TRAUMA AND RESILIENCE: A LIFESPAN PERSPECTIVE

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ROADMAP TO RESILIENCE: A GUIDE FOR MILITARY, TRAUMA VICTIMS AND THEIR FAMILIES

Donald Meichenbaum
(211 Pages Price $35)

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About The Author

This book traces Dr. Meichenbaum's 45 year career and offers the "untold story" of how Cognitive Behavior Therapy emerged and how it has evolved including the controversies along the way. The book features a personal account of Dr. Meichenbaum's many contributions to the field of Cognitive Behavior Therapy. Additionally, it includes a number of follow-up articles which point toward the future.

Reviews of this groundbreaking book and journey:

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How to spot HYPE in the field of psychotherapy: A 19 item Checklist

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Approaches to bolster resilience in victims of Human Trafficking: Core tasks of interventions

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WHAT IS YOUR ADVERSE CHILDHOOD EXPERIENCES (ACE) SCORE
(See https://www.cdc.gov/brfss Behavioral Risk Factor Surveillance System)

1. Did you live with anyone who was depressed, mentally ill, or suicidal?

2. Did you live with anyone who was a problem-drinker or alcoholic?

3. Did you live with anyone who used illegal street drugs or who abused prescriptions?

4. Did you live with anyone who served time in prison, jail or other correctional facility?

5. Were your parents separated or divorced?

6. How often did your parents or adults in your home ever slap, hit, kick, punch each other?

7. How often did a parent or adult in your home physically hurt you in any way?

8. How often did a parent or adult in your home ever swear at you, insult you, or put you down?

9. How often did anyone at least 5 years older than you, or an adult, try to make you touch them sexually?

10. How often did anyone at least 5 years older than you, or an adult, force you to have sex?

What is your ACE score? How have you evidenced resilience, in spite of these adverse events?
TABLE 3

“HOW TO” DEVELOP PERSISTENT PTSD and RELATED ADJUSTMENT PROBLEMS

At the Cognitive Level

Engage in self-focused, “mental defeating” type of thinking. Perception that one has lost autonomy as a human being, lost the will to exert control and maintain identity, lost the belief that one has a “free will”. See self as a “victim”, controlled by uninvited thoughts, feelings and circumstances, continually vulnerable, unlovable, undesirable, unworthy. Use dramatic metaphors that reinforce this style of thinking. “I am a prisoner of the past”, “Entrapped”, “Contaminated”, “Damaged goods”, “A doormat”, “A pariah”. A form of mental exhaustion, mental weariness.

Hold erroneous beliefs that changes are permanent, the world is unsafe, unpredictable and that people are untrustworthy. Hold a negative, foreshortened view of the future and the belief that life has lost its meaning.

Engage in self-berating, self-condemnation, self-derogatory “story-telling” to oneself and to others (i.e., self blame, guilt-engendering hindsight, biased thinking; anger-engendering thoughts of viewing provocations as being done “on purpose”).

Engage in upward social comparisons, so one compares poorly in one’s coping abilities. Be preoccupied with what others think of you. Engage in comparison of self versus others; before versus now; now versus what might have been.

Ruminate repeatedly, dwell on, focus upon, brood, pine over loses, “near miss” experiences. Replay over and over your concerns about the causes, consequences and symptoms related to negative affect and losses. Use repetitive thinking cycles (“loss spiral”).

Engage in contra-factual thinking, repeatedly asking “Why me” and “Only if” questions for which there are no satisfactory answers.

Engage in avoidant thinking processes of deliberately suppressing thoughts, using distracting behaviors, using substances; avoidant coping behaviors and dissociation.

Have an overgeneralized memory and recall style which intensifies hopelessness and impairs problem-solving. Difficulty remembering specific positive experiences. Memories are fragmented, sensory driven and fail to integrate traumatic events into autobiographical memory or narrative.

Engage in “thinking traps”. For example, tunnel vision as evident in the failure to believe
anything positive could result from trauma experience; confirmatory bias as evident in the failure to retrieve anything positive about one’s self-identity; or recall any positive coping memories of what one did to survive, or what one is still able to accomplish “in spite of” victimization; mind-reading, overgeneralizing, personalizing, jumping to conclusions, catastrophizing; “sweating the small stuff”, and emotional reasoning such as viewing failures and lapses as “end points”.

