NUMINUS

Applied Psychedelic-Assisted Therapy: Cases, Conditions, and Context

WORKBOOK

NUMINUS CARE MODEL

An integrative and transformative mental wellness approach has a focus on whole-person health, including lifestyle and behaviour changes in which physical and mental health are deeply connected–not existing in isolation. This is at the heart of the Numinus Care Model.

TRAUMA- AND VIOLENCE-INFORMED CARE

Trauma is a transdiagnostic risk factor for mental and physical wellbeing. Informed professionals understand the types and physiological, psychological, and behavioural impacts of trauma.

CULTURAL SAFETY AND HUMILITY

Cultural humility is an ongoing process of self-critique in order to achieve a culturally safe environment. Cultural safety allows Indigenous Peoples to live their full sense of self and identity when accessing services.

JUSTICE, EQUITY, DIGNITY, & INCLUSION

Health professionals must prioritize dignity and human rights in the face of injustice. Services should be equitable and inclusive. Health professionals must commit to ongoing learning about oppression, racism, and discrimination.

HARM REDUCTION

Harm reduction is any program, policy, or intervention that seeks to reduce or minimize the adverse health and social consequences associated with certain behaviours such as substance use.

CONNECTION

This approach recognizes the importance of relationship-building in healthcare to create meaningful opportunities for people to connect with each other throughout their healing journey.

MINDFULNESS

Mindful awareness encompasses contact with all available modes of sense perception (vision, sound, interoception, etc.), as well as awareness of arising and passing emotions and phenomena (thoughts, images, embodied experiences, etc.).

EMBODIMENT

Embodied awareness provides access to one's present truth and past as it shows up through embodied implicit memory. Embodiment includes interoception which allows us to feel and relate to what is going on in our bodies.

THERAPEUTIC STANCE

At Numinus, we have identified particular elements that define an optimal 'therapeutic stance' for delivering psychedelic-assisted therapy. We encourage all health professionals, regardless of prior training, to develop this common language and understanding. Health professionals must *embody* these elements in order to show up well for their clients; they cannot remain merely abstractions or ideas as this will not create a fertile intersubjective field between health professional and client for integrative and transformative healing and learning to take place.

INNER DIRECTED THERAPY

Health professionals should relax into uncertainty of what is unfolding, or about to unfold, within a client's present moment process in psychedelic-assisted therapy, and to support this appropriately. Needs and opportunities for healing and learning are met skilfully as they arise emergently, rather than through pre-planned processes.

UNCONDITIONAL POSITIVE REGARD

This involves showing abiding recognition of a person's inherent human worth irrespective of the person's values and actions. When one is fully acknowledged and supported as they are, without judgment, resistance to change lessens (Rogers, 1942). With less resistance, one can more readily step into the change process.

APPRECIATION FOR HUMAN SUFFERING

This appreciation recognizes suffering is part of the human condition (Cooper, 2016). Health professionals should trust the client's inner healing process by refraining from attempting to 'help' by palliating their experience. Instead, encourage them to lean into the experience while providing skillful and loving support.

EMPATHETIC ABIDING PRESENCE AND LISTENING

Demonstrable components of empathetic abiding presence include evenly suspended attention, mindfulness, empathetic listening, "doing by non-doing," and responding to distress with calmness and equanimity (Phelps, 2017). A nurturing, safe clinical context is essential for healing.

BEING GROUNDED, SELF-REGULATED, AND ALIGNED

Being physiologically and energetically grounded, self-regulated, and aligned is essential when working with individuals in altered states of consciousness and with those who have experienced significant traumatic stress. Health professionals should self-monitor and self-regulate.

ORIENTATION TOWARDS PHENOMENOLOGY

A phenomonological orientation concerns itself with unfolding the subjective "inner" experience of the client, including their thoughts, emotions, body sensations, behaviours, or impulses to act. Questions asked and language chosen invite client self-exploration.

RELATIONSHIP-CENTERED CARE

Attention to the quality of the therapeutic relationship is always prioritized with an understanding that desired therapeutic outcomes will naturally follow, in keeping with the contextual model of psychotherapy. Relationship-Centered Care also acknowledges that all relationships have power dynamics.

LOVE

Health professionals should have lived experiences with agapic love (also known as altruistic or selfless love) to be able to empathically resonate and meet a client in that state and to be comfortable experiencing this natural human state within frameworks of professionalism as love is commonly encountered in this modality.

TOP-DOWN AND BOTTOM-UP PROCESSING

Using the model of the brain as a hierarchical information processor, top-down or long-route processing versus bottom-up or short-route processing refers to the area (or level) of the brain which is dominant in guiding the processing that is occurring in the client's experience.

SELF-AWARENESS AND ETHICAL INTEGRITY

Psychedelic-assisted therapy has unique ethical risks. Self-awareness includes investigating and challenging one's implicit biases, establishing a strong and trustworthy therapeutic relationship, maintaining appropriate boundaries, and identifying and managing countertransference.

MODULE 1

TRANSDIAGNOSTIC CONSIDERATIONS

Case 1

PART 1

A colleague has been providing psychotherapy to Alex, a 45-year-old man suffering from treatment-resistant depression. He is irritable or numb most of the time, has difficulty getting out of bed, often feels overwhelmed by family life (he is married with 2 small children) and is socially isolated. He often over-eats, does no exercise, and is overweight. He contemplates self-harm when difficult experiences pile up. He no longer works and is on long-term disability. He takes several medications to manage his mood and has tried many different types of therapy, including CBT, ACT, mindful self-compassion, and ketamine-assisted therapy. At the beginning of these treatments, his mood is often hopeful and energized, but this shifts to disappointment and anger when the treatment becomes challenging.

Alex has been reading about the research on psilocybin-assisted therapy and is interested in pursuing that treatment for his depression. His doctor prepared an application to Health Canada's Special Access Program on Alex's behalf to obtain legal access to psilocybin-assisted therapy at your clinic. The application was accepted, and your colleague invites you to be her co-therapist in this treatment.

Discussion

- What else would you like to know at this stage?
- Do you think psilocybin is appropriate in this case? Why or why not?
- What risks and contra-indications would you contemplate for Alex in psilocybin-assisted therapy?
- How would you approach establishing your relationship with the co-therapist?

