DOMESTIC VIOLENCE PERSONALIZED SAFETY PLAN

Name: _____________________________________________  Date: _________________________________

The following steps represent my plan for increasing my safety and preparing in advance for the possibility for further violence. Although I do not have control over my partner’s violence, I do have a choice about how to respond to him/her and how to best get myself and my children to safety.

STEP 1: Safety during a violent incident. Women cannot always avoid violent incidents. In order to increase safety, battered women may use a variety of strategies.

I can use some of the following strategies:

A. If I decide to leave, I will ______________________________________________________.
   (Practice how to get out safely. What doors, windows, elevators, stairwells, or fire escapes would you use?)

B. I can keep my purse and car keys ready and put them (location) _____________________
   ______________________ in order to leave quickly.

C. I can tell _____________________________ about the violence and request that she or he call the police if she or he hears suspicious noises coming from my house.

D. I can teach my children how to use the telephone to contact the police, the fire department, and 911.

E. I will use _____________________________________________ as my code with my children or my friends so they can call for help.

F. If I have to leave my home, I will go to _________________________________________.
   (Decide this even if you don’t think there will be a next time.)

G. I can also teach some of these strategies to some or all of my children.

H. When I expect we’re going to have an argument, I’ll try to move to a place that is low risk, such as _____________________________. (Try to avoid arguments in the bathroom, garage, kitchen, near weapons, or in rooms without access to an outside door.)

I. I will use my judgment and intuition. If the situation is very serious, I can give my partner what he/she wants to calm him/her down. I have to protect myself until I/we

STEP 2: Safety when preparing to leave. Battered women frequently leave the residence they share with the battering partner. Leaving must be done with a careful plan in order to increase safety. Batterers often strike back when they believe that a battered woman is leaving a relationship.

I can use some or all of the following strategies:

A. I will leave money and an extra set of keys with ________________________________ so I can leave quickly.

B. I will keep copies of important documents or keys at ________________________________.

C. I will open a savings account by _______________________, to increase my independence.

D. Other things I can do to increase my independence include: ______________________________________________________________.
E. I can keep change for phone calls on me at all times. I understand that if I use my
television credit card, the following month’s phone bill will show my batterer those
numbers I called after I left. To keep my phone communications confidential, I must
either use coins, or I might ask to use a friend’s phone card for a limited time when I
first leave.

F. I will check with _________________________ and _________________________ to see
who would be able to let me stay with them or lend me some money.

G. I can leave extra clothes or money with _________________________.

H. I will sit down and review my safety plan every _______________ in order to plan the
safest way to leave the residence. _________________________ (domestic violence
advocate or friend’s name) has agreed to help me review this plan.

I. I will rehearse my escape plan and, as appropriate, practice it with my children.

STEP 3: Safety in my own residence. There are many things that a woman can do to increase
her safety in her own residence. It may be impossible to do everything at once, but safety measures
can be added step by step.

Safety measures I can use:

A. I can change the locks on my doors and windows as soon as possible.

B. I can replace wooden doors with steel/metal doors.

C. I can install security systems including additional locks, window bars, poles to wedge against
doors, an electronic system, etc.

D. I can purchase rope ladders to be used for escape from second floor windows.

E. I can install smoke detectors and fire extinguishers for each floor of my house/apartment.

F. I can install an outside lighting system that activates when a person is close to the house.

G. I will teach my children how to make a collect call to me and to _______________ (name of
friend, etc.) in the event that my partner takes the children.

H. I will tell the people who take care of my children which people have permission to pick up my
children and that my partner is not permitted to do so. The people I will inform about pick-up
permission include:

_________________________________ (name of school)
_________________________________ (name of babysitter)
_________________________________ (name of teacher)
_________________________________ (name of Sunday-school teacher)
_________________________________ (name[s] of others)

I. I can inform _________________________ (neighbor) and _________________________ (friend)
that my partner no longer resides with me and that they should call the police if he is observed near
my residence.
STEP 4: Safety with an Order of Protection. Many batterers obey protection orders, but one can never be sure which violent partner will obey and which will violate protective orders. I recognize that I may need to ask the police and the courts to enforce my protective order.

The following are some steps I can take to help the enforcement of my protection order:

A. I will keep my protection order _________________________ (location). Always keep it on or near your person. If you change purses, that’s the first thing that should go in the new purse.

B. I will give my protection order to police departments in the community where I work, in those communities where I visit friends or family, and in the community where I live.

