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COMPLEX TRAUMA

*By **ROBERT PARKER**, Focusing Trainer, New York, USA*

Ellen (a composite of several clients) was a 45-year-old woman, who entered therapy for help with marital problems and parenting issues. She had a good therapist, but one who was inexperienced with trauma. In the third session, she described a confrontation with her teenage son, which was especially difficult for her. During the description, she briefly put her hand up to her throat; her therapist picked up on this gesture.

Therapist: *Can you notice what you are feeling, right there?*
Client: *I don't know . . . it's like there's something caught in my throat . . .*
Therapist: *See if you can stay with that . . . what's that like?*
Client: *It's an anxious feeling, as if I'm choking.*

The choking feeling appeared a few times over the next several sessions, usually when she was talking about confrontations with males; it was associated with feelings of fear and helplessness. As she explored the feeling, a memory emerged of having been sexually abused by an uncle when she was six. She associated that feeling with the fear and anxiety she felt with her son. Suddenly, everything made sense.

It seemed like a therapeutic breakthrough, but Ellen dropped out of therapy shortly afterward. Instead of getting better, Ellen began having nightmares and became increasingly irritable and prone to weeping spells and angry outbursts. In a matter of months, she lost her job and her marriage was on the rocks. This is the world of Complex Post Traumatic Stress Disorder (PTSD).

PTSD is a fascinating field where researchers and clinicians, working together, have given us extensive clinically relevant knowledge. One key discovery has been the difference between Simple and Complex PTSD.

Simple PTSD is what most people mean by "trauma." Survivors of life-threatening situations (war, rape, traffic accidents, etc.) often experience intrusive memories, avoid situations that remind them of the trauma, and feel continuously "on edge," expecting the trauma to reoccur. This is the soldier who sits in a restaurant with his back to the wall and hits the floor when a car backfires. Simple PTSD is now fairly well understood, both physiologically and psychologically, and there are a number of effective treatments.

But imagine a child growing up in a chronically abusive environment. The child has no way of knowing what "normal" is. Where the survivor of Simple PTSD feels, “That was a really scary event in my life," this child feels, "This is life." The ongoing trauma affects all aspects of development; for example, the child may be chronically

***Shirley Turcotte's Complex Trauma training group, pictured here, completed their work in 2009.** A new training will begin in New York City in January 2010. To register, see the announcement on page 2. Shirley is fourth from the right in the front row, with her arm around her son. Rob Parker is third from the left in the middle row. He can be reached at rparker@lifeforward.org.*

afraid and therefore avoid challenges, do badly in school, avoid social relationships, etc. Instead of a single trauma or traumatic situation, there are a multitude of traumas. In all of this, the child learns to cope more or less well, so that the adult who comes in for therapy can appear fairly strong, yet actually be extremely fragile. In contrast with Simple PTSD, this trauma is . . . well, complex.

Shirley Turcotte is intimately acquainted with Complex Trauma. The daughter of a sadistic pedophile, she lived on a reservation with extreme physical and sexual abuse until she ran away from home at age 14. She had severe symptoms of Complex PTSD, and professional therapists did not know how to help her. So Shirley began healing herself, drawing on her own intuition, traditional aboriginal Canadian teachings and her own deep spirituality. After she helped herself, she began helping others, and she gradually developed a remarkably sensitive, coherent, and effective treatment protocol for Complex PTSD.

Shirley discovered Focusing independently, and her therapy is now Focusing-Oriented. Her work is similar to traditional client centered therapy. However, neuroimaging studies show that during flashbacks, the speech centers of the brain literally shut down, thus the usual reflection is useless. Rather the therapist reads body language and guides the therapy process. Shirley calls her approach "client centered, therapist driven."

In contrast to many other approaches, Shirley is less concerned with what happened to the client, than with where the client is blocked and can't carry forward. When we grow up with trauma, we fragment in order to survive. Parts of us that were terrified are split off and forgotten because we don't have time for them; we are too busy surviving. But these stopped processes remain in our bodies, trying to carry forward and be heard. They appear as intrusive memories, nightmares, devastating inner critics, cutting rituals, and other "symptoms." We don't recognize these "symptoms" as lost parts of ourselves; instead, we (and our therapists) just want to get rid of them.