PART 2

In the first Preparation Session, Alex appears anxious and disconnected. When he speaks about difficulties in his life, he expresses little affect. He is also agitated and restless when you or your co-therapist explain that you will be there to support whatever he needs in the psilocybin session. He tends to rely on sarcastic jokes in the more intimate moments of the session e.g. “Yeah, I should hope you guys will be there to support me with the price I’m paying, ha ha.”

In a second Preparation Session, you learn that Alex has a trauma history. When he was in elementary school, he was sexually assaulted by an older boy. His parents refused to talk about it with him, and he felt significant confusion and shame about the experience. He was also bullied regularly at school. He was a sensitive child, but his parents were typically unavailable – they seemed not to want to be burdened by his emotional difficulties.

Discussion

- How would this information add to your case conceptualization?
- What are the goals of the treatment? (Consider DSM criteria, co-morbidities, and other psycho-social concerns)
- What is important to cover in Preparation before moving on to the Psilocybin Session?
- What internal and external resources does Alex need to support his journey?

PART 3

The morning of the Psilocybin Session, Alex took 25mg of synthetic psilocybin and focused inward, listening to music through headphones with eye shades on. After several hours of deep, internal processing, he took off the headphones and eyeshades and said he was “done” and needed to “get out of there.” He did not want to talk about it for a while, so the three of you sat together chatting superficially. Eventually he began sharing about his journey: he was processing memories from different phases of his life, while experiencing sadness, regret, and self-compassion. He had several deep insights around the theme of his sensitivity and the "filter” he learned to apply to his experience to help shield himself from the intense emotions he felt. He believes he needs to make more space in his life to feel his emotions more fully. These reflections were highly constructive and became the focus of the integration therapy. He was hopeful that the session would have impact on his long-term well-being.

Two weeks later, Alex showed up to an Integration Session totally shut down and angry with the therapists. Since the Medicine Session, his wife and two kids got sick, and he was overwhelmed by all the childcare responsibilities he had to take on. He felt he was in worse shape than before the Psilocybin Session and is angry with himself and the treatment team for getting his hopes up.

Discussion

- What are the immediate priorities at this stage? What’s your rationale?
- What risks do you need to assess?
- In what way do these developments shift your view of the treatment overall, if at all?
- How might you help him restore hope?

Case 2

PART 1

You have been providing traditional psychotherapy to Mary, a 42-year-old, woman for several months. Mary has a demanding and lucrative job. She is married to a successful professional and the couple has a young daughter. Mary self-referred to you for support in dealing with a “burnout.” She has a long history of these episodes, which are typically the culmination of long periods of feeling anxious and overstimulated at work. At a certain point, her body just shuts down and she becomes functionally impaired: she is exhausted, has difficulty getting out of bed, concentrating and being present for loved ones, and finds no enjoyment or meaning in her activities. These episodes can last several months and take a big toll on her life and self-esteem. In general, Mary tends to be obsessive, perfectionistic, and self-critical and has a history of eating disorders. She has had several periods of dependence on clonazepam for sleep. She is now desperate to find a way out of the current episode and begins inquiring about ketamine-assisted therapy (KAT). You are trained to deliver KAT but are yet to take on a first case. After some deliberation, Mary decides to go ahead with KAT and is impatient to start so she can be in good shape to enjoy the summer.

Discussion

- What else would you like to know at this stage?
- Do you think ketamine is appropriate in this case? Why or why not?
- What risks and contraindications would you contemplate for Mary in this treatment?
- What are the goals of the treatment? (Consider DSM criteria, co-morbidities, and other psycho-social concerns)
- What is important to cover in Preparation before moving on to the ketamine treatment?

PART 2

You and Mary decide to proceed with the KAT treatment. She passes the medical screening and meets DSM-V criteria for major depressive disorder and so is accepted into the ketamine clinic. The protocol in this clinic involves 3 IM ketamine sessions over three weeks, each followed by an Integration Session the following day. The dosing of ketamine starts in the low range and increases over the course of the sessions, subject to the client's comfort. In the first Medicine Session, Mary was anxious about the ketamine administration and struggled to let go into the experience. The ketamine did not have much of an effect, and she expressed disappointment and impatience in the Integration Session the following day. She was a little more at ease in the second Medicine Session, which involved a higher dose, experiencing a pleasant, relaxing, dream-like state. Her mood returned to the depressed baseline by the next morning, however. At this point, she is increasingly discouraged about the limited impact of the treatment and is worried that the 3rd medicine session will also be "a bust."

Discussion

- What stands out for you in Mary's experience in the Ketamine Sessions?
- How would her experience in the Ketamine Sessions influence how you plan to work with her going forward?
- Check in with your own feelings: how do you feel toward her and the treatment so far?

PART 3

In the third Medicine Session, Mary opts for the high end of the dosing range and has a big experience. Her body vibrates with positive energy, and she feels a deep sense of joy, connection, and love for her daughter, herself, and all living beings. She leaves the session on a high. In the Integration Session the next day, Mary is upbeat and feels like her depression has finally lifted. She is grateful to you and the treatment and will reflect on how she wants to proceed with ongoing therapy.

Discussion

- What stands out for you at this phase of the treatment?
- How would you help Mary embody and anchor her ketamine experience to ensure sustainable change?
- What are the key clinical variables to track over the course of integration therapy, assuming she continues with ongoing sessions?
- To what extent do you think the ketamine-assisted therapy successful treated Mary's depression?

MODULE 2

DEPRESSION AND ANXIETY

Case 1

PART 1

You receive a self-referral from Rosanna for therapy because she sees you provide psychedelic integration services. She is contemplating using psilocybin to help her with her mood and anxiety. Here is what you learned from the first few sessions.

Rosanna is 33 years old and has a history of depression and anxiety. She has been diagnosed with bipolar type II. Since her teen years, she has suffered from mood swings and periods of depression and experiences anxiety about her mood shifting and changing. She suffers from some self-worth issues. She has a job doing research and market analysis for a small company. Her social connections are quite strong, although she does isolate herself when she is having depressive episodes. She has been curious about exploring psychedelics to try and support uncovering what is at the root of her struggles and to try and gain more acceptance and tools for navigating her mood fluctuations. She would like to know whether you believe psilocybin will help her and, if so, if you would accompany her on her journey.

Discussion

- Do you think psilocybin is appropriate for this person; why or why not? Please discuss any potential risks and protective factors
- How would you respond to her request? (Note this therapy is not legal in your jurisdiction)

PART 2

A friend of hers recommends a licensed therapist who sits with clients for clients taking psilocybin, as part of her “harm reduction” practice. While this is not a legal context, Rosanna feels safe as the therapist has been practicing psychology for many years and has a lot of experience with psilocybin. Rosanna needs to provide her own medicine, which she acquires online, and pursues integration with you after the experience.