Evidence “stuckiness” in one’s thinking processes and behavior. Respond to new situations in post-deployment settings “as if” one was still in combat (misperceive threats).

At the Emotional Level

Engage in emotional avoidance strategies (“Pine over losses”, deny your feelings, and the possible consequences).

Intensify your fears and anger.

Experience guilt (hindsight bias), shame, complicated grief, demoralization.

Fail to engage in grief work that honors and memorializes loved ones or buddies who were lost.

Fail to share or disclose feelings, process traumatic memories. Focus on “stuck points”

At the Behavioral Level

Engage in avoidant behaviors of trauma-related feelings, thoughts, reminders, activities and situations; dissociating behaviors.

Be continually hypervigilant, overestimating the likelihood and severity of danger.

Engage in safety behaviors that interfere with the disconfirmation of emotional beliefs and the processing (“restorying”) of trauma-related memories and beliefs.

Engage in delay seeking behaviors. Avoid seeking help. Keep secrets and “clam up”.

Engage in high risk-taking behaviors; chasing the “adrenaline rush” in an unsafe fashion; Put self at risk for revictimization.

Engage in health-compromising behaviors (smoking, substance abuse as a form of self-medication, lack of exercise, sleep disturbance that goes untreated, poor diet, dependence on energy drinks, abandonment of healthy behavioral routines).

Engagement in self-handicapping behaviors (“excuse-making”), failure avoidance behaviors.
Use passive, disengaged coping behaviors, social withdrawal, resigned acceptance, wishful thinking and emotional distancing.

**At the Social Level**

Withdraw, isolate oneself, detach from others.

Perceive yourself as being unwanted, a “burden”, thwarted belongingness, distrusting others. (“No one cares”, “No one understands”. “No one can be trusted”).

Associate with peers and family member who reinforce and support maladaptive behaviors. Put yourself in high-risk situations.

Experience an unsupportive and indifferent social environment (i.e., critical, intrusive, unsympathetic- - offering “moving on” statements).

Fail to seek social support or help, such as peer-related groups, chaplain services, or professional assistance.

**At the Spiritual Level**

Fail to use your faith or religion as a means of coping.

Have a “spiritual struggle” and view God as having punished and abandoned you.

Use negative spiritual coping responses. Relinquish actions to a higher power, plead for miracles, or divine intervention; Become angry with God; Demandingness.

Experience “moral injuries” that compromise values. Lose your “moral compass” and “shatterproof beliefs”, experience a “soul wound”.

Avoid contact with religious members.
Resilience is the ability to adapt and thrive despite experiencing adversities. It reflects the ability to “bounce back” following traumatic and victimizing experiences.

Resilience and posttraumatic stress can coexist. Individuals may be resilient in one domain and not in others, or they may be resilient at one time period and not at other periods of their lives.

Such psychological processes as positive emotions, optimism, active coping, social supports and prosocial behaviors, meaning making, humor, and exercise can foster and support resilience and reduce the intensity and duration of stress responsivity. Such positive activities are associated with reduced HPA axis reactivity. The impact of positive emotions is cumulative; repeated positive emotional experiences over time prime the system for optimal response to negative stimuli by expanding physical, psychological, intellectual and social resources (Fredrickson, 2001). There is a protective capacity of positivity.

NEURO-Psychological mechanisms That nurture resilience

1. Reframing/Reappraisals is the ability to frame events in a relatively positive light. Functional MRI studies have shown increased activation in the lateral and medial prefrontal cortex regions and decreased amygdala activation during reappraisal. The increased activation in the lateral prefrontal cortex (the “executive” center) helps modulate the intensity of emotional responses and keeps the amygdala in check. Resilient individuals are better able to extinguish and contextualize traumatic emotional memories and can more readily retrieve positive memories.

2. Use of Humor is a way to engage in cognitive reappraisal and emotion regulation. A network of subcortical regions that constitute core elements of the dopaminergic reward system are activated during humor.

3. Optimism is the inclination to adapt the most hopeful interpretation of the events which influences emotion regulation, contributes to life satisfaction, and increases psychological and physical health. An optimistic future-oriented outlook has been associated with increased activity in the amygdala and anterior cingulated cortex. For instance, optimists have lower rates of dying after cardiovascular disease over 15 years, compared to pessimists.