Shirley's approach involves listening to the body rather than to the words, discovering the trauma situation and what the client is/was trying to do there, and reflecting that back to the client. Shirley follows a careful procedure, going into one issue at a time, resolving that one issue, and then moving out, all with surgical precision.

As we saw with Ellen, complex trauma is a field where therapy is tricky, and mistakes can be costly. The professional community offers many therapist training programs, but after learning and teaching in this field for three decades, one of the best programs I have seen is the one Shirley offered recently in Manhattan (see photo). The program consists of five three-day modules, covering areas such as phases of treatment, real versus false memory, flashbacks, dissociation, and intergenerational trauma. Much of what Shirley teaches is not available anywhere else; her approach is uniquely spiritual, and grounded in the experience of the trauma survivor.

Shirley is giving this program again in January 2010. If you're a therapist working with trauma, I recommend it highly; the program has helped me to grow as a therapist and as a person. In particular, it helped me help Ellen.

When I first saw Ellen, her focus was not trauma but recovering from her previous therapy. She was experiencing almost continuous flashbacks and needed badly to get her life under control. We worked for about two years on safety: recognizing flashbacks, managing stress, and setting limits with people who were psychologically abusing her.

Once Ellen felt safe, we discussed the risks and benefits of exploring the early trauma, and she decided to explore it. There were many traumas; she had experienced chronic physical, psychological, and sexual abuse during most of her childhood. But by reflecting and following her body language, we learned that what she had been reliving was not her own abuse but her desperate attempts as a child to protect and care for her younger siblings.

She had been a five-year-old hero, carrying on her shoulders the weight of a world that was too heavy for the grown-ups around her. And as she was able to listen to that part of herself, the feelings of panic, fear, and anger gradually subsided, replaced by an inward appreciation of that heroic little girl.

FOCUS ON: *DENNIS WINDEGO*

*An Interview with **DIONIS GRIFFIN**, Focusing Trainer, Georgia, USA*

Can you describe your background?

I am an Ojibway from the Nicickousemenecaning tribe. I am talking to you now from the bush, where I am camping on my native land, as a healing retreat.

You heard of Focusing from Shirley, isn't that right?

When I began counseling, my clients often re-experiencd memories of trauma and abuse, sometimes sexual abuse. Shirley Turcotte came to train us concerning sexual abuse, which I knew nothing about. I noticed that Focusing gave the client control of the direction of healing, which was different from the directive methods I was using at the time. It took me a while to let go of control!

I phoned Shirley during the next few years, to debrief and be supervised by her. Then, some years later, in 1997, I took her two year course in Winnipeg, a module course similar to the one she will give in the NYC area this coming January. Focusing made more sense to me then. It dealt with issues I was seeing in my clients; it gave me more tools for helping them.

Dennis Windego, Focusing Coordinator, Ontario, Canada, can be reached at windego@tbaytel.net

Tell us more about your work now.

For 20 years, I have been traveling across Canada and into the US to work with native people and help them recover from traumatic incidents. I have also founded the Aboriginal Peoples Training Programs in Thunder Bay, Ontario, where I teach Focusing with Complex Trauma in depth to other counselors who work with aboriginal agencies and in cross-cultural settings.

The Cree Board of Health and Social Services of James Bay currently employs me. Some communities in James Bay are accessible only by plane; some have roads, but all are isolated. Nobody trusts the local psychological services, because everyone there knows each other's history. The people come to me because I'm not part of the community. Yet they can relate to me because I've been where they are. I am a residential school survivor.

What is a residential school survivor?

The residential school system was the educational policy in Canada for about 150 years. The state separated Indian children from their families and taught them to devalue themselves and their culture. Many former students were physically or sexually abused and neglected. Some even died. So I understand intercultural, intergenerational trauma. The problem continues today, because the trauma we experienced as children is often recreated in our own families, where it can be a lack of bonding and/or violence between family members.

So you deal with these issues.

Clients come to my office for consultation or are referred by doctors. But since some clients are reluctant to talk about their problems inside the community, I organize retreats on the land. These are several day sleep-overs with tents. An elder from the village is invited to come and share the community's history and life teachings, including stories of animals. A moose or other hunt may be organized. I sit on a log a little apart and let people come to me as they wish; they know what I am there for; in this way, the therapy is in their control and non-threatening,

They come and share memories from their community, a suicide, for instance, or a fire that resulted in death. On the land they are at home, at their roots. If they ask for advice, I give it. Otherwise, I stay with their felt sense. Often we clear a space. "Put that memory on that log," I might say, and they might reply, "It feels better over in that branch." They will remember this map of their issues. They know their land.