During the middle part of the medicine session, Rosanna, has a vision of being in a forest and merging with the plants and trees. She feels the forest lifting her up, while fireflies, birds, and other animals dance around her. She sees bright light surround her and slowly move inside of her. She hears a loud voice saying that she is a goddess of the universe and shouldn’t let anything or anyone ever tell her otherwise. She feels deep joy, peace, and what she calls “bliss.” She then starts seeing herself made up of both golden light and darkness. She sees the contrast between these two parts of herself and realizes that the darkness is beautiful in and of itself and served to highlight her beauty. This insight is very meaningful to Rosanna, but she is unsure of how to incorporate it into her healing of depression and anxiety.

Discussion

- How would you incorporate this vision into your conceptualization of Rosanna’s depression and anxiety?
- How would you help Rosanna integrate this insight to ensure sustainable change?
- Based on this case, how do you think mystical-type experiences can help clients overcome or cope with depression and anxiety?

Case 2

PART 1

You receive a phone call from a colleague who wants to refer a client. You owe your colleague a client and agree to take on the client. This is what you learn in that call and in the first session with the client:

Doug is in his mid 50's and is a doctor who works part time. He has been suffering from OCD, Anxiety and Depression on and off for his entire life. For many years he was able to cope with limited functional impairment, practicing mindfulness and taking different antidepressant medications. About three years ago he came off his medication and his depression came on very strongly. He tried going back on the same medication but did not receive the same benefits. His psychiatrist has been trying different medications with little success. Doug struggles to get out of bed on the days he is not working. He is becoming increasingly anxious about going out of his house and his OCD symptoms have been also getting increasingly worse. He has come looking for help for his depression and is considering psychedelics for help.

Discussion

- Do you think psychedelics are appropriate for this person; why or why not? And if yes, which one(s)? Please discuss any potential risks and protective factors.
- What would be the most pertinent information to collect in your assessment of this case?
- Given a transdiagnostic framework, how would you conceptualize the underlying causes of his depressive symptoms?

PART 2

Doug goes ahead and finds a clinic to do a series of IV Ketamine for Depression over the course of six weeks. They are suggesting two infusions a week for the first three weeks and then one infusion for the last three. There is no therapist present at the sessions although there is a psychiatrist overseeing the treatment. They encourage the client to bring music to the session and suggest a couple of playlists. Doug requests you support him for integration afterwards.

During the first medicine session, Doug was pleasantly surprised with feeling a wave of kindness. He felt warm and pleasant sensations in his body and saw colors dancing around him. He was reminded of the lovingkindness meditation that he used to practice regularly but has not done in recent years. He has a strong intuition that he needs to be kinder to himself. As the treatment progresses, Doug has a harder and harder time connecting with that intention to be kinder to himself. He describes the re-emergence a very harsh, inner critic that doesn't believe he deserves that kindness.

Group Activity

Pick one person to be the therapist, another to be the client and any remaining participants can be observer(s). Please role play practicing Embodied Inquiry exploring any of the following:

- Being curious about what gets in the way of him being kind to himself
- How does that show up in his body?
- Can you inquire into the parts (critic or kinder part)?

*This is just for learning purposes and so please remember that we are here to learn together and try new skills.

PART 3

In one of the integration sessions several weeks later, Doug was feeling especially open and vulnerable. He saw an image of an inner child part who was sitting in the fetal position, alone, in the dark. He said this part was overwhelmed with guilt, which he feels regularly as an adult and tries to manage through his compulsions. The guilt feeling is accompanied by a sinking feeling of dread in his stomach.

Discussion

- How would you incorporate that vision and insight into integration therapy?

MODULE 3

POST-TRAUMATIC STRESS

Case 1

This case is based upon a real case; identifying information such as gender/pronouns, age and other identities have been intentionally omitted to preserve confidentiality.

PART 1

Your clinic/organization has received a self-referral from a person seeking to apply for and receive MDMA-assisted therapy for PTSD through Health Canada's Special Access Program. Their parents both passed away in the last year and left an inheritance which they hope to use for this "breakthrough" treatment they heard about on Netflix. They feel at the end of the line, having exhausted treatment options, and are hoping this will be something that finally helps.

During the intake and screening process, you learn the following. They identify an 'incident trauma' (cause for their PTSD) as having come across their mother unconscious in her bedroom, after having overdosed on prescription antidepressants, at age 11. They report lifelong psychological distress following this incident, and state they feel haunted by this memory despite otherwise having very little recollection of events of childhood. They are single, and report self-isolation, no history of long-term partnership, and having "good friends" – but at a distance, in other cities. They report loneliness and believe that no one really understands them, they often fear people are against them, and they blame their current lack of social engagement on living in a "very snobby, cold and isolating city" that they feel stuck in. They are accomplished academically, having achieved a PhD, but are currently not working due to their distress.

They are hoping that MDMA-AT will help them "not feel like this anymore", since nothing else has worked. They score 65 on the PCL-5 screening tool for PTSD and have an ACE score of 4.

Other presenting symptoms include:

- Difficulty sleeping
- Chronic tension headaches, migraines, and irritable bowel syndrome
- Suicidal ideation (no history of attempts)
- Difficulty with decision making
- Self-criticism regarding body image and ability to take care of themselves
- A chronic fear of having something wrong with them that is 'beyond repair'
- Chronic emptiness
- Overwhelming sadness they attempt to pacify with addictive internet searching or binge eating

They report not having success with previous cognitive-behavioural therapy, and mild symptom reduction but challenging side effects with prescribed SSRIs.

Discussion

In small groups, please designate a recorder and discuss the following questions and considerations:

- Do you think psychedelics are appropriate for this person; why or why not? And if yes, which one(s)? Please discuss any potential risks and protective factors.
- What preparation considerations would you have for a client with this presentation?
- What do you think realistic treatment goals are for this client?

PART 2

During preparation sessions, they express ruminative concerns about being damaged beyond repair, and a fear of being a 'lost-cause' even for MDMA-AT despite research and publicity about its effectiveness.

Their medicine sessions are rich and, from the perspective of you and your co-therapist, quite profound in content, emotional expression, and corrective experiences.