C. There should be county and state registries of protection orders that all police departments can call to confirm a protection order. I can check to make sure that my order is on the registry. The telephone numbers for the county and state registries of protection orders are: ______________________ (county) and ______________________ (state).

D. I will inform my employer; my minister, rabbi, etc.; my closest friend; and __________________ that I have a protection order in effect.

E. If my partner destroys my protection order, I can get another copy from the clerk’s office.

F. If the police do not help, I can contact an advocate or an attorney and file a complaint with the chief of the police department or the sheriff.

G. If my partner violates the protection order, I can call the police and report the violation, contact

STEP 5: Safety on the job and in public. Each battered woman must decide if and when she will tell others that her partner has battered her and that she may be at continued risk. Friends, family, and co-workers can help to protect women. Each woman should carefully consider which people to invite to help secure her safety.

I might do any or all of the following:

A. I can inform my boss, the security supervisor, and ______________________ at work.

B. I can ask ______________________ to help me screen my telephone calls at work.

C. When leaving work, I can ______________________.

D. If I have a problem while driving home, I can ______________________.

E. If I use public transit, I can ______________________.

F. I will go to different grocery stores and shopping malls to conduct my business and shop at hours that are different from those I kept when residing with my battering partner.

G. I can use a different bank and go at hours that are different from those kept when residing with my battering partner.
STEP 6: Safety and drug or alcohol use. Most people in this culture use alcohol. Many use mood-altering drugs. Much of this is legal, although some is not. The legal outcomes of using illegal drugs can be very hard on battered women, may hurt her relationship with her children, and can put her at a disadvantage in other legal actions with her battering partner. Therefore, women should carefully consider the potential cost of the use of illegal drugs. Beyond this, the use of alcohol or other drugs can reduce a woman’s awareness and ability to act quickly to protect herself from her battering partner. Furthermore, the use of alcohol or other drugs by the batterer may give him an excuse to use violence. Specific safety plans must be made concerning drugs or alcohol use.

If drug or alcohol use has occurred in my relationship with my battering partner, I can enhance my safety by some or all of the following:

A. If I am going to use, I can do so in a safe place and with people who understand the risk of violence and are committed to my safety.

B. If my partner is using, I can ____________________________________________________
   and/or ________________________________________________________________________.

C. To safeguard my children I might ________________________________________________.

STEP 7: Safety and my emotional health. The experience of being battered and verbally degraded by partners is usually exhausting and emotionally draining. The process of building a new life takes much courage and incredible energy.

To conserve my emotional energy and resources and to avoid hard emotional times, I can do some of the following:

A. If I feel down and am returning to a potentially abusive situation, I can ____________________
   ________________________________________________________________________________.

B. When I have to communicate with my partner in person or by telephone, I can ______________
   ________________________________________________________________________________.

C. I will try to use “I can ...” statements with myself and be assertive with others.

D. I can tell myself, “_________________________________________”
   whenever I feel others are trying to control or abuse me.

E. I can read ____________________________________________________ to help me feel stronger.

F. I can call __________________________________ and ____________________________ for support.

G. I can attend workshops and support groups at the domestic violence program or ______________
   ______________________________ to gain support and strengthen relationships.

STEP 8: Items to take when leaving. When women leave partners, it is important to take certain items. Beyond this, women sometimes give an extra copy of papers and an extra set of clothing to a friend just in case they have to leave quickly.

Money: Even if I never worked, I can take money from jointly held savings and checking accounts. If I do not take this money, he can legally take the money and close the accounts.
Items on the following lists with asterisks by them are the most important to take with you. If there is time, the other items might be taken, or stored outside the home. These items might best be placed in one location, so that if we have to leave in a hurry, I can grab them quickly. When I leave, I should take:

*Identification for myself
*Children’s birth certificate
*My birth certificate
*Social Security cards
*School and vaccination records
*Money
*Checkbook, ATM card
*Credit cards
*Key - house, car, office
*Driver’s license and registration
*Medications
*Copy of protection order
*Welfare identification, work permits, green cards

Passport(s), divorce papers
Medical records - for all family members
Lease/rental agreement, house deed, mortgage payment book
Bank books, insurance papers
Address book
Pictures, jewelry
Children’s favorite toys and/or blankets
Items of special sentimental value

**Telephone numbers I need to know:**

Police/sheriff’s department (local) - 911 or __________________________
Police/sheriff’s department (work) _________________________________
Police/sheriff’s department (school) _________________________________
Prosecutor’s office _______________________________________________
Battered women’s program (local) ____________________________________

National Domestic Violence Hotline: 800-799-SAFE (7233)
800-787-3224 (TTY)
www.ndvh.org

County registry of protection orders _________________________________
State registry of protection orders ___________________________________
Work number _____________________________________________________
Supervisor’s home number _________________________________________

I will keep this document in a safe place and out of the reach of my potential attacker.