What do you do in the colder months?

Aside from my office appointments, I hold indoor workshops. I use various teaching games. My car holds a lot of props [I drive there if I can.], and I am constantly inventing new approaches. There is Family Sculpting in which clients form a human sculpture representing their family dynamics.

Continued on page 5

FOCUSING, TRAUMA AND TIME TRAVEL

By Leslie Ellis, Focusing Trainer, British Columbia, Canada

Focusing is a multi-purpose therapeutic tool which I have found to be most helpful, in some cases critical, for FOT (Focusing-Oriented Therapy) work with trauma. It seems almost magical the way Focusing can take clients back in time to heal the earliest places of trauma, the injured places where adaptive patterns got laid down in the first place. The body remembers the horrific places which the mind has fragmented and repressed, and it will lead a person there quite readily when it feels safe and ready to do so. The body seems to have infinite patience, and ideally waits for the time when one is mature and strong enough to process its story. But the process of healing takes expert observation and firm, compassionate direction to unravel. It does not happen by itself, nor with reflection alone.

I have worked as a FOT therapist in this trauma-sensitive way for over a decade--with a huge debt to the life's work of Shirley Turcotte. She has experienced healing from unspeakable trauma herself and has helped thousands of others recover from the worst kinds of abuse and torture. There is scant reference to this way of working with trauma in Focusing literature, but Turcotte has passed on her knowledge through extensive teaching and through the recording of many sessions, in keeping with the oral tradition of her aboriginal heritage. At some point, she may write it all down. In the meantime, I will try to do it justice.

Spotting the Regression

Under enough stress or certain triggers, the body may bring up past trauma before the person is ready for it. Thus symptoms of post-traumatic stress disorder arise, such as nightmares, flashbacks, dissociation and other involuntary reenactments of the event. Whether a person comes to therapy because he/she feels ready to face an inner demon or because these demons are involuntarily intruding, Focusing can help the client find the way home.

The first step for the therapist is to spot regression when it happens. Once you know how to see it, you see it often. In fact, in every Focusing session, there is some regression--the question is only how far back does it go, and how deeply is it repressed? When it is recent history, it's easy to understand what the body is saying and how to move forward. With deeper places that have been hidden away for a long time, the Focuser needs an experienced guide who knows how to navigate the terrain.

To spot regression, watch for subtle clues that depict a child's body language--posture curling inwards, eyes downcast, protruding lower lips--little things that you see in a child in trouble. Sometimes regression goes back to babyhood; then a whole different body sense appears: instability in the trunk, mouth puckering, exploratory hand gestures. Spending time around babies and children helps, but anyone can be trained to spot these states.

There are other clues. The words the client chooses may become childlike. Or they may have no words at all. It's common for children, especially in times of fear, to go silent. That is when you really need to be attuned to what the body has to say. You may become a voice for those who can't speak for themselves.

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Going back in time . . . and doing it safely

When the client's body shows you that it is at least partly in the past, ask him/her to notice this and talk about it with you. It is very important that the client keep one foot in the present as this work proceeds, and ideally, a comfortable distance is maintained from the traumatized place. If too close, it can re-traumatize, and/or affect the ability to stay with that place. Clients need the ability to calmly observe themselves in two places, both in the present and the past.

Reliving the past does not change anything. As Gendlin says, "To understand psychotherapy, would be to understand how the present process can change the past . . . We work on the past because it is implicit in our present experience and throws it off . . . Therapy can be understood as designed to let the past function differently." (Gendlin, *Emotion in Therapy,* 1991).

Focusing allows us to change our relationship to past trauma, as we see it from a stronger, wiser vantage point, and from a place where the trouble

is over, and we have survived. People who are experienced meditators may find this observing-self easy to access, while others find it strange at first and need time to develop this skill. A client was experiencing severe headaches, especially at work. She was also feeling victimized there, with a strong sense that her colleagues disliked her and were plotting to have her fired, or at least were making her life so miserable that she would be forced to leave. Although she enjoyed her work, she was very stressed and began to dread going in.