In their 3rd medicine session, they set an intention: "Show me who I really am", with a desire to access a stronger sense of self and/or different reference for self. During this session, they experience many images and metaphors that echo the wounding of not being allowed to be or become who they truly are during their childhood: they experience being pressed into a container they don't fit into and being a bird with broken wings. They struggle to experience self-compassion, but rather express horror and distress with these images. With co-therapy support, they eventually break through to an experience of being "like the sky – so clear and free, full of beautiful stars" and then becoming a bird flying freely through that sky. Throughout this session, they reached out for handholding by the co-therapists (asking for and receiving help, naming needs), and were able to take in support of the therapists. This felt new and very warm and healing to them. Following this, they spontaneously moved into an 'energetic purging', with tears and retching into a bucket, grieving and moving out energies of shame and disgust associated with their painful childhood.

It is now the integration session the next day, and when asked what is staying with them from the previous day's session, they respond by fixating on the sense of brokenness they experienced symbolically in the MDMA-session, like having broken wings, and how painful and distressing this was. Fears are coming up again about being too broken for this treatment to work.

Group Activity

Pick one person to be the therapist, another to be the client and anyone else can be an observer(s). Please role play practicing Embodied Inquiry exploring any of the following:

- Practicing using pendulation between the image/experience of flying in the sky, connecting it with body sensations and emotions in the present, and the image/experience of having contorted and broken wings.
- Elaborating the resource of being in connection with the therapists (corrective experiences).
- Working with the part that is afraid and fixates on the sense of brokenness and is afraid that the treatment won't work.
- Exploring alternative interpretations of the content of the session, as opposed to a confirmation of being broken

Case 2

PART 1

You get a referral for a Ketamine assisted therapy client in the clinic you are working in. The client is looking to treat their depression, and upon review of their past medical records, you see a history of depression and ADHD diagnosis. On the first intake call you find out the following:

Sam is a 32-year-old, white female and uses she/they pronouns. They are a professional, with a history of high achievement.

They have a long history of trauma. Growing up there was domestic violence and emotional abuse at home. They were also sexually abused by a professional in the community from the age of 7-15 and their father knew about it. Their mother was a school counsellor, an alcoholic, and had an eating disorder. The father was emotionally abusive. Both parents were generally unavailable and provided no protection for them growing up. On their intake form their mother currently is listed as an “incredibly close relationship to this day” and as their most supportive relationship along with their dog Molly. They are currently living with their mother, which they find challenging. They have attempted suicide twice in their life, once when they were 17 and more recently in 2021 while in an abusive relationship.

Other presenting symptoms and concerns are:

- Nightmares
- Flashbacks
- Binge eating disorder (in remission)
- Persistent emptiness
- Anhedonia
- ADHD
- Restlessness
- Difficulty with decision making
- Difficulty with emotional regulation
- Lack of trust in themselves
- Confusion about what is true, especially in relationships when there is conflict
- Lack of congruence between how others perceive them, and how they feel on the inside

They recently moved to BC from Ontario and are having a hard time coping and navigating this transition and the stress at work, where they have taken on a leadership position. They want to ‘get a better handle on their life’ and are wondering if KAT could be beneficial for them.

Demo Prep Session

PART 2

During this session, they remain sitting and opt not to use eyeshades or headphones. While they engage relationally with you throughout, they are able to focus their attention “inside” with eyes closed for periods of time. During one such period, they experience themselves standing in a field of tall grass that is gently blowing in the wind, with a clear blue sky above. They note they feel safe here. They then see hundreds of delicate purple petals of the oxalis plant (one of the plants they have at home) floating up all around them and into the sky like butterflies. They experience sensations of heaviness in the chest and the whole body. They express sadness and say, “they are all the parts of me that I’ve lost connection with because of the trauma”. When asked how old they are, they reply “young…different ages…it’s so sad…I just want them to come home (cries)”. You ask where in their body home might be, and they motion to their abdomen, stating, “it’s here…but it’s like there’s too much tension here for them to come home.”

Group Activity

Pick one person to be the therapist, another to be the client and anyone else can be an observer(s). Please roleplay practicing Embodied Inquiry at this point in their ketamine session, exploring any of the following:

- Using Embodied Inquiry to slowly explore the tension feeling in the abdomen
- Elaborate a resource that came up from the medicine session.
- Using parts language to explore the tension in the abdomen e.g. if it were a part, what might it’s role, fears, and needs be

MODULE 4

CHRONIC AND SERIOUS ILLNESS

Existential Vulnerabilities and Resiliencies

Vulnerability	Resilience
Confusion	Curiosity, Clarity
Isolation	Connection
Despair	Hope
Helplessness	Agency
Meaninglessness	Purpose
Fear	Courage
Resentment	Gratitude

Possible Questions to Explore Vulnerabilities and Resilience

CONFUSION VS CURIOSITY, CLARITY

- Example Questions: How do you make sense of what you are going through? When you are uncertain how do you make sense of it? To whom or to what do you turn to when you are feeling confused?

ISOLATION VS. CONNECTION

- Example Questions: When you have a difficult day, with whom do you talk? In whose or what presence do you feel a bodily sense of calm or peace? Who or what really understands your situation?

DESPAIR VS. HOPE

- Example Questions: From what sources do you draw hope? What keeps you from giving up? Who in your life assumes you can stay hopeful amid adversity? What does this person know about you that other people may not know?

HELPLESSNESS VS AGENCY

- Example Questions: What is your prioritized list of concerns? What concerns you most? What most helps you stand strong against the challenges of this illness? What should I know about you as a person that lies beyond your illness? How have you/how might you kept/keep this illness from taking charge of your entire life?

MEANINGLESSNESS VS. PURPOSE

- Example Questions: What keeps you going on difficult days? For whom, for what, does it matter that you continue to live? What do you hope to contribute?

FEAR VS. COURAGE

- Example Questions: Have there been moments when you have been tempted to give up but did not? Who or what kept you from giving up? What might it look like for you to see yourself being a courageous person? Can you imagine that others see you as a courageous person? If so, how would they describe your courage?

RESENTMENT VS. GRATITUDE

- Example Questions: For whom or what are you most deeply grateful? Are there moments when you still feel joy despite all you are going through? Can you describe those moments? If you were to look back on this illness at a future time, what would you say added to your life?

Case 1

ASSUMING MEDICAL AND PSYCHOLOGICAL CLEARANCE

The client is a 40-year-old married female with 2 young children (10 and 12). She is a partner at a large law firm. Her spouse works full time as an 8th grade math teacher. The client was recently diagnosed with life limited prognosis of Stage IV Colon Cancer. Her life expectancy is about one year.