As Southwick and Charney (2012, p. 25) observe, “optimism serves as the fuel that ignites resilience and provides energy to power the other resilience factors”. But it is realistic optimism that works best, whereby individuals pay close attention to negative information, and not blind optimism that does not work.

4. Active goal-directed problem focused coping of taking direct actions when stressful life events are potentially changeable can increase neurotransmission in the mesolimbic dopaminergic pathways that increase pleasurable feelings and that stimulate reward
centers such as the ventral striatum. Dopamine release in the brain leads to “openness to experience”, exploratory behaviors, and to the search for alternatives. A form of active coping is to engage in Behavioral Activation (physical exercise) which has positive effects on mood such as depression and that promotes resilience and neurogenesis. Exercise increases the level of serotonin, norepinephrine, dopamine and by stimulating the reward circuits in the brain. Exercise has also been shown to increase the size of the hippocampus and serum levels and increase brain volume (prefrontal cortex), especially among the elderly.

In some instances, when stressful events are not changeable, the use of emotional-palliative coping strategies such as acceptance, distraction, spirituality are the best ways to cope.

5. **Prosocial behaviors and social supports** and social competence, altruistic behaviors, helping others, and empathetic capacity facilitate resilience. The neuropeptides oxytocin, and vasopressin have been found to increase trust, compassion and enhance the reward value of social stimuli. Cortical “mirror neurons” have also been implicated in the regulation of positive emotions and can reshape the circuitry responsible for resilience. They play a role in facilitating social interactions by promoting shared understanding and empathy.

For example, compassion contributes to an increase in the level of endorphins, endogenous cannabinoids, endogenous morphine, dopamine, vasopressin, nitric acid, and oxytocin. In addition, the stimulation of the Autonomic Nervous System (ANS) engenders compassion, as compared to negative emotional distress. Compassion also triggers an orientation response and accompanying heart rate deceleration tied to respiratory sinus arrhythmia, heart rate variability and reduced startle responses and skin conductance (vagus nerve response), as well as triggering “mirror neurons”. Resilient individuals are better able to bond with others and attract social support.

Low levels of social support have been linked to increased rates of depression, anxiety and PTSD. In a 9 year prospective study, individuals with no or few social supports had 1.9 to 3 times the risk of dying from a variety of illnesses, including cancer, cerebrovascular and cardiovascular diseases, as compared with those who had optimal social supports (Malta, 2012). Among the elderly, loneliness is a strong predictor of early morbidity and has the same predictive power of smoking and lack of exercise.

Helping individuals increase their social supports and engaging in caregiving activities trigger the immune system to respond positively and stimulate the reward circuits along the medial forebrain bundle and engages dopaminergic neurons. Various hormones and neuropeptides like oxytocin and vasopressin facilitate social engagement and increase adaptation to stress by increasing empathy, eye contact, social cognition and problem-solving skills. Such positive attachment relationships buffer physiological stress responses.
6. **Meaning-making** is another strategy that can buffer against negative feelings and is associated with resilience. Having a role model who provides a “guiding light” and developing and following a personal “moral compass”, holding spiritual beliefs, and engaging in religious faith-based practices bolster resilience and facilitate recovery. For example, consider the experiences of Jerry White (2008), who lost limbs to landmine explosions and who founded Landmine Survivors Network, which later became the Survivor’s Corp. It is designed to foster a mindset of “Survivorship”, which he defines as “choosing to live positively and dynamically in the face of death, disaster and disability; a form of meaning making. His approach is designed to combat the development of a “victim mentality” where individuals tend to pity themselves, resent their circumstances, live in the past and blame others. White believes that a victim-minded person is generally inflexible, stuck in his or her grievances, and is seemingly unable to let go, find hope, or move forward. Over time, a victim’s intense focus is on their own personal suffering which can interfere with his or her ability to take positive action, relate to others in a healthy manner, or participate more fully in daily life.

White proposes **five steps** to help trauma survivors to tap their innate resilience and grow stronger.

1. **Face facts**: acknowledge and accept what has happened, the suffering and loss. Find a way to live with it and piece together a “personal story”.

2. **Choose life**: live for the future, not in the past.

3. **Reach out**: connect to others who have “been there”. Reach out to peers, friends and family.

4. **Get moving**: set goals and take action for a healthy recovery. Develop an individual action plan and identify your life priorities. Each step engenders hope and builds self-confidence. Regularly evaluate your progress and when needed re-evaluate and change one’s objectives. Such individual action plans are a contract of sorts with oneself and with others.