In a Focusing session, her body exaggerated her symptoms so we could see them clearly. She sensed a tight band of pain around the crown of her head, a hard squeezing that was almost unbearable. As she stayed with it, it subsided. Next she felt cold and sensitive to a very bright light. Her body seemed to be telling us about its birth trauma, and when I checked this out, her tears came, but also a huge sense of relief. She said she had been adopted at birth into a family that did not seem to want her. She could trace back the feelings of being unwanted to her very first day in the world! After working this through during several sessions, she began to find the situation at work more tolerable. She was able to separate past rejection from the perceived present rejection. She realized she was projecting an intensity on the current situation that truly wasn't there. As this client's relationship with her past experiences changed, her headaches disappeared and a lot of other mysteries in her life began to make sense to her.

When you listen to the body and make sense of what it is trying to say, it can relax and let go of the trauma it has been holding. You don't have to get the story exactly right, and the person may never remember concrete details. But as long as you can articulate the essence of the experience, provide validation and a witness to what happened, the body can change its relationship to it in the present, and the trauma symptoms will subside.

Focus On: Dennis Windego, *continued from page 3*

There is Role Playing of conflict scenarios. I ask the group to improve on the accuracy of each scene. I might play a role myself. I do what I call "Problem Posing" rather than problem solving. I put the problem out there and facilitate everyone's participation. A dialogue arises with everyone involved in solving the problem, which eliminates the back stabbing or cliques common in large groups. I pose open-ended, Focusing kinds of questions.

Can you give an example?

In the rope game, participants pair off and tie themselves together. I explain that this represents how a victim is bonded to a perpetrator, or the sufferer is bonded to his trauma. The two dance together, possibly for a lifetime. Then I ask them to disconnect without removing the rope or using their hands. They try to do it but end up still attached. When one pair figures it out [I'm not giving the solution away], there is an "Aha!" moment. How they feel about the bond changes; how they live with it in their bodies shifts. That is how healing occurs.

As one pair succeeds, some others watch carefully. The successful group helps others learn; they in turn help more people. I explain that is how communities heal. By living this experience, the participants feel empowered. After the game, they journal. They write how this game relates to their life. I explain the difference between emotions and the felt sense. The emotions are their reactions, such as: "I wanted to cut the rope!" "I wanted to push the other person down." "I felt like giving up." The felt sense is what they felt in their bodies, how they carried the problem; the felt sense can shift. Then, whoever wants to share, does so, but there is no pressure. We are dealing with each person's sacred place, which we respect and honor.

How long do you typically spend in each community?

Sometimes I am invited for extended periods. I have been asked to do a Diversion Program, mandated counseling or retreats in place of jail. It depends on the vision of the community. Right now, I am spending time on my own retreat, getting my own vision. Today I sat under an eagle's nest. The eagle is the animal with vision. He represents a cleared space from which we can observe our life and our trauma. Instead of being in it, he sees beyond.

When people are in crisis, such as after a homicide or suicide, all the senses and reactions are activated. There are physiological responses. Focusing flushes these things out of the body, helps each person achieve clarity and the realization that events are not who they are. Through Focusing, I help them gain distance. Two or three months later, I may return for counseling and more space clearing, so that they can find their inherent resources.

Trauma narrows the view. At first, we become attached to our trauma rather than to ourselves. New trauma comes to open up the old. It is easy to get overwhelmed and lost. Focusing helps us reconnect to ourselves, get a vision of a larger self. We see that we are much more than what has happened to us.

In the Recovery Room *By Janet Penny-Cook, Focusing Trainer, California, USA*

As a nurse and therapist in the recovery room, I find FOT and trauma training to be invaluable tools for a wide variety of patients who often experience great anxiety when scheduled for surgery. There are mothers who have miscarried, people newly diagnosed with cancer or chronic pain patients. The young Iraq vet may be stressed about how this surgery will impact his family and his return to duty.

I am often the first person they see as they arrive in the sterile medical setting, and I am starting their intravenous, adding more trauma to a stressful situation! Here I use some basic Focusing techniques and clear a space for them. Just giving patients permission to sense what their bodies are feeling and know that this time is for them can be validating. For instance, when patients say they are anxious, I might ask, "Where is the anxiousness in your body? Is there something it might need to say before your procedure?" Or, "Is there a place we can put this anxiety to make room for your body's healing?" You see the "shift" as they are able to take a breath.