PART 1

PREPARATION SESSION DEMO

- Please identify the client's vulnerabilities according to Existential Therapy.
- Track what therapeutic skills seem relevant to working with end-of-life care.

PART 2

MEDICINE SESSION SCRIPT

During the Medicine Session, the client has a powerful and transformative experience. She expresses a feeling of connection to the Universe that she has never felt before, a realization that existence is more than the limits of her body, her time, her place. She also experienced a powerful connection to her ancestors and to future generations. She struggles to express this experience and states it is like "we are all linked like a chain". The client states the experience was very re-assuring to her and alleviated her overwhelming fear of death. She still has some anticipatory anxiety and grief, but it is not overwhelming.

PART 3

SMALL GROUP ACTIVITY

Pick one person to be the therapist, another to be the client and anyone else can be an observer(s). For the role play, imagine you are conducting the Integration Session for this client. Please explore her experience and how it might affect the way she handles her view of her illness and her relationships moving forward. If helpful you can use one or more of the following prompts:

- Working with the insight “we were all linked like a chain,” practice identifying and supporting a shift from a vulnerability into a resiliency
- Explore how a new implicit or explicit resiliency frames her view of her relationship with her illness, her relationships, or her work

PART 4

DEBRIEF IN LARGE GROUP

Case 2

ASSUMING MEDICAL AND PSYCHOLOGICAL CLEARANCE

About three years ago, a 42-year-old male, underwent back surgery to address a life of chronic pain due to congenital scoliosis. The surgery increased, rather decreased, his pain leaving him in an existential crisis. The day before his first visit at your clinic, his spouse took him to the emergency department for suicidal ideation, with a loose plan to overdose on medications. He was discharged from the ER with a safety plan that included ketamine-assisted therapy at your clinic. Per his ER Safety Plan, his wife removed all the medications from their house.

Within the first five minutes of your first session, the client states: “if my wife had not taken me to the ER yesterday, I would not have had to cope with this incredible pain every minute of every day. I think it might be nicer to be pain-free and dead than alive and in this much pain.”

The client describes his pain before the surgery “as a constant nagging.” After the surgery, he describes it as “unmanageable, unbearable, overwhelming.” The client states “I cannot do anything without feeling intense pain.”

During the session, the client states he feels very distant and isolated from his wife (who he describes as loving and supportive). The client states that he used to have a vibrant social life, spending time with other couples, his best friend, his sister, and his parents. The client also states that he used to love to play, write, and listen to music.

The client does not think ketamine will help: he took psychedelics as a teen and young adult, and it did not help with his pain then so he wonders why would it help now?

PART 1

Small Group Discussion

- Do you think ketamine is appropriate for this person? Why or why not? Please discuss any potential risks and protective factors
- What comes up for you in exploring active suicidality during a Preparation Session? How comfortable are you with this risk?
- Would you discuss the client's safety plan from the day before? Why or why not? If yes, what would you discuss/do with the document?
- How would you approach intention setting with this client?

PART 2

DEBRIEF

PART 3

LARGE GROUP DISCUSSION

- Discussion of slide and outcome
- Other questions to be discussed:
    - What vulnerabilities shifted to resiliencies?
    - How might you address possible relapse of suicidality?
    - How might you encourage the client to continue to strengthen his resiliencies?

MODULE 5

SUBSTANCE USE DISORDERS

Normative Feedback Questionnaires

In this section of the workbook, you will find the following questionnaires:

- Timeline Follow-back All Substances
- Short Inventory of Problems
- Clinical Substance Use Motives

Additional Resources

You will also find the following handouts which you can refer to during Module 5 live session:

- Readiness Rulers
- The Change Plan

TIMELINE FOLLOW-BACK ALL SUBSTANCES

1. Assessment Period

THESE DATES DEFINE THE "ASSESSMENT PERIOD".

Date of last visit _____ Yesterday's date _____

2. Which substances were used during the Assessment Period?

Used	Substance	Short Form
	Alcohol (ethanol)	EtOH
	Alcohol (isopropyl)	Iso
	Amphetamines (Crystal Meth)	Am
	Benzodiazepines	BZO
	Buprenorphine (Naloxone)	BUP
	Cannabinoids (Marijuana)	THC
	Cocaine	COC

Used	Substance	Short Form
	Crack	Cra
	Down (unspecified)	DoU
	Fentanyl	FYL
	Hallucinogens	Ha
	Heroin	Hr
	Hydromorphone	HDM
	Inhalants	In

Used	Substance	Short Form
	Morphine (Kadian)	MOR
	Methadone	MET
	Nicotine	Nic
	Oxycodone	OXY
	Sedatives	Se
	Other:	
	Other:	

3. For all substances used during the Assessment Period, fill in Table 2. Table 1 is optional and may be used to quickly enter substances used consistently – Table 1 will be used to populate Table 2.

Frequency A = < 1/month C = 1/week E = Everyday B = 1-3x/month D = ≥2/week	Route of Administration 1 = oral 3 = smoking 5 = IV injection 2 = nasal 4 = non-IV injection 99 = other	Standard Drinks (EtOH) 12oz of beer, 5oz of wine, or 1oz of hard liquor/spirits (Report as a whole number)

Table 1: Substances used **consistently** for the entire Assessment Period — Not applicable

Substance	Frequency	Administration Route	Start Date (first date used within Assessment Period)	Additional info (if consistent ethanol use, add # of SD)

