創傷治療導向-戒毒輔導治療模式」的應用過程。由於個案的取材是香港華人社會的生活背景，所以在這一章我們特別以中文編寫，以真實反映和呈現整個評估、介入和治療的過程。為了保障當事人的私隱，我們對個案的背景資料作出適當的整理，而保留主要的臨床狀況和治療過程。

6.1 背景資料

陳小姐出生於一般家庭，父親從事小生意，母親是工人，家裏有三姊妹，她排行第二，與姐妹相差的年齡大概二至三年。陳小姐的職業是鋼琴老師，教兒童鋼琴。陳小姐26歲時因失戀而自殺入院，亦因有濫藥情況，經醫務社工轉介到濫用精神藥物者輔導中心跟進(下稱戒毒輔導中心)。陳小姐18歲時在Disco初次嘗試毒品包括K仔和搖頭丸，後來亦有接觸可卡因和俗稱白瓜子的安眠藥 (Zopiclone)。剛到戒毒輔導中心的時候，陳小姐濫用安眠藥的情況很嚴重。經過社工的評估和介入後，了解到個案的情況複雜，於是轉介見臨床心理學家劉姑娘，合作處理心理創傷和繼續戒毒治療。劉姑娘接手個案的時候，雖然陳小姐的情況比之前有很大的改善，但精神和情緒狀況都很不穩定，有暴食症 (Bulimia Nervosa) 和強迫症 (OCD) 的症狀，常常有刜手自殘行為，沒有社交，經常處於孤立無援的狀態。

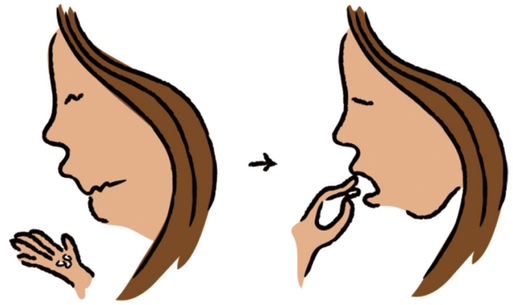
“過去有幾年光景，自殺的念頭不斷在我腦海中徘徊，家裏的窗框已經彎曲了，因為那時我曾想跳樓自殺，還用碎了的玻璃割傷自己的身體，當時家人和身邊朋友，只當我是酗酒和濫藥的人，但沒有人明白我的痛苦。十多年來，我不斷濫用白瓜子，瘋狂時更是一次過吞服200多粒。每天起床的第一件事，不由自主就是把白瓜子吞進肚裏，我喜歡那種迷迷糊糊的狀態，因為清醒對我來說很痛苦……"

對陳小姐而言，以往的生活是一場惡夢。

陳小姐的爸爸大部分時間需要打理生意，很少在家裏，照顧女兒及家務事宜主要由媽媽負責，媽媽對女兒的管教很嚴苛，從來不會稱讚和肯定孩子，而且經常責罵和虐打孩子，三姊妹都很害怕媽媽，常常擔驚受怕。由於媽媽成長於收養家庭，小時候被忽略照顧和虐待，所以很少照顧女兒的情緒需要，總是以責罵來代替關心，常常把怒氣發洩在女兒身上，會突然發脾氣責打她們。陳小姐小時候為了減少媽媽對自己的責罵，很用功讀書，成績很好，用功練琴，也很勤力地做家務，希望能得到媽媽的讚賞。然而，這個心中想被愛的渴望一直都未能得到滿足。

陳小姐11歲上中學的時候，正值青少年反叛期，除了上學外，父母擔心孩子會學壞，所以禁絕她課餘的社交，以致負面的情緒加劇，整個人開始出現抑鬱徵狀，情緒變得非常不穩定，更失去上學的動力。父母不理解她的抑鬱狀態，對於她拒絕上學，媽媽會掌摑她，甚至用傢俱擲打她，爸爸亦曾用一部很大的收音機擲向她的背部。面對父母不斷和長期的身心虐待，無論她如何痛苦呼求，換來的只有更多的打罵和更多的拒絕，這些恐懼的畫面歷歷在目，是陳小姐對父母最深的痛苦記憶。