5. **Give back**: be thankful for what you do have. Contribute to others and to your community. Express gratitude - - thanking people who have helped. Express generosity - - giving back more than taking. Move from being a beneficiary to a benefactor.

In **summary**, the experience of positive-balanced emotions such as optimism, joy, pride, contentment, compassion, love, forgiveness, gratitude, humor have been associated with distinct neurobiological and psychological changes that provide a protective capacity. The positive emotion of **awe**, which reflects positive feelings of being in the presence of something vast that transcends our understanding of the world contributes to altruistic behaviors and to a sense of community. Awe helps shift one’s focus from a narrow self-interest to the interests and wellbeing of a group to which individuals belong. Sights and sounds of nature, collective rituals,
Meichenbaum

artistic events of music and dance elicit positive emotions that have behavioral and physiological sequelae. These neurobiological responses include:

Increase of neurotransmitters like cortisol levels that facilitate pathway communication between Prefrontal Cortex (PFC) and subcortical systems like the amygdala. For instance, GABA (gamma amino butyric acid) which is an inhibiting neuropeptide made in the orbitomedium PFC (OBPFC) when released "turns down" the alarm system of the amygdala. The left PFC, a site associated with positive emotions such as happiness, is more activated during Compassion Meditation.

These positive emotions reduce physiological arousal and broaden and build an individual's focus of attention, allowing more creative inclusive, flexible, integrative perspective taking, engenders positive reappraisal of difficult situations, fosters problem-focused coping, and facilitates the infusion of ordinary events with meaning. Fredrickson et al. (2002, 2008), in her Broaden-and-Build Theory, highlights that the impact of positive emotions is cumulative. Repeated positive emotional responses to negative events expands and builds psychological and behavioral resources. (Also see Carl et al., 2013; Fava and Ruini 2003, Well-being therapy; James et al., 2013, McEwen, 2007; Ochner and Cross, 2008; Russo et al, 2012; Southwick et al., 2011).
Use Physical exercise -- Behavioral Activation and use Active Coping Strategies (See McNally, 2007).

Use Emotional Regulation and Tolerance Skills and Increase the Protective Capacity of Positivity that Buffers Negative Feelings (See Kim & Humann, 2007).

Focus and savor positive emotions and ruminations, past (reminiscence) and anticipate positive emotions (anticipating). Engage in goal setting and affective forecasting in the form of positive future-oriented imagery that nurtures hope. Avoid "dampening" or minimizing positive events ("I don't deserve this." "This won't last").

Engage in Mindfulness Exercises -- pay attention in a particular way, on purpose in the present moment, and nonjudgmentally (See Chiesa et al., 2013; Salzberg, 2011).

Engage in Loving-kindness Meditation and engage in Acts of Kindness

Engage in gratitude exercises ("Give back and pay forward").

Engage in Forgiveness exercises Toward others and Toward One-self -- Compassion is the awareness of the suffering of others and oneself, coupled with the wish and effort to alleviate it.

Engage in Meaning-making Activities and Cognitively Reappraisal ("Healing through meaning")

Use Spiritual-related Activities-- Use of One's Faith and engage in communal religious activities (See Meichenbaum "Trauma, spirituality and recovery" on Melissa Institute Website)

Increase Social Supports -- keep interpersonally fit by participating in positive activities; selectively choosing and altering situations, improving self-presentation (smiling, dressing up), improving communication skills and accessing social networks (See Uchina et al., 1996).

Use humor, Have fun and build-and-broaden Positive Emotions ("Bucket List Activities")

Each of these Activities will help bolster resilience by increasing the accompanying neurobiological processes. There is increasing data that a course of psychotherapy- even without medication- had measureable physical consequences in the brain.
GENERIC CASE CONCEPTUALIZATION MODEL

1A. Background Information
1B. Reasons for Referral

2A. Presenting Problems (Symptomatic functioning)
2B. Level of Functioning (Interpersonal problems, Social role performance)