**Review date:** _____________________

Produced and distributed by:
What Does Safety Mean

To survivors of domestic abuse or sexual assault, safety means freedom from violence or abuse. While the primacy of safety should be emphasized for everyone, providers will want to keep in mind that safety may mean additional things for people facing issues besides violence (Trujillo, 2009). Here are some examples of what people may need, in addition to freedom from violence, in order to feel safe:

For a person in recovery from substance abuse or addiction: Having a network of people who support recovery and sobriety. Being in an environment free of constant triggers or pressure to drink alcohol or use illicit drugs.

For a person with mental health concerns: Being able to talk about one’s feelings and issues, or one’s own view of reality, without fear of being discounted or acquiring yet another label. If on medication, having a reliable source of affordable refills, so one doesn’t have to worry about running out.

For a person with disabilities: Full accessibility to any needed services. Freedom from bullying or exploitation. Being taken seriously rather than discounted. Being seen as a full-fledged human being capable of making one’s own decisions.

For a person who has experienced societal abuse or oppression: Being in an environment where diversity is respected. Freedom from being bullied, discounted or discriminated against because of misconceptions about one’s race, sexual orientation or other difference. Freedom to talk about one’s feelings, issues or view of reality without being stereotyped.

For a person facing intergenerational grief/historical trauma: Having one’s own customs, values and beliefs respected and honored. Freedom to practice one’s own customs or hold one’s own values and beliefs without pressure to conform to the dominant culture.

For a person living in poverty: Having a reliable source of income from employment, subsistence or public assistance. Ability to access enough resources to meet basic needs.

For a person who is homeless: A place to keep one’s belongings without fear of them getting stolen. A place to sleep without fear of arrest or of being harassed. Privacy for such things as taking a shower or changing clothes.

For a person being exploited by the commercial sex industry: Being able to talk about what’s going on in one’s life without fear of arrest or stigma. Being able to choose where one works, or with whom to have a sexual relationship. Freedom from exploitation.

For a person who is or has been incarcerated: Freedom to come and go from one’s place of residence without constant monitoring. The ability to discuss problems or challenges without fear of “getting violated” (an interesting turn of phrase that means getting sent back to jail or prison for violating probation or parole).

From Real Tools: Responding to Multi Abuse Trauma
By Debi Edmund & Patti Bland
Building Bridges with Domestic/Sexual Violence (D/SV) Specialists

As with most human services, connecting with domestic and sexual violence providers is usually a process, not an event. Survivors of violence, abuse and other forms of acute trauma may need your assistance in connecting with the right provider, overcoming barriers, and following through. Your willingness to provide this assistance – while respecting the survivor’s leadership – can make all the difference in ensuring a “warm handoff” to both internal and external providers.

Elements of a warm handoff:

- Know the program/organization to which you are referring the patient (and if you don’t know, call to ask).
  - What is their service area? Where are they located? Are they accessible for this patient? Do they have staff who speak the same language as the patient? Who is the patient’s contact person?
- Ensure, where possible, that you are connecting the patient to the organization in real time.
  - This may be of particularly important in highly lethal circumstances.
- Identify immediate barriers to help-seeking and collaboratively problem solve with patient to ensure patient has tools to overcome those barriers (Transportation barriers? Language barriers?).
- Be willing to lend the use of your office and/or phone, as these may be the only safe way for the patient to contact or meet with the D/SV specialist. Healthcare appointments provide excellent cover for meetings with anti-abuse specialists.
- Ensure, with the patient’s permission, that you are including the domestic/sexual violence specialist in any discussion about the immediate action plan.
- With the patient’s permission, share your understanding of the situation with the D/SV specialist. Remember that federal law may prevent D/SV specialists from reciprocating. Do not be offended if they cannot share information in return, especially in advance of having met with the patient privately.
- Ensure that the patient has the opportunity to speak for themselves. Speaking up and sharing one’s story is often a crucial step in regaining agency.
- Make it explicit that the patient can reconnect with you if for any reason they cannot connect to the domestic/sexual violence specialist.
- Set another appointment with your patient to check in both on their medical/emotional well-being, as well as on their safety.
- Always respect a patient’s choice. In circumstances where you are exceptionally concerned for a patient’s safety, but the patient is not seeking the services of a D/SV specialist, there is a distinct difference between handing someone a phone number and encouraging them to call on the one hand, and picking up the phone, dialing it yourself, and introducing the patient to the person on the other end of the phone. The patient can still say no in either case, and if so, that “no” should be honored, but the latter course of action conveys concern and builds a personal connection in a very different way.