陳小姐絕望地感到自己不能得到父母的愛，她在11歲那年，第一次自殺，飲滴露想了結生命，離開痛苦的家庭和人生，幸得及時被搶救保存生命。由於感到沒有家庭溫暖，陳小姐把希望寄託在男朋友身上。她很早就談戀愛，12歲時經歷第一次失戀，再一次吞服大量止痛藥企圖自殺，被搶救之後，常常有抑鬱和低落的情緒，經常和朋友一起借酒消愁，經常用硬物傷害自己和自殘。20歲那年，陳小姐才被診斷患上了嚴重的抑鬱症，晚上嚴重失眠，父親給了她第一顆白瓜子，她嘗試了之後很喜歡那種放鬆和迷糊的感覺，自此之後不斷靠白瓜子來減輕痛苦的情緒，服食的份量越來越多。



24歲那年，陳小姐吸食白瓜子的數量已接近200粒，她發現已經開始不能控制自己的行為，常常迷迷糊糊，不自覺地到超級市場高買，偷的只是日常用品。每每清醒後也不知道曾到過哪兒，也不記得有過高買的行為。後來，她因盜竊被定罪入獄，出獄後再次因失戀而自殺，再次入院接受治療，出院後經醫務社工轉介到戒毒輔導中心接受服務。

6.2 評估與個案分析

6.2.1 關係創傷 (Relational Trauma)

陳小姐是很典型的因心理創傷而濫藥的個案。她從兒童時期開始已經不斷經歷各種心理創傷，主要來自她與父母之間的關係和衝突，最大的創傷不只是父母的打罵，更是父母的拒絕。研究顯示，兒童期所受的創傷會大大增加日後發展濫藥或沉溺行為的風險。兒童階段是我們初步發展人際關係的關鍵時間，和照顧者的關係是我們最初與人相處的經驗，這個經驗形成了我們大腦中對人際關係和對世界最原始的印象。兒童期所受到關係的創傷能使人失去對自己和對他人的信心，嚴重地影響日後他們與自己和與他人發展健康的關係。我們在這書中不斷強調基於腦神經生物學 (Neurobiology) 的發現，人是為關係而生，能與自己和他人建立良好的關係，才能建立生活的希望和滿足感。否則就會墮入像弗蘭克 (Frankl, 1988) 所說的“存在真空” (Existential Vacuum) 的痛苦景況中。

從陳小姐的個案中，我們看到濫藥的源頭是在關係的創傷，陳小姐通過濫藥來減輕因為得不到愛，以及不能正常地與自己和與他人建立良好關係而帶來的巨大痛苦。

6.2.2 內在自我關係的評估 (Intrapersonal Assessment)

我們的自我價值感是在不斷與他人的互動和關係中逐漸形成的，尤其重要的是在孩童時期的第一段關係，也就是我們與照顧者的關係。陳小姐面對媽媽不斷的否定、指責甚至虐打，在陳小姐的內隱記憶 (Implicit Memory) 中形成了一個堅固的對自己的負面形象。當人覺得自己沒用和沒價值的時候，身體就會常常處於危險的警覺狀態，那就是多重迷走神經理論 (Polyvagal Theory) 中的危險模式 (Danger Mode)，希望能通過外在好的表現和外在的成就，博取別人的讚賞和肯定，但這種安慰往往都是很短暫的，而且取決於外在的因素。

陳小姐小時候通過努力讀書和做家務希望能得到媽媽的肯定，這是她第一個補償負面自我形象和取得愛的努力。這個嘗試失敗了之後，進入青少年階段的陳小姐開始發展和男朋友的關係，希望在家庭以外能夠得到關愛，但內裡對愛的渴求根本很難在年紀輕尚未成熟的男朋友身上得到滿足。此外，由於她從小被忽略和否定，在選擇朋友的時候，往往較難找到真正關心和愛自己的人，有些人甚至會習慣找一些忽略和否定自己的人做朋友或建立關係，原因是這些關係對她們來說是比較熟悉的相處模式。所以童年的傷害為日後更多的傷害埋下了伏線。

由於缺乏了自我肯定和良好的內在自我關係，陳小姐在過去的成長和生活當中往往需要很多非適應性 (Maladaptive) 的應對機制來補償不斷出現的自責和羞愧的感覺。缺乏自我肯定的人常常缺乏安全感，並活在自我感覺危險的模式中，因此情緒往往會很焦慮，對別人的看法非常敏感，並處於警戒的狀態。這就是陳小姐焦慮和抑鬱的情緒產生的緣故。起初是焦慮，當焦慮無論怎樣努力都不能消除時，就會進入無望和放棄 (Hopeless / Shutdown Mode) 的狀態，產生抑鬱的情緒。陳小姐的自殘行為、強迫症和進食失調，以致後來的濫藥行為，都是因缺乏自我價值感而產生焦慮情緒的彌補方法，而情緒低落和自殺的傾向就是在經過不斷的努力後，而情況仍沒有改善，轉為無望和放棄狀態的行為表現。