3. Comorbidity
3A. Axis I
3B. Axis II
3C. Axis III

4. Stressors (Present/Past)
4A. Current
4B. Ecological
4C. Developmental
4D. Familial

5. Treatments Received (Current/Past)
5A. Efficacy
5B. Adherence
5C. Satisfaction

6. Strengths
6A. Individual
6B. Social
6C. Systemic

7. Summary Risk and Protective Factors

8. Outcomes (GAS)
8A. Short-term
8B. Intermediate
8C. Long-term

9. Barriers
9A. Individual
9B. Social
9C. Systemic
FEEDBACK SHEET ON CASE CONCEPTUALIZATION

Let me see if I understand:

Boxes 1 & 2: REFERRAL SOURCES AND PRESENTING PROBLEMS

"What brings you here is...." (distress, symptoms, present and in the past)
"And it is particularly bad when...." “But it tends to improve when you....”
"And it is affecting you (how....in terms of relationships, work, etc.)”

BOX 3 COMORBIDITY

“In addition you are also experience (struggling with)....”
   And the impact of this in terms of your day-to-day experience is....”

BOX 4: STRESSORS

“Some of the factors (stressors) that you are currently experiencing that seem to maintain your problems are.... or that seem to exacerbate (make worse) are....” (Current/ecological stressors)

“And its not only now, but this has been going on for some time as evident by ...” (Developmental stressors)

“And its not only something you have experienced, but your family members have also been experiencing (struggling with).... “And the impact on you has been....” (Familial stressors and familial psychopathology)

BOX 5: TREATMENT RECEIVED

“For these problems the treatments that you have received where – not type, time, by whom.”

“And what was most effective (worked best) was.... as evident by...”

“But you had difficulty following through with the treatment as evident by...” (obtain an adherence history) “And some of the difficulties (barriers) in following the treatment were....”

“But you were specifically satisfied with...and would recommend or consider....”

BOX 6: STRENGTHS

“But in spite of...you have been able to....”

“Some of the strengths (signs of resilience) that you have evidenced or that you bring to the present situation are....”

“Moreover, some of the people (resources you can call upon (access) are....” “And they can be helpful by doing....” (Social supports)

BOX 7: SUMMARY OF RISK AND PROTECTIVE FACTORS

“Have I captured what you are saying?” (Summarize risk and protective factors)

“Of these different areas, where do you think we should begin?” (Collaborate and negotiate with the patient a treatment plan. Do not become a “surrogate frontal lobe” for the patient.)

BOX 8: OUTCOMES (GOAL ATTAINMENT SCALING PROCEDURES)

“Let’s consider what are your expectations about the treatment. As a result of our working together, what would you like to see change (in the short-term)?”

“How are things now in your life? How would you like them to be? How can we work together to help you achieve these short-term, intermediate and long-term goals?”

“What has worked for you in the past?”

“How can our current efforts by informed by your past experience?”

“Moreover, if you achieved your goals, what would you see changed?”

“Who else would notice these changes?”

BOX 9: POSSIBLE BARRIERS

“Let me raise one last question, if I may. Can you envision, can you foresee, anything that might get in the way – any possible obstacles or barriers to your achieving your treatment goals?”

(Consider with the patient possible individual, social and systemic barriers. Do not address the potential barriers until some hope and resources have been addressed and documented.)

“Let’s consider how we can anticipate, plan for, and address these potential barriers.”

“Let us review once again...” (Go back over the Case Conceptualization and have the patient put the treatment plan in his/her own words involve significant others in the Case Conceptualization Model and treatment planning. Solicit their input and feedback. Reassess with the patient the treatment plan throughout treatment. Keep track of your treatment interventions using the coded activities (2A, 3B, 4C, 6B, etc.) Maintain progress notes and share these with the patient and with other members of the treatment team.)
CORE TASKS OF PSYCHOTHERAPY

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Role of Case Conceptualization Model (CCM) that informs assessment and treatment decision-making (See CCM below and the accompanying Report Format).

1. Assessment Procedures.

   a) Risk factors toward self and others
   b) Presence of co-occurring disorders
   c) Strengths- evidence of Resilience, “Islands of competence” and access to social resources and supports

2. Development, maintenance and monitoring of Therapeutic Alliance - - Be culturally, developmentally and gender sensitive.

   a) Use of Motivational Interviewing practices (See www.motivationalinterviewing.org)
   b) Use guided discovery probes - - Socratic questioning procedures (See Art of Questioning below)
   c) Use Feedback Informed Treatment (FIT) procedures. FIT asks patients to rate on a session-by-session basis, their Progress and the Quality of the Therapeutic Alliance. Bertolino (2017), explains the FIT assessment procedure as follows: (See Bertolino, 2017 use of session-by-session patient ratings)

   “Completing this scale is a bit like taking your temperature. In a minute or less, we can get an idea about how you think things are with you and your life. Just as your temperature tells us something about how much distress your body is in, so do the scores on this scale. And like your temperature, this scale will let us know how things have been with you during the past week up through today, - not tomorrow or in a month. Right now we are trying to understand how we can help you which is more difficult if we don’t have a good idea of how you are doing to begin with. Can you help us out?” (Bertolino, 2017, p. 197).