In the fast paced setting of recovery rooms, grief work is going on. There is the formerly hopeful mother who has just miscarried, then the young mother who, having found a lump in her breast, is deeply concerned for herself and her children. Sometimes it is not the pain medication that offers the best healing, but sitting with individuals in a "Focusing way" so that they can allow their bodies to release or hear that "inner body knowing."

Chronic pain patients in the recovery room listen to their bodies, but often in a negative way. They get depressed and frustrated when their bodies are not functioning as they want. Focusing can allow the painful places to speak and have space. Once clients are able to listen to their bodies without focusing on what their body is "not" doing, there can be a release and a shift. For an individual in chronic pain, being able to experience the body as having something to say puts their pain in a positive light.

Our Iraq veterans offer a special set of challenges. The broken bones and body parts get surgically put back together, but the process of returning to consciousness after the induction of anesthesia can be particularly challenging. Often individuals wake up from surgery feeling confused. The nurses and doctors may be confronting someone convinced he is on the frontline, demanding his gun, and screaming with rage because he just killed a 14 year old child. Sometimes they are back in another childhood trauma. Shirley Turcotte refers to this as "collapsing memory," whereby the current trauma has triggered another trauma memory from a previous experience.

A collapsing memory can be unsettling for medical professionals who are not familiar with PTSD and how the body stores memories. The behavior can look like a psychotic break. It is important to speak loudly and clearly--stating the patient's name and date. I have also found it helpful to talk about their present lives, asking, "Do you have children, what are their names, ages." Often speaking of their current lives can return them to a lucid state. It is important to bring them back to the present and not get caught up in the past.

In one situation a soldier woke up, screaming to be free of all the blood. When I asked where all the blood was, he said, "In the basement, it's all in the basement." When I asked if he was alone in the basement, he said, "No." I did not ask who was there with him. I told him who I was and that we were in the recovery room and asked him to open his eyes if he could.

At this point I am not trying to do a full Focusing session, but I recognize he is in a collapsing memory, and he is terrified. The blood and trauma associated with surgery have triggered an earlier trauma memory. My goal is not to explore this trauma with him but to help his re-entry from the unconsciousness of anesthesia through the memory to the present. The next memory that is triggered for the patient is that he wants his gun. He is screaming, "Give me my damn gun NOW!" This is war, and he is fighting for his *Continued at the bottom of page 7*

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A Focusing Story

By Lieneke Hewlett, Focusing Trainer, British Colunbia, Canada

In working with trauma in FOT, I have noticed the importance of knowing where my client is in his/her healing path. Where there has been childhood trauma, the initial Focusing work is generally helping the client release the traumatic event in a place and time of the past. However, when the client has done a lot of Focusing work on traumatic memories and has advanced Focusing skills, a felt sense of a memory can be about something that needs attending to in the present.

Session Summary (details altered to protect confidentiality):

My client is experiencing a felt sense which is part of his past traumatic memory. He has described the felt sense that comes with this memory, and we are both waiting for the "more" of it. Is it about going back to that original place and time to unwind that memory more thoroughly, or is something else needed here? The felt sense of being invisible to those around him is familiar and strong.

I reflect, "Here is this familiar place where you feel invisible." He nods. It feels so lifelong and large to him that I get a hunch it is partly vicarious and ask, "Is all of this yours?" He checks and gets a little surprise, "No, half belongs to my mom." He has vicariously taken on some of his mom's feelings of invisibility and needs to give back that part which does not belong to him. He has done this before on other issues and is familiar with the process. So we find a way that feels right to give that which does not belong to him back to his mom.

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Then, we sit with what's left, waiting and sensing. It's smaller now, but still strong. "What needs to happen here, where it feels so invisible?" We wait. His regression into his past emerges strongly, and he feels compelled to solve the problem and get others to see him by making them understand him--telling people his feelings, his thoughts, his story. It seems to him that if only others would understand him better, he might get rid of this feeling of being invisible. But he knows from experience, that's not going to be the answer.

We wait, then I quietly ask, "Is there a way in which, if you could be more visible to yourself, that you would feel more visible?" He pauses. His initial impulse is to reject this new idea, but he stops himself. I repeat it gently, "If you could be more visible to yourself, what would it be like?" He wrestles to keep a Focusing attitude, to just sit beside this idea and get to know it. We wait so he can try to connect with this idea. He shifts and says, "If I could be visible to myself, no one could make me invisible." We sit in the profound truth and sacredness of this new idea, letting it sprout fully. After some time, I ask the unspoken question, "Is there anything that could help you to see yourself, to be there for yourself more?"