白瓜子 (Zopiclone) 本來是一種安眠藥，也有鎮靜情緒的作用，但濫用會造成依賴和上癮，嚴重影響精神狀態。而這種鎮靜的作用正好幫助陳小姐穩定和接納自己害怕被拒絕和否定的焦慮情緒，但由於身體會對白瓜子產生耐藥性 (Tolerance)，因此陳小姐需要不斷提高劑量才能達到鎮靜的效果，以致她最後發展到要每天服食200粒的嚴重狀態。

自殘行為很多時會被用來作為減輕心理痛苦的方式，因為在傷害身體之後，大腦會分泌腦內啡 (Endorphin) 來止痛，這些物質是人體分泌類似嗎啡的天然止痛劑，可以減輕痛苦和使人愉快。同時個案也和我們分享，傷害身體後，能感受到身體的痛苦，對於心靈上的痛苦，好像是得到了一種共鳴，反而會感覺舒服一些。我們從身心整合 (Mind Body Integration) 的角度去理解，這是案主不自覺地讓自己能增加和身體感覺連接的方式，但如果他們能學習和運用正確的身心整合技巧，或者就不會傷害自己了。

陳小姐的暴食症也是由於內在自我關係出現問題的一種補償方式，當暴食的時候，陳小姐可以得到短暫飽肚(照顧自己身體需要)的滿足感，但之後又擔心引致肥胖而失去別人的喜愛，所以用扣喉的方式把食物吐出來，這些行為的背後都是由於不能有一個穩定的自我肯定，而需要不斷通過外在因素來自我肯定和穩定自己情緒的結果。

陳小姐的強迫症表現在她對時間觀念非常執著，她每天為自己安排嚴格的日程，假如時間安排未能達到她的期望，她會不耐煩和情緒波動。陳小姐通過這些外在對時間的控制來肯定自己，讓自己覺得沒有浪費時間，這也是自我價值感不足的一種補償方式。

6.2.3 人際關係模式的評估 (Interpersonal Assessment)

陳小姐的個案同時讓我們看到父母的成長經歷對孩童的依附關係形成有很大的影響。陳小姐的媽媽由於在童年時得不到父母的愛，而形成了她對陳小姐的拒絕和否認，她並不是不愛女兒，而是她並不知道適當照顧和教導孩子的方法，所以關係的創傷是可以一代傳一代的，假如陳小姐沒有得到恰當的治療，這個創傷將會繼續延續下去。

陳小姐的低自尊 (Low Self-esteem) 形成了很極端的逃避型 (Avoidant) 的依附模式，就是覺得自己沒有價值，需要通過外在表現，得到別人的肯定和認同才能肯定自己的價值。

劉姑娘剛剛見陳小姐的時候，她面容憔悴瘦削，情緒低落。常常低頭避開和人的眼神接觸，不自覺地流露對自己不滿和自責的說話，很少會主動提及自己過去的事情，迴避接觸使她傷心的往事，也很害怕被人否定和拒絕。

陳小姐在教小孩鋼琴時能得到孩子的認同，她對孩子很有愛心，很盡心地教導他們，而且她會用各種方法去鼓勵這些孩子，包括用心給他們畫畫。但陳小姐面對自己的時候，回到家裏或者面對自己的感情問題，就會回復無望和無助的狀態，她並不能欣賞自己對孩子的愛心和在工作上的成績。

6.3 介入與治療

6.3.1 治療師的自我照顧 (Therapist's Self-Care – Intrapersonal Techniques)

面對陳小姐的個案，由於涉及大量痛苦的回憶和創傷的經歷，治療師在細心聆聽的過程中，很容易被捲入其中，產生同情疲勞 (Compassion Fatigue) 的現象，進而發展成為替代性創傷 (Secondary Trauma) 的危險。就如這書中之前所提到的，我們的鏡像神經元 (Mirror Neuron) 是一把兩刃的劍，一方面可以幫助我們進入案主的內心世界，但同時亦可以使我們重新經歷和體驗案主的痛苦記憶和創傷的經歷，造成同情疲勞。因此治療師作好自我照顧穩定自身情緒，堅固內在自我關係的工作是創傷治療導向的治療工作中不可或缺的一環。