FIT has patients fill out ORS (Outcome Rating Scale) and SRS (Session Rating Scale of the therapeutic alliances). The therapist reviews these scores with the patient “where he/she is at,” and develops a collaboration strengths-based patient-driven treatment plan (see FIT-Outcomes.com).
3. Collaborative goal-setting - - Nurture HOPE

a) Establish SMART goals (Specific, Measureable, Attainable, Relevant, Timely)

b) Use Goal-attainment Scaling Procedures - - “As yet”; “So far” statements

c) Focus on issues of transfer and maintenance of treatment gains across settings and over time in order to achieve “lasting changes”

4. Conduct Psycho-Education

a) Use CLOCK metaphor

i) **12 o’clock** - - External and internal triggers

ii) **3 o’clock** - - primary and secondary emotions (Treat emotions as a “commodity” - - “What do you do with your feelings?”)

iii) **6 o’clock** - - Automatic thoughts and images
- Implicit assumptions
- “If … then” Rules
- Beliefs, Developmental Schemas

iv) **9 o’clock** - - Behaviors and reactions of others

Use metaphor of “vicious cycle” and **what is the impact, toll, price you and others pay?**

b) Highlight the Role of Resilience - - Build and broaden positive emotions and activities

c) Use Time Lines

**Timeline 1** - - From birth to the present, enumerate stressors (experiences of trauma and exposure to violence), and interventions, if any

**Timeline 2** - - “In spite of behaviors”. Evidence of strengths, signs of resilience from birth to the present. Also, include evidence of intergenerational transmission of “strengths”. What got passed on? Lessons learned.

Highlight “exceptions” - - when problems not present or less. Be solution-focused
Timeline 3 - present and future - oriented focused. Start now and extend Timeline into the future.

5. Teach Intra- and Interpersonal skills

   a) Focus on emotion-regulation skills and problem-solving skills.

   b) Focus on interpersonal skills - “scripted” behaviors

   c) Build in generalization guidelines (Do before, during and after training - put the patient in a Consultative Role). Use Patient Checklist.


7. Provide Integrative Treatment approaches, where indicated to address the presence of co-occurring disorders, such as Complex PTSD, depression, Substance abuse disorders. (See Alexander et al. 2013; Jaycox, 2004, 2009, Wolmer et al. 2011).

8. Provide Active Aftercare and Follow-through Procedures. Conduct a:

   a) Risk Analysis-triggers. Use CLOCK Metaphor

   b) Use Booster Sessions

   c) Use Ongoing Internet Consultations

   d) Involve Significant Others in Treatment, throughout, (See list of Websites for Family-based Interventions)
USE “CLOCK” METAPHOR

12 o’clock -- external and internal triggers
3 o’clock -- primary and secondary emotions
6 o’clock -- automatic thoughts, thinking processes such as ruminating, schemas and beliefs
9 o’clock -- behaviors and resultant consequences

1. Place hand at 9 o’clock and move it around imaginary clock and say “It sounds like a vicious ...”. allow client to finish this sentence with “cycle” or “circle”. Explore how his/her account fits a “vicious cycle”.

2. Treat 3 o’clock primary and secondary emotions as a “commodity”. What does the client do with all his/her feelings. For example, “stuff them”, “drink them away”, “act out”.

3. If that is what he/she does with such emotions, ask, “What is the impact, toll, price he/she and others pay, as a result? If the client answers, “I do not know”, then the therapist should say “I do not know either, how can we go about finding out? Moreover, how will finding out help you achieve your treatment goals of X (be specific)?”