Remember - for patients who are Deaf or Hard of Hearing:
People with hearing disabilities can use the Mass Relay service to communicate with any of your local domestic and sexual violence organizations: Dial 711 in Massachusetts or 800-439-0183 from anywhere. TTY users should dial 800-439-2370. Survivors can ask to be connected to the number of the organization they wish to speak to.
Indicators of Possible Child Sexual Abuse

Medical Indicators of Sexual Abuse in Children
- Genital bruising, genital/anal tears
- Sexually transmitted infections
- Urinary tract infections
- Pregnancy in underage child or young adult

** Please remember that discovering such evidence is unusual. The nature of childhood sexual abuse is such that there are usually no clinical indicators, even upon a PediSANE exam.

Additional Health Impacts that Can Indicate Trauma, Including CSA
- Disturbances in sleep habits (night terrors, insomnia, fear of sleeping alone, fear of sleeping in a given location)
- Changes in eating habits
- Immune system challenges (colds, sore throats)
- Body aches (headaches, GI distress)

Possible Behavioral Indicators of Trauma, Including CSA
- Fearful
- Anxious
- Angry outbursts
- Isolated, withdrawn
- Sexual knowledge, language or behaviors that are not appropriate for the child’s age
- Excessive masturbation or other sexualized behaviors
- Poor hygiene
- Age-inappropriate knowledge of sexual topics
- Regressive behaviors (reverting to prior developmental behaviors including crawling, wetting the bed, baby talk, etc)
- Aggressive behaviors with peers, pets, etc.
- Engaging in self-injurious behaviors (cutting, hair pulling, etc.)

** Please be aware that children and adolescents may display a wide range of behaviors in response to sexual abuse. This is a generic list. Please be alert to abrupt changes any child’s health, demeanor and behavior.

Possible Academic Indicators of Trauma, including CSA
- Drop in grades, attendance, engagement in school activities
- Inability to concentrate
- Changes in peer group, lack of a peer group

Erin C. Miller, 2017
Do No Harm: The Principles of Trauma-Informed Care

- Assume that everyone you serve has experienced some form of violence, abuse, or trauma in their life – build a practice that treats those experiences as the norm rather than the exception
- Utilize the empowerment model
  - Empower model posits that individuals are not to blame for what has happened to them. Rather it holds out the possibility that they can become change agents within their own lives. And it makes it a collective responsibility to proactively support each individual in becoming that change agent.
- Recognize that violence & abuse have a significant impact on development and on coping strategies
  - Through a trauma lens, most of what healthcare and human services providers generally consider “maladaptive” or pathological – substance abuse, cutting, eating disorders, transactional sex – might be more accurately framed as hard-wired if not necessary in response to inescapable circumstances of chronic abuse. If a patient or colleague is being humiliated and belittled everyday by a partner who is causing them to fear for their children’s safety, but leaving is more dangerous than staying (which it often is), then they are going to start to drink to stay calm, to stay functional as an employee and as a parent. If a patient is experiencing flashbacks after being sexually assaulted, and they haven’t slept in weeks because of the nightmares, and their entire body is constantly on high alert, and the medications their psychiatrist is giving them are not working (and most survivors have counterintuitive responses to most psychopharm meds), they are going to start to cut to ground themselves. A trauma lens would encourage providers to understand health conditions as “problems” to be redressed, but also as deeply creative adaptations to untenable situations. In short, a trauma-informed approach asks healthcare staff to honor these adaptations as sources of strength and resilience. This does not mean that we do not express concern, nor that we do not help patients and colleagues to work towards healthier responses! It simply means that as providers, we do no recapitulate cycles of shame, judgment or blame.
- Work to maximize the control that the survivor has, honor their choices, even (if not especially) when you disagree with them
  - As providers, we give survivors of abuse a gift by honoring their “no”. Remember that people who use abusive behaviors, by definition, disrespect others’ attempts at boundary setting, they disrespect other peoples’ “no.” In practice, this principle involves handing power, agency and choice back to someone who was robbed of it, however temporarily
- Base everything you do on relational collaboration
  - Goals are collaboratively defined, so too are strategies. The partnership is itself a place of healing.
- Work from a place of supporting resilience rather than emphasizing challenges
- Minimize the possibilities for revictimization
  - All survivors approaching systems – even the best and most compassionate systems – face the possibility of being revictimized, however unintentionally. We have power. Each and every one of us serves as a gate keeper.
- Create an atmosphere that prioritizes the survivor’s need for safety, respect and acceptance
- Understand that violence & abuse happen in a sociopolitical context.
- Understand that trauma affects providers as much as it affects patients. Know that these principles apply to our colleagues and all of us as much as to the people we serve. Practice diligent self-care.