劉姑娘每次面對陳小姐的時候，在專注陳小姐狀況的同時，也會很留意自己的呼吸和自己內在身體的信號。劉姑娘所進入的狀態，就是我們之前所提到的雙調諧 (Dual Tuning) 狀態，在這個狀態中治療師一方面會不斷地進行自我的身心整合 (Mind Body Integration)，也就是讓自己不斷地留意和接收從身體和環境而來的訊息，並且讓自己的腦島 (Insula) 不斷地進行情緒和身心狀態的調節和整合，使自己的意識不會因為極度負面的資訊而離線；另一方面劉姑娘會利用自己的鏡像神經元專注陳小姐的身體語言和身心狀態，每時每刻都追蹤 (Moment to Moment Tracking) 她的情緒和內在經驗，保持與陳小姐同步。而每當劉姑娘意識到自己開始有不舒服的感覺時，她會坦誠地向陳小姐表達，並且會叫陳小姐慢下來，表達她聽到陳小姐的痛苦經歷的感受。我們的案主在描述他們痛苦經歷的時候，很容易會過度的表達，因為他們可能已經處於解離的狀態 (Dissociation)，沒有意識到所表達的內容的沉重，能夠在這個時候讓案主慢下來，可以給我們自己空間去消化和整合這些痛苦的資訊，同時也讓案主明白我們對他們所表達的內容是有感覺的，使他們有一種被明白，被關注和被瞭解的感受:“原來我的經歷，劉姑娘也感到難受，那麼我感到辛苦也是正常的。我需要照顧自己的感受。” 這樣案主就能從解離的狀態回復到與自己身體和內在身心的整合和連接，這樣的介入可謂一舉兩得，一方面能自我照顧，同時對案主產生治療的作用。劉姑娘就是在這個雙調諧的狀態中不斷的接納、明白和肯定 (Accept Attune Affirm) 案主。不斷感受和追蹤自己與案主的身心狀態，從而不斷按情況和需要調節整個治療的進程，使大家的情緒和身心狀態都能保持在可承受的範圍內 (Window of Tolerance)，而不致太焦慮或太低落，這是很重要的基本策略和技巧。

治療師的內在平穩狀態，是讓陳小姐學習並感受這份安穩的起始點。要提供這份平靜安穩，治療師要能好好保持個人內在平靜安穩，才能協助案主學習調適個人的情緒狀況，以致達到平靜安穩，這是相互調節（Co-regulation）的概念。當案主看到治療師平靜安穩的表情和狀態時，她的鏡像神經元就會讓她產生相類似的平靜狀態和表情。

6.3.2 接納、明白和肯定 (AAA：Accept Attune Affirm)

陳小姐表示第一次見社工的時候，她覺得自己很幸運，因為當她說自己的經歷時，社工一邊聽一邊在流眼淚，她當時很驚訝，因為從小到大，家人從來不會專心聽她說話，只會怪責她，更加不會有人為她流過一滴眼淚。她覺得這位社工很有耐性地聽，很溫柔地回應。從社工的眼淚中，陳小姐覺得這位社工明白她的痛苦。於是，在這狀態下，陳小姐開始很樂意繼續來見社工，在輔導室中，她覺得很被明白，從原來害怕被人否定的緊張狀態，轉化為感到在輔導室是安全的，可以開放自己和處理自己面對的困難。社工的接納體現在她留心聆聽陳小姐的經歷，讓陳小姐的經歷感動自己，使自己能置身在陳小姐的處境中，完全明白和體會陳小姐的痛苦和感受。社工的眼淚和溫柔地表達她對案主的明白和體諒，讓陳小姐深深地感到被肯定的感覺。

建基於社工成功的前期工作，劉姑娘進一步加強了AAA的過程。AAA是使案主能獲得安全感和自我價值感的重要途徑。有創傷的人就像驚弓之鳥，對人充滿防衛，對陌生人的接近會有驚恐，因為她在以往的親密關係中遭受到別人對自己的傷害，人的接近亦是無形中的刺激或觸發（Trigger）。當案主被觸發時，他就會進入危險警戒的狀態並且會防衛（Defense），會緊張和心跳加速，進而發展至無望關閉（Shutdown）的狀態，甚至感覺變得麻木（Numbing）。輔導員若在此時和案主說毒品禍害或戒毒資訊時，因在防衛機制影響下，案主容易誤會外來的資訊，反而覺得輔導員在批評他，她會戰戰兢兢，甚至不再見輔導員。