4. Encourage the client to collect data (self-monitor) when the “vicious cycle”, as the client describes it, actually occurs? Explore with the client when he/she engages in such behavior and the “impact, toll, price”. “If it has this impact, then what can the client do?” It is not a big step for the client to say, “I should break the cycle or circle”. The therapist can then explore how the client now goes about breaking the cycle -- thus, view present symptoms and behaviors as their attempt to “break the vicious cycle”. (Use dissociation, substances, avoid, act out). Thus, the patient’s current symptoms/behaviors reflect a “stuckness” problem of using past behaviors (time-sliding to break the vicious cycle).

5. Explore with the patient more adaptive ways “to break the cycle.”
CORE COMPETENCIES FOR PSYCHOTHERAPISTS

Donald Meichenbaum, Ph.D

1. Establish, maintain and routinely monitor the quality of the therapeutic alliance.

2. Actively communicate an accepting, supportive, helpful, empathic, validating message. Meet the patients where they are “at” and guide them to what may be more beneficial for them. Follow their lead and take things slowly and be patient.

3. Conduct a comprehensive assessment of the reasons for seeking treatment or having been mandated for treatment (e.g., presenting symptoms, current concerns, life problems). Conduct a functional, situational and developmental analyses.

4. Assess for the client’s and significant other’s explanatory models or implicit theories about the nature of the presenting problems and what it will take to change. (Solicit explanations about the treatment and possible barriers and provide a treatment rationale).

5. Be culturally sensitive, as well as gender and developmentally sensitive. (Be culturally competent).


7. Use the “Art of Socratic Questioning” and a discovery-oriented approach. Encourage the client to tell and retell his/her story at his/her “own pace”.

8. Develop and use a Case Conceptualization Model and provide feedback to the client and significant others.

9. Engage the client in collaborative goal-setting that nurtures “hope” and adjust goals collaboratively over the course of treatment. Elicit evidence of “strengths”. Use “In spite of” statements and use Time Lines. Encourage positive expectations that psychotherapy can be beneficial in facilitating change.

10. Use Motivational Interviewing procedures (Express Empathy, Avoid Argumentation, Develop Discrepancy, Support Self-efficacy) that can impact their willingness and commitment to change.

11. Conduct ongoing psycho-education in order to help them become more aware of the determinants of their behavior and the interconnections between their feelings, thoughts, behaviors and reactions of others. Use a “Clock” metaphor of 12 o’clock
referring to external and internal triggers; 3 o’clock referring to primary and secondary emotions; 6 o’clock referring to thinking process (automatic thought and images, thinking processes and schemas/beliefs, expectations and attribution; 9 o’clock referring to their behaviors and reactions of others and how these contribute to a “vicious cycle”. Increase the client’s self-awareness of how he/she inadvertently, unwittingly, and unknowingly produce reactions in others that confirm their beliefs.


13. Address therapy-interfering behaviors, therapeutic impasses (“ruptures” to therapeutic alliance) and reasons for treatment nonadherence. Consider the therapist’s possible contributions to alliance problems. Attend immediately to any strains or “ruptures” in the alliance that can lead to treatment failure.


16. Improve credibility of the therapist by fostering client change early in treatment (e.g., symptom reduction, improve relationships).

17. Help the client engage in inter-session activities (“Homework” assignments).

18. Train intra emotional self-regulation and interpersonal skills. Build in generalization guidelines. (Do not “train and hope” for transfer). Provide integrative treatments for clients with comorbid disorders.


20. Provide corrective experiences within and outside of treatment. Use gradual exposure-based interventions with traumatized/victimized clients, where indicated. But be sensitive to other dominant emotional reactions including, guilt, shame, complicated grief, anger and “moral injuries” and tailor interventions accordingly.

21. Encourage and challenge the clients to take a risk in how they behave in the hope of finding results with more positive consequences, or “data” that they will take as “evidence” to unfreeze their beliefs about themselves, others and the future.

23. Help the client become his/her "own therapist"/"detective". "Restore" one's life.

24. Prepare for termination (Taking stock of changes and planning for the future).

25. Engage in psychotherapist self-care behaviors and experience "vicarious resilience".


27. Behave in an ethically responsible manner. (Respect boundaries and be aware of psychological treatments that cause harm).
Outcome Rating Scale (ORS)

Name: ______________________ Age (Yrs): ___
ID#: ________________________ Sex: M/F
Session #: __________ Date: ____________________

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels.