Table 2: Substances used **inconsistently** for the entire Assessment Period					Not applicable	
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
___ month ___ day Alcohol: (N) (Y) ___(SD) Drug Use: (N) (Y) Am___ BZO___ BUP___ COC___ Cra___ DoU___ FYL___ Ha___ Hr___ HDM___ In___ MET___ MOR___ Nic___ OXY___ Se__ THC__ Other____	___ month ___ day Alcohol: (N) (Y) ___(SD) Drug Use: (N) (Y) Am___ BZO___ BUP___ COC___ Cra___ DoU___ FYL___ Ha___ Hr___ HDM___ In___ MET___ MOR___ Nic___ OXY___ Se__ THC__ Other____	___ month ___ day Alcohol: (N) (Y) ___(SD) Drug Use: (N) (Y) Am___ BZO___ BUP___ COC___ Cra___ DoU___ FYL___ Ha___ Hr___ HDM___ In___ MET___ MOR___ Nic___ OXY___ Se__ THC__ Other____	___ month ___ day Alcohol: (N) (Y) ___(SD) Drug Use: (N) (Y) Am___ BZO___ BUP___ COC___ Cra___ DoU___ FYL___ Ha___ Hr___ HDM___ In___ MET___ MOR___ Nic___ OXY___ Se__ THC__ Other____	___ month ___ day Alcohol: (N) (Y) ___(SD) Drug Use: (N) (Y) Am___ BZO___ BUP___ COC___ Cra___ DoU___ FYL___ Ha___ Hr___ HDM___ In___ MET___ MOR___ Nic___ OXY___ Se__ THC__ Other____	___ month ___ day Alcohol: (N) (Y) ___(SD) Drug Use: (N) (Y) Am___ BZO___ BUP___ COC___ Cra___ DoU___ FYL___ Ha___ Hr___ HDM___ In___ MET___ MOR___ Nic___ OXY___ Se__ THC__ Other____	___ month ___ day Alcohol: (N) (Y) ___(SD) Drug Use: (N) (Y) Am___ BZO___ BUP___ COC___ Cra___ DoU___ FYL___ Ha___ Hr___ HDM___ In___ MET___ MOR___ Nic___ OXY___ Se__ THC__ Other____
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Table 2 (continued)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
___ month ___ day Alcohol: (N) (Y) ___(SD) Drug Use: (N) (Y) Am___ BZO___ BUP___ COC___ Cra___ DoU___ FYL___ Ha___ Hr___ HDM___ In___ MET___ MOR___ Nic___ OXY___ Se__ THC__ Other____	___ month ___ day Alcohol: (N) (Y) ___(SD) Drug Use: (N) (Y) Am___ BZO___ BUP___ COC___ Cra___ DoU___ FYL___ Ha___ Hr___ HDM___ In___ MET___ MOR___ Nic___ OXY___ Se__ THC__ Other____	___ month ___ day Alcohol: (N) (Y) ___(SD) Drug Use: (N) (Y) Am___ BZO___ BUP___ COC___ Cra___ DoU___ FYL___ Ha___ Hr___ HDM___ In___ MET___ MOR___ Nic___ OXY___ Se__ THC__ Other____	___ month ___ day Alcohol: (N) (Y) ___(SD) Drug Use: (N) (Y) Am___ BZO___ BUP___ COC___ Cra___ DoU___ FYL___ Ha___ Hr___ HDM___ In___ MET___ MOR___ Nic___ OXY___ Se__ THC__ Other____	___ month ___ day Alcohol: (N) (Y) ___(SD) Drug Use: (N) (Y) Am___ BZO___ BUP___ COC___ Cra___ DoU___ FYL___ Ha___ Hr___ HDM___ In___ MET___ MOR___ Nic___ OXY___ Se__ THC__ Other____	___ month ___ day Alcohol: (N) (Y) ___(SD) Drug Use: (N) (Y) Am___ BZO___ BUP___ COC___ Cra___ DoU___ FYL___ Ha___ Hr___ HDM___ In___ MET___ MOR___ Nic___ OXY___ Se__ THC__ Other____	___ month ___ day Alcohol: (N) (Y) ___(SD) Drug Use: (N) (Y) Am___ BZO___ BUP___ COC___ Cra___ DoU___ FYL___ Ha___ Hr___ HDM___ In___ MET___ MOR___ Nic___ OXY___ Se__ THC__ Other____
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Notes

Form completed by

Date

SHORT INVENTORY OF PROBLEMS - REVISED (SIP-R)

ADAPTED FROM KILUK ET AL., 2013

PLEASE INDICATE HOW OFTEN EACH OF THE FOLLOWING CONSEQUENCES HAS OCCURED IN THE PAST 3 MONTHS.

PHYS = Physical SOC = Social INTR = Intrapersonal INTER = Interpersonal IMP = Impulse control

1. I have been unhappy because of my drinking or drug use. (INTRA)

2. Because of my drinking or drug use, I have lost weight or not eaten properly. (PHYS)

3. I have failed to do what is expected of me because of my drinking or drug use. (SOC)

4. I have felt guilty or ashamed because of my drinking or drug use. (INTRA)

5. I have taken foolish risks when I have been drinking or using drugs. (IMP)

6. When drinking or using drugs, I have done impulsive things that I regretted later. (IMP)

7. Drinking or using one drug has caused me to use other drugs more. (IMP)

8. I have gotten into trouble because of drinking or drug use. (SOC)

9. The quality of my work has suffered because of my drinking or drug use. (SOC)

10. My physical health has been harmed by my drinking or drug use. (PHYS)

11. I have had money problems because of my drinking or drug use. (SOC)

12. My physical appearance has been harmed by my drinking or drug use. (PHYS)

13. My family has been hurt by my drinking or drug use. (INTER)

14. A friendship or close relationship has been damaged by my drinking or drug use. (INTER)

15. My drinking or drug use has gotten in the way of my growth as a person. (INTRA)

16. My drinking or drug use has damaged my social life, popularity, or reputation. (INTER)

17. I have spent too much or lost a lot of money because of my drinking or drug use. (SOC)

CLINICAL SUBSTANCE USE MOTIVES QUESTIONNAIRE (CSMQ)

ADAPTED FROM BLEVINS ET AL., 2018

Listed below are reasons people might be inclined to use substances. Using the five-point scale below, decide how frequently your own substance use is motivated by each of the reasons listed.

You use substances...	Almost never (1)	Some of the time (2)	Half of the time (3)	Most of the time (4)	Almost Always (5)
Social/Enhancement					
As a way to celebrate					
Because it is what most of my friends do when we get together					
To be sociable					
Because it is customary on special occasions Because it makes a social gathering more enjoyable					
Because I feel more self-confident or sure of myself					
Because it is exciting					
To get a high					
Because it's fun					
Because it makes me feel good					
Other Substance Use					
Because I was under the influence of another substance					
To counteract the effects of other substances					
Coping with Anxiety					
To relax					
Because it helps me when I am nervous					
To reduce my anxiety					

You use substances...	Almost never (1)	Some of the time (2)	Half of the time (3)	Most of the time (4)	Almost Always (5)
Withdrawal					
To prevent feeling sick from substance use					
To avoid withdrawal symptoms					
Loneliness					
To make me feel less alone					
To stop me from feeling so hopeless about the future					
Because it helps me feel less lonely					
To help me feel more positive about things in my life					
Pain/Sleep					
To deal with physical pain					
To reduce my nightmares or night terrors					
Because it makes my physical pain bearable To numb my pain					
Coping with Depression					
To cheer me up when I'm in a bad mood					
Because it helps me when I am feeling depressed					
To forget painful memories					
To stop me from dwelling on things					
To turn off negative thoughts about myself					
To forget my worries					
Relieving Boredom/Getting Energy					
Because I have nothing else to do					
To give me energy					
It is something to do when I am bored					

READINESS RULERS

The conversation facilitated through the provision of personalized feedback can flow seamlessly into a conversation using readiness rulers, introducing the client to the concept of the change plan, and getting them thinking about the future.