因此活化和啓動案主的安全狀態，是能否聯繫案主和治療取得成功的關鍵。作為治療師，要對案主完全的接納，當我們能夠對自己和案主有深度的接納和關愛（Compassion）時，我們就能使自己處於多重迷走神經理論（Polyvagal Theory）中所描述的安全狀態，也是社交聯繫（Socially Engaged）的狀態，我們的聲音、語調和身體語言，自然就能讓案主感到安全，幫助他們也進入安全的狀態。我們不需要刻意留意自己的聲音和身體語言是否有安全感，因為這樣反而使我們緊張，我們只需要留意自己是否有平靜安穩和關愛案主的狀態，我們的身體語言是隨著我們內在的狀態而產生的。

劉姑娘的接納和關愛態度，使她能很自然地欣賞到陳小姐身上的優點，包括她的努力、堅持不放棄和她對孩子的愛心。劉姑娘讓自己被案主身上的亮點來觸動自己，而且對陳小姐的這些特點產生濃厚的興趣，和她一起深入去探討和明白這些優點的形成和背後的原因。如果愛與被愛的關係，正如腦神經科學所啟示的，是我們每個人的核心的時候，即使我們在很痛苦的狀態下，我們也會流露出這些有關的亮點。雖然陳小姐在家裏得不到溫暖和愛，但是她對孩子的付出和愛心，是她內在愛與被愛的需要的自然流露，劉姑娘對這些事情的留意，使陳小姐能看到和聯繫這些自己內在的亮點和情感需要，而治療師對這些亮點的肯定，使她也能對自己肯定，而重新建立內在自我和諧的關係，開始接納自己，體諒和明白自己的遭遇、努力和愛心。重建自我內在關係（Intrapersonal Relationship）是一個很重要的過程，治療師在這個過程中通過人際的互動向案主表達接納，明白和肯定，使案主能接納自己，重新連繫自己的身體、情感和需要，重獲一種穩定的自我接納的價值感和安全的存在感，減少通過外在的因素和別人的讚賞，來滿足內心平靜的需要。

在治療後期的階段，劉姑娘曾詢問陳小姐：“你認為個人改變的轉捩點是怎樣開始的？”陳小姐回答：“我的改變是因為從你眼中看到我自己是好的，是你告訴我，我有很多好的地方，讓我開始有動力。”陳小姐的分享，印證了AAA過程的必要和重要性。

6.3.3 創傷的治療

通過AAA和案主建立了穩固的治療關係後，同時也使案主獲得了初步的自我認同和安全感，情緒狀態得以初步穩定。接著劉姑娘開始專注創傷的治療工作。

第一步，需要幫助案主了解她的濫藥和她的創傷經驗之間的關係。大部份曾有創傷經驗的人，他們會用「痴線」去形容自己，他們很多時或會有創傷後壓力症（PTSD）的徵狀，包括無時無刻都覺得情緒困擾或擔驚受怕，甚至常常處於一個遑恐狀態；他們會迴避人，包括不能上班、不能去接觸人，對人不信任甚或反應過度敏感；身心常感覺很不舒服、失眠、發惡夢或有回閃片段（Flashback）。所以，我們要了解案主在甚麼高危情況下，在甚麼的情緒下，會特別容易吸食毒品/濫藥，這是一個介入點，同時讓我們和案主都了解情景、情緒和濫藥的關係。這個理解，是右腦的經驗開始和左腦的認知結合的開始，也是接觸創傷經驗的開始。

案主較常會很簡單地告訴我們，習慣起床就濫藥，不開心就吸食，或者別人給我毒品就不加思索地吸食。所以處理的重點是倘若案主表示會因為不開心的情況下濫藥，我們會嘗試理解那個情景會是怎樣，不開心的程度，濫藥後的感覺，並表達我們的理解等等。正如這書中的理論部分所述，濫藥和創傷經驗類似的地方是，它們都是儲存在右腦的內隱記憶（Implicit Memory），而缺乏左腦和認知有關的外顯記憶（Explicit Memory），因此案主多會給我們的描述是很經驗和感受性的，唯有當他們感到有安全感時，才能開始打開認知的左腦，聯繫毒品與創傷的關係。處理創傷是一個需要經歷不舒服和困難的過程，當案主能明白毒品的功能（Function of Drugs）是逃避和減輕創傷的痛苦時，他們就能產生動力面對和處理自己的創傷問題。同時由於明白濫藥的真正原因，也減輕了對自己的自責和羞恥感。