Inspired by Hopper, Bassuk, & Olivet, 2010; Van der Kolk, Roth, et al, 2005
Compiled by by Erin C. Miller, 2017
Trauma-Informed Behaviors/Actions with Older Adults

- Assume the older adult is competent and can take action on their own behalf until there is significant evidence to the contrary. If there is significant evidence to the contrary, this does not relieve the provider of the responsibility to partner with the older adult victim in whatever capacity the older adult is able.
- Seek to spend time with the older adult before you spend time with their providers or family members.
- Listen before you speak.
- Ask the older adult what their goals and strengths are before you ask them what their challenges are.
- Remember that it may not be necessary to understand the nature of the trauma (particularly past traumas and/or multiple/chronic traumas) to do your job well and empower the older adult to improve their own health, safety and wellbeing. Unless the worry is about a current or recent trauma where there is an ongoing concern for the older adult’s safety, asking the older adult to relive the traumatic experience may do more harm than good. Action can be taken to relieve the older adult’s post-traumatic symptoms without “unpacking” their history of childhood sexual abuse or their experiences of intimate partner violence in their early 40s.
- If the older adult volunteers their trauma history without prompting, do not squash their disclosures. However, be mindful of how long the conversation continues. Sharing one’s traumatic experiences and having one’s pain publicly witnessed and honored by another human being can be profoundly healing. However, reliving such experiences can also be activate distressing physiological reminders of the event. Restoring healthy boundaries – including boundaries around time – is an essential foundation for healing from trauma. There is a reason therapy sessions and support group meetings are time-limited. Seek to consensually limit how long the older adult focuses on the traumatic events. Be explicit about your fears of reawakening traumatic body responses if necessary.
- Reflect the language the older adult is using – avoid using words like violence, abuse, or criminal behavior as the older adult may not initially conceive of what has happened to them as abusive or criminal. Use both language and grammar that is as neutral as possible.
- Introduce yourself and be explicit about your role and their rights, including their right to refuse your services. Honor the older adult’s “no”. Remember that building trust and healing trauma take time. The nature of trauma, and particularly trauma borne of interpersonal abuse, is that the human being who has survived it has had little ability to say “no” – no I don’t want to have sex with you, no I don’t want to be spoken to in that way, no I don’t want you to take my money. Providers plant a seed by honoring the older adult’s “no”.
- Be mindful of proximity to the older adult, body language, word choice and tone of voice. Convey warmth and support.
- Be mindful of the environment in which you are speaking with the older adult. Speak to the older adult in a private space. If possible, speak to the older adult in a space that is comfortable for them.
- Never touch the older adult without first asking permission.
- If you are younger than the person for whom you are providing services, be sure to find the balance between extending appropriate deference and respect, and including the older adult as a peer.
- Be mindful of any relevant, culturally-specific expectations around interactions between older adults and younger members of the community. For example, in Southeast Asian communities, a younger provider will
often be expected to pay deference to an older adult even in a situation where the provider has extensive knowledge and skill. Embrace humility – if you are unclear about the older adult’s expectations around deference to their age, ask.

• Trauma interferes with human beings’ sense of time. Be prepared to have victims miss or forget appointments.

• Trauma interferes with information processing – a challenge which may (or may not) be compounded by aging. Be patient with the person in front of you and be prepared to repeat yourself often.