Example Script

- *"Does this have you thinking about any goals about your [substance use]? Are there any changes you might like to make in your [substance use]? What would you like your [substance use] to be like? How would you like for things to be different if you made a change? What do you think will happen if you do not change anything? What would be the advantages of making a change?"*

If the client identifies goals, then therapists are encouraged to elicit readiness/willingness and confidence/ability using the following **readiness rulers**.

Example Scripts

- *"On a scale from 1 to 10, with 10 being very ready to change, how ready or willing are you to make a change in your* [substance use]*?"*
- *"On a scale from 1 to 10, with 10 being very confident, how confident or capable do you think you are in making a change?"*

These can then be followed by asking:

- *"Why is it a ___ and not a ___* [lower number]*? What would it take to go from a ___ to a ___* [higher number]*? What would you be willing to try?*

The task of the therapist at this point is to use Motivational Interviewing strategies to elicit and reinforce the client's motivation to change and to start to think about goals they may want to set for their change plan. This may include:

- Affirming that the client has expressed a clear goal of becoming abstinent
- Noting that the client has a clear goal of reducing substance use but not stopping completely
- Acknowledging that the client has feelings of ambivalence, with one part of the client's hopes including becoming abstinent or reducing use

Having noted the client's current level of readiness for change, the therapist can then introduce the change plan.

ABOUT THE CHANGE PLAN

ADAPTED FROM MILLER AT AL., 1995

Upon having summarized the personalized feedback report or conversation and reflecting the possible goals that the client has shared, therapists can ask the client what current goals for their substance use they would like to include in their change plan. Once the change(s) that the client wants to make are clarified, therapists are to seek to clarify why they want to make the change(s) they've specified and what steps they plan on taking to make these changes. As appropriate, the therapist is also to initiate discussion concerning specific coping strategies in managing the challenges of making changes to substance use, as well as dealing with high-risk situations.

The Change Plan Worksheet (see below) itself may be used as a format for taking notes of the client's plan as it emerges, though it should not be given to the client to start this section. Rather, the change plan should emerge organically from the preceding motivational dialogue, with a copy being given to the client at the end, as well as a copy being added to their file.

When completing the "steps" portion of the change plan, the steps may include the client's plans for incremental decreases/changes in use or the strategies they will use to cut down or quit their substance use. Though abstinence is generally the goal the therapist holds, it must be kept in mind that the client must come to the conclusion of their goals on their own. Though abstinence from substance use may be commended, the therapist must not prescribe it or impose it upon the client. If the client seeks to set a goal of moderating their substance use rather than abstinence, this is their choice; however, the therapist should express concerns they may have around this in a non-imposing manner, giving the client the opportunity and autonomy to come to their own conclusions. The therapists expression of concerns may be more important if the client is suffering from a severe substance use disorder and/or significant harm or risk of harm stemming from their substance use. Use of factual information related to failing to adequately cut back the substance use can be very powerful for this.

The client can be helped in thinking about people from whom they can seek and obtain support while going through this change. If appropriate, the therapist can consider inviting the client to try role-playing approaches to asking for support.

Example Scripts

- *"Would you feel comfortable asking* [person] *for support if you are feeling like engaging in* [substance use]*?"*
- *"How would you like the person to respond to you in a way that you will respect and appreciate? What type of support may they be able to offer that would be helpful?"*
- *"Would you feel comfortable asking* [person] *to remind you when you have engaged in* [substance use] *a certain amount?"*
- *"How would you like* [person] *to remind you in a way that you will respect and appreciate?"*

A useful strategy here can also be for the therapist to draw on previous successful experiences with quitting or reducing substance use in order to identify strategies that might be helpful this time. If appropriate, the therapist can also discuss (and perhaps role-play) ways of handling emergency situations.

The client may ask for specific information when trying to create a viable change plan. Some such questions may involve specifics related to the biological and behavioural underpinnings of substance use, as well as potential dangers associated with them. The number of possible questions is too large to conceivably plan answers for all of them, and the therapist should try to provide accurate and useful information to the client, with follow up to ensure it was clearly conveyed and to establish the thoughts and feelings the client may have around the new information. Clients may ask for information that the therapist does not know, and it is perfectly acceptable for the therapist to express that they do not know, but that they will research the question and get back to the client at the next session or by email. Indeed, this is vastly preferable to providing inaccurate information.

The client may also ask for the therapist's advice. It is appropriate for the therapist to share their advice, provided it is framed as being an opinion and with room and permission for the client to disagree. However, it may be useful to turn this back to the client, with the therapist expressing that they do indeed have an opinion, but that it is up to the client to form their own based on the facts provided to them. Specific instructions should not be given, and skills should not be trained; any questions seeking such advice should be turned back to the client to see what their thoughts are on how they could achieve the result they are asking about.

Therapists are encouraged to conclude this discussion of the client's change plan by summarizing the conversation and checking the accuracy of the summary with the participant. If time allows, therapists are encouraged to ask clients about their level of confidence in the Change Plan.

- *How confident are you, on a scale from 0-100%, that you will make the change that we have been discussing?"*
- *It's great that you report being ___ confident. What would it take to increase that number or why is that number not lower?*

If time permits, therapists are also encouraged to explore with the participant what they can do to increase their level of confidence.

OPPORTUNITY TO DISCUSS CHALLENGES AND/OR WORRIES

Through the course of developing the change plan, the therapist and client will have discussed things that could interfere with them achieving their goals. If the therapist feels that there may be more challenges or barriers to the client achieving their goals, they may take the opportunity here to ask about any other challenges they foresee or any worries they may have that they have not yet spoken about that could inhibit their success. The therapist can then work with the client to problem-solve was to address those challenges or worries. As discussed above, it may be helpful here to have the client think about other instances in which they have cut down or quit substance use and the barriers that they faced at that time.