如果她說濫藥成為了習慣，好像陳小姐說，每當一起床就吸食，就是一種習慣，沒有甚麼特別。我們會記下，會與案主一起去思考及探討，怎樣變成了一個習慣，為何一起床就要吸食等，如果不吸食，會有甚麼狀態，這個狀態使她聯想到甚麼？通過和案主一起反思，感受和探討，慢慢讓案主明白當中毒品與創傷經歷的關係。同時我們會給案主一些創傷後壓力症（PTSD）的心理教育資訊，增加案主對自己問題的認識和理解。

當案主能逐步地在治療的過程中建立安全感，和理解濫藥與創傷的聯繫時，他們開始能回憶，並且和治療師分享過去痛苦的經歷，治療師可以通過“記憶重固”（Memory Reconsolidation）的技巧，幫助案主解決和治療這些創傷的問題。這個技巧的重點是當案主在回憶創傷經驗時，如果治療師能為案主提供一個安全正面的體驗，這個體驗就會成為一個修正性的經驗（Corrective Experience），大腦會記下新的經驗，在下一次記憶被觸動時，新的記憶會取代以往創傷性的記憶。很關鍵的部分是，當治療師和案主一起回顧這些經歷時，能留意和追蹤案主的狀態，通過關係策略和技巧，讓案主能不斷地調節產生的負面感覺和情緒，是產生修正性經驗的關鍵。劉姑娘在和案主回顧過往創傷經歷時，會運用“除去孤單感”（Undo Aloneness）的技巧，提醒陳小姐治療師在她旁邊陪伴她，並且會按情況幫助案主調節呼吸，和留意身體的感覺，幫助案主做身心的整合，不斷營造新的修正性的正面經驗。

6.3.4 內在自我關係的建立

陳小姐的童年創傷經歷經過了一段時間的處理後，基本上得到醫治。劉姑娘繼續培養陳小姐自我身心聯繫的技巧，如接地（Grounding）和靜觀（Mindfulness）等。在過程中繼續地接納和肯定陳小姐，使陳小姐能通過與治療師的關係，把自我接納和肯定內化成真正屬於自己的東西。

6.3.5 跨專業的合作

值得一提的是，陳小姐在整個治療的過程中都定期到物質誤用診所覆診和進行藥物治療，在治療的過程中我們與精神科醫生有緊密的合作。精神科的藥物介入，能較快調整案主的精神狀態，和減輕原發性或毒品引致的精神疾患的症狀，也能減少案主對毒品的依賴，從而減少毒品的傷害和危機，同時讓案主能在更佳的狀態下，更好地接受心理治療。

6.4 預防復吸與結束治療

陳小姐經過社工和臨床心理學家的介入治療，目前白瓜子的服食數量已由原來的200顆減至每天1顆。她很早已經和以前吸食毒品的朋友斷絕聯繫，同時她最近回到學校進修英文，希望能改進自己。在學校裏，創傷得到治療的陳小姐開始能結交新的朋友和維繫彼此間的關係。她能面帶微笑，眼神再沒有迴避別人的目光，而且能有幽默感地和精神科醫生開玩笑，和她剛來中心時的情況比較，她好像成為了另外一個人。

6.5 後記

對陳小姐而言，以往的生活是一場惡夢，縱使偶爾仍心有餘悸，但她能感受到那是過去的事。從關係上的創傷慢慢得到治愈，使她能體諒自己的困難，並明白別人的苦；明白自己的需要，並能對別人的需要施予援助。現在陳小姐修復了很多破碎的關係，與母親也重拾關係，更開展了一段新的親密關係。

創傷被治癒，往往可帶來更大的成長，我們稱之為創傷後成長 (Post Traumatic Growth)。

在新冠狀病毒期間，看見身旁的老伯伯沒有戴口罩，陳小姐會把身上的口罩給予他；看見長者沒有東西吃，她會隨即把自己的食物遞上。陳小姐終於可以面對和感受周邊的事物，愛自己的同時也能把愛分享給別人，她內心的善良終於可以表達出來了。

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