• Trauma can shut down the speech centers of the brain. This may make it profoundly difficulty for the older adult to find language for what has happened to them. Be prepared for victims to share sensory details – the color of someone’s shirt, the temperature of the room, the view out a window – that appear irrelevant. If you are concerned about ongoing or recent violence, abuse or neglect, follow these sensory details. The body remembers in cases where the brain cannot. In addition, be mindful that older adults in particular (due to generational norms and/or cognitive challenges) may have added difficulty verbalizing the nature of the trauma they have experienced. Pay attention to behavioral cues such as agitation, sudden onset of memory challenges, confusion, distress, anger, sexualized behaviors, or behavioral expressions of fear or ambivalence around specific people, places or things.

• Trauma interferes with memory encoding. Be prepared for the older adult to share stories that have missing elements. Do not push if the older adult cannot remember or find language for what has happened to them. Inability to remember can have a protective function.

• Trauma’s combined impact on memory, speech, and executive function may cause the older adult victim’s story to appear inconsistent or disorganized. In addition, the older adult’s story may change over time. This does not mean that it is not true.

• Expect the older adult to engage in “maladaptive” coping: substance use, cutting, eating disorders, dissociative behaviors, even behaviors that look OCD, or ADD, amongst others. Reframe such behaviors as both normal, hardwired responses to recurrent toxic stress and signs of creativity, adaptability and strength. Avoid judgement. Avoid shaming. Avoid blaming.

• Help the older adult to recognize their coping strategy as a necessary survival skill in the fact of trauma, while recognizing the significant health impact. Offer tools to grow additional coping skills (journaling, prayer for older adults who are faith-based, exercise, as well as opportunities for social connectedness and mastery) that the older adult can utilize if they decide they want to work on growing alternatives in parallel with their current coping strategies.

• Provide psycho-education about common responses to trauma, including mental, cognitive & physical health impact, common coping mechanisms, and possible healthy coping mechanisms to might be used to mitigate the health impact (mindfulness meditation, chair yoga, neurofeedback, trauma-informed therapy, support group meetings, etc). Be prepared to provide both tools (for example, mindfulness meditation CDs) and warm handoffs to fellow providers who offer relevant services (clinicians certified in neurofeedback, organizations that run older adult-specific support groups, and trauma-informed yoga instructors)

• Be willing to openly and explicitly provide victims with guidance about harm reduction techniques specific to their coping strategies.

• Recognize that the work can itself be traumatic. Practice good self-care.
• If you have your own primary trauma history (and many of us do) recognize the impact of your personal history on your professional practice. Seek to expand your circles of support around the intersections of your personal trauma and the traumatic experiences you may be exposed to in your professional life.
• Seek out trauma-informed supervision.
• If you are a manager or supervisor, work towards trauma informed policies and protocols for your organization.
• Recognize that physical, emotional, mental and spiritual safety for providers is the foundation of trauma-informed care for victims.

<table>
<thead>
<tr>
<th>Provider Offer or Expression of Genuine Concern</th>
<th>Possible Victim Interpretation</th>
<th>Trauma-Informed Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I think there are some things we need to work on.”</td>
<td>I am the problem.</td>
<td>“What are your dreams, your goals for yourself? How can I best be of service to you?”</td>
</tr>
<tr>
<td>“I'd want to refer you to a therapist.”</td>
<td>I am crazy. I knew it. So this really is my fault.</td>
<td>“If you are willing, I would like to connect you to someone who understands (combat, sexual abuse, partner violence). There is nothing wrong with you. You are having a normal response to a screwed up situation. This is a stressful situation. You deserve support. I want to help you continue to expand your circles of support.”</td>
</tr>
<tr>
<td>“I am concerned about your drinking”</td>
<td>I am a bad person. My provider is judging me, just like everyone else. They are going to try to separate me from the only things that make me feel ok in my body.</td>
<td>“I want you to know that lots of the people I have the privilege of listening to use alcohol to cope. It is actually a very creative strategy for dealing with very difficult challenges. I am concerned about the impact that the alcohol is having on your blood pressure. If you are curious, I might have some suggestions of things that might help, in addition to the alcohol. Some of the people I talk with have shared with me what works for them. Perhaps some of those same things might work for you. Or maybe you already have things, in addition to alcohol that help you to feel calmer.”</td>
</tr>
<tr>
<td>“We are going to take care of these things for you. You don’t need to”</td>
<td>• I am helpless. I am incompetent. • No one thinks I am worthy of</td>
<td>“Are there steps that we can take together to achieve your goals?”</td>
</tr>
<tr>
<td>worry.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>being involved.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• I am not in charge.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>