My client had already done Focusing work on memories of feeling invisible and many had already been released. Despite this, his sense of feeling invisible to others kept returning. Finding out that some of it was still stuck because it was vicarious was part of what was needed. The other part was his shift when he discovered that he didn't need to worry about whether other people saw him as long as he could be there for, and visible to, himself.

Recovery Room, *continued from page 6*

life. He is yelling about body parts and more blood. My language is the same; I tell him who I am, and that we are in the recovery room. I continue to ask him his name and to re-orientate him to the present. Although in a recovery room there are narcotics and pain medications that we could use, if we don't recognize the previous trauma, it will make the recovery and reorientation much longer, not to mention extremely stressful for the patient.

Focusing and trauma training have been invaluable tools for me when working with individuals in various states of consciousness. It is gentle and respectful, allowing the body to express and honor itself. Even when there isn't the time for a full session, the techniques of Focusing can allow for great healing.

From Focusing-Oriented Therapy To Community Change

By Anne Poonwassie, Focusing Coordinator, Winnipeg, Canada

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As a teacher of Focusing-Oriented Therapy, I am amazed at the impact of Focusing in paving the path to community wellness and social change. Prairie Region Centre for Focusing, Complex Trauma and Experiential Therapies (PRCF) was founded ten years ago spearheaded by Shirley Turcotte. Since then, hundreds of mental health workers have participated in training programs, seeking culturally relevant and effective therapeutic approaches in addressing complex trauma, and Focusing-Oriented Therapy proved relevant and effective in their work.

Focusing-Oriented therapeutic process reflects aborginal cultural imperatives of non-interference and allows people control over their healing process. Focusing also implicitly resonates traditional teachings. I have heard aboriginal elders say many times that when people experience problems in their lives, they need to turn around and look back to where they came from, find the place where the trouble started, see what needs to be done there, then make their way back to the present--the Focusing trauma work, in a nutshell.

Aboriginal communities have struggled with the impact of colonization, and present-day systemic oppression compounds the debilitating effects. Front line workers come to PRCF work with post traumatic stress resulting from intergenerational trauma, grief trauma, familial trauma and various types of abuse experienced in residential schools. Suicide rates in aboriginal communities are five times higher than those of the general population. Effective complex trauma treatment tools are of utmost importance to them.

The training at PRFC emphasizes several key components. First, students are provided with safety tools. These include: working with one small piece at a time and letting the body determine that piece; negotiating a collaborative relationship with the trauma place and/or pieces of it; visiting a memory as an adult observer, not reliving it as a child or as the victim; bringing an attitude of interest and curiosity into the process; and most, importantly, closing all memory places fully and completely before ending a session.

When working with the crux of the trauma, a safe/manageable distance is emphasized. Possible crux questions in Focusing may include: Do you see yourself there, in that place you are describing? In working with regression, using past tense and referring to the child place in the third person also helps build a manageable distance from the trauma: How old was that little girl when it happened? Students learn to work through the crux completely, integrating the memory and separating merged time zones that produced traumatic symptoms.

It is essential to properly exit the processed memory. Questions such as: How did you survive that? or What was the best of you there that you can bring into today? help to move the Focuser out of the memory and into present time. Students are reminded to close each trauma piece, and the session, at least four times: 1. What do you need to do to close this now? 2. Is there anything else you need to do with this before you leave it? 3. Is there anything else? 4. Check. Are you back to your adult self? A solid closing esures leaving the session in a grounded state.

How does FOT translate into community change? First, the cultural imperative of interconnectedness in aboriginal communities is experienced in close multi-level attachments: individual, family, community and, ultimately, the nation. Every step towards health by any community member impacts at all those levels. Secondly, many traditional approaches, such as healing and sharing circles, are ideal spiritual practices that move the FOT tools far beyond one-on-one work. In such groups, connections are naturally created; common ground is found in individual experiences, and past atrocities are witnessed not just by the therapist, but also by community members. Shared spiritual experiences often result in megashifts. They build connections and strengthen communities socially, spiritually and even economically. I value our students and our graduates for the personal courage and professional integrity they bring to the journey of possibilities.