PROVIDING COPING SKILLS AND RELAPSE EDUCATION

The therapist should also work with the client to identify potential triggers that could increase the client's susceptibility to substance use, as well as seek to establish and discuss individualized coping strategies for each potential roadblock. The therapist is encouraged to draw on their existing training and knowledge from working with substance use and addictive behaviours to determine appropriate coping skills and relapse prevention strategies. The therapist may also refer to the resources provided in the asynchronous portion of this course for more information on potential interventions based on coping and relapse prevention skills training.

CHANGE PLAN WORKSHEET

Instructions

The Change Plan Worksheet (CPW) is to be used during to help in specifying the client's action plan. You can use it as a format for taking notes as the client's plan emerges. The information needed for the CPW should emerge through the motivational dialogue. This information can then be used as a basis for your recapitulation (see below). Use the CPW as a guide to ensure that you have covered these aspects of the client's plan:

- "*The changes I want to make are..."* In what ways or areas does the client want to make a change? Be specific. It is also wise to include goals that are positive (wanting to begin, increase, improve, do more of something) and not only goals that could be accomplished through general anesthesia (to stop, avoid, or decrease behaviors)
- "*The most important reasons why I want to make these changes are..."* What are the likely consequences of action and inaction? Which motivations for change seem most impelling to the client?
- "*The steps I plan to take in changing are..."* How does the client plan to achieve the goals? How could the desired change be accomplished? Within the general plan and strategies described, what are some specific, concrete first steps that the client can take? When, where, and how will these steps be taken?
- "*The ways other people can help me are..."* In what ways could other people (including the significant other, if present) help the client in taking these steps toward change? How will the client arrange for such support?
- *"I will know that my plan is working if..."* What does the client hope will happen as a result of this change plan? What benefits could be expected from this change?
- *"Some things that could interfere with my plan are..."* Help the client to anticipate situations or changes that could undermine the plan. What could go wrong? How could the client stick with the plan despite these problems or setbacks?

Preprinted Change Plan Worksheet forms are convenient for MET therapists. Carbonless copy forms are recommended so you can write or print on the original and automatically have a copy to keep in the client's file. Give the original to the client and retain the copy for the file.

Change Plan Worksheet

The changes I want to make are:

The most important reasons why I want to make these changes are:

The steps I plan to take in changing are:

The ways other people can help me are:

Person	Possible Ways to Help

I will know that my plan is working if:

Some things that could interfere with my plan are:

MODULE 6

COMPLEX POST-TRAUMATIC STRESS

Case 1

PART 1

France is a 32-year-old, cis-gender, heterosexual female with some indigenous ancestry. She is currently not employed and lives with her father in a rural town about an hour from the city. She is estranged from her mother. She has no social connections and very little contact with the outside world aside from her father and occasional conversations with her grandparents on her father's side. She is bright, educated, and used to work but has withdrawn from all activities because of social anxiety, depressed mood, panic attacks, insomnia, and nightmares all rooted in a diagnosis of C-PTSD.

France grew up in an unstable and at times violent home. Her mother and father both have complex trauma histories. Her mother abandoned France when she was young but has come in and out of her life since then. Her father uses drugs and alcohol and has physically assaulted her on several occasions. There are no other extended family members or friends available for support.

France feels deeply lonely and craves connection with others. However, she is also highly sensitive and has difficulty sustaining meaningful relationships. She is easily overwhelmed by fears of getting hurt, being abandoned, or even hurting others unwittingly and has decided to avoid relationships altogether. Her father does his best to care for her but has his own challenges and is often frustrated by her dependence.

She has tried medications in the past, but they have not provided any relief of her symptoms and often come with uncomfortable side effects. She has tried many different types of psychotherapy over many years, paid for by her father. She read about psychedelics online and believed that psychedelic-assisted therapy might be her last hope. She applied and qualified for a clinical trial, but she was feeling too depressed to start. She managed to find a ketamine clinic in the city with a sliding scale that was willing to offer her 3 sessions of KAT with a supervised trainee. She engaged in this treatment with the hope that it would improve her mood enough to participate in the trial.

The KAT was helpful. France appeared to benefit from the antidepressant effects of the ketamine and had the unfamiliar experience of feeling safe and connected to the therapist at the same time. After the KAT sessions, she had enough energy and hope to proceed with the trial.

Discussion

- What risks and protective factors are relevant for the case conceptualization? What aspects of France's developmental adversity and intersecting identities would you consider?
- Would you provide PAT to this participant? Why or why not?

PART 2

The two co-therapists working on the trial were both white, cisgender health professionals, one female and one male. France's alliance with the therapists developed slowly through the assessment and preparation phases. In the first Medicine Session, France had an insight, through imagery and narrative, that her soul was only temporarily in her current body. She believed she had been incarnated in other forms before and will be again in the future along its trajectory of spiritual evolution. She also believed that her and her father's souls were journeying together and that there was a higher purpose to their ongoing interpersonal conflict.

The female co-therapist has some training in shamanic and transpersonal approaches to medicine work, some of which she received from indigenous elders, and so was comfortable working through these insights with France. The male therapist has little exposure to these frameworks and was less engaged in the Medicine and Integration Sessions in which those discussions took place. This gap created some distance between him and France which disrupted the development of safety in the therapeutic alliance.

Discussion

- If you were her therapist, how would you make sense of her spiritual insights and how would that inform how you proceed with integration?
- How would you approach addressing the emerging threat to the therapeutic alliance?

PART 3

In a later Medicine Session, France experienced an intense craving for human connection and requested physical touch from the male co-therapist. He sat next to her with his arm around her shoulders for a long time. She reported that this experience was very meaningful. She felt grateful for that intimacy, but it also reminded her of how lonely she usually feels which triggered deep sadness.

In an Integration Session a few days later, France was in deep distress, feeling sad and lonely and contemplating self-harm. She regretted opening herself up that feeling of connection to the therapist, knowing that it was just part of a clinical trial and that the protocol limits ongoing connection. She decided long ago that it's better to shut down and not feel that need, rather than live with the intense, painful cravings all the time.

By the end of the trial, France's PTSD symptoms had improved somewhat, but she continued to feel fragile and vulnerable and requested ongoing support. For a variety of reasons, neither co-therapist was able to continue providing therapy to France, but she was referred to a colleague who began seeing her shortly after the trial terminated.

Discussion

- How would you support France in her processing of shame and vulnerability?
- How would you approach terminating therapy with France?

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