Individually:
(Personal well-being)

I—Examination Copy Only—I

Interpersonally:
(Family, close relationships)

I—Examination Copy Only—I

Socially:
(Work, School, Friendships)

I—Examination Copy Only—I

Overall:
(General sense of well-being)

I—Examination Copy Only—I

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Session Rating Scale (SRS V.3.0)

Name____________________ Age (Yrs):____
ID#____________________ Sex: M / F
Session #____ Date:__________________

Please rate today's session by placing a hash mark on the line nearest to the description that best fits your experience.

Relationship:

I did not feel heard, understood, and respected

I felt heard, understood, and respected

Goals and Topics:

We did not work on or talk about what I wanted to work on and talk about

We worked on and talked about what I wanted to work on and talk about

Approach or Method:

The therapist's approach is not a good fit for me.

The therapist's approach is a good fit for me.

Overall:

There was something missing in the session today

Overall, today's session was right for me

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1) IPV has an impact on interpersonal and social adjustment impacting emotional intimacy, relationship distress, partner accommodation, inadvertent “enabling”.

2) High Expressed Emotion (HIEE) can exacerbate complex PTSD, negative communication, poor conflict management skills contribute to familial distress.

3) Emotional avoidance (fear, guilt, shame, anger, grief, sadness, moral injuries) and the lack of sharing are risk factors for the development of PTSD and Complex PTSD, and the accompanying family disruptions.

4) Cognitive-behavioral Conjoint Therapy (CBCT) includes 15 sessions couples treatment of 75 minute sessions. CBCT does not include individual sessions - only seen as couples. A pre-treatment individual assessment with each partner is conducted in order to obtain a couple history and to assess for safety concerns. A emotionally safe therapeutic environment is established from the outset. The sessions may include a co-therapist and they can engage in “side-bar” discussions with the couple “eaves-dropping” about treatment decision-making.

   CBCT consists of three phases: The initial sessions may be held twice weekly and later sessions conducted once a week. A three month set of booster sessions may be included.

   Phase I provides a rationale for treatment and a psycho-education about PTSD and related symptoms, and assesses for and ensures safety in the relationship. Rapport building and collaborative goal-setting are included. The therapist throughout acts as a "coach", and encourages the couple to communicate directly with each other, not act as an intermediary “translator” (“Can you tell John what you want him to know about how you feel?”).

   Phase II helps couples to develop communication skills (active listening, paraphrasing, editing, conflict management and social problem-solving). The couple is encouraged to engage systematically in activities that reduce PTSD-related avoidance and that increase mutually pleasant activities, and that enhance relationship satisfaction, (cach each other doing "nice" things). They are also taught ways to become sensitive to early warning signs and how to ... use mutually-agreed upon Time Out procedures. They learn how to “shrink” the impact of trauma and PTSD in their relationship.

   Phase III addresses “stuck points” and problematic ways of thinking, feeling and behaving. Treatment includes Relapse Prevention and Self-attributional processes and benefit-finding activities. Treatment also includes out-of-session practice assignments.

5) Treatment can use the CLOCK metaphor and highlights a strengths-based approach. (“What attracted the couple to each other? Are these attributes still present? Give specific examples.”) See Meichenbaum’s Roadmap to resilience book for a list of ways to improve communication skills in couples and families.
6) Where indicated, couple therapy may include disclosure-based exposure sessions and working with trauma-related emotions and the development of a "healing theory".

7) Another form of couples therapy is to use partner-assisted interventions where the partner acts as a "coach" or "pseudo-therapist", as in the case of in vivo graduated exposure exercises. Such partner and family support can supplement and be adjunctive to individual treatments.

8) Psychoeducation and skills building is common to various forms of couple and family therapy, as well as in vivo behavioral practice. Ensure that the couple "takes credit" for changes. Highlight meta-cognitive verbs and "RE" words with examples.
APPLICATION OF THE CLOCK METAPHOR

12 O'CLOCK -- Appraisal of external and internal triggers

3 O'CLOCK -- Primary and Secondary feelings

6 O'CLOCK -- Automatic thoughts, thinking processes and underlying beliefs

9 O'CLOCK -- Behavioral Acts and resultant consequences (Reactions of others)

Consider how Sue Johnson uses the CLOCK in her Couples' Therapy

THERAPIST: "You hear her say that you are too difficult." (12 o'clock trigger). "You felt helpless" (3 o'clock). "You try to push it aside." (9 o'clock) "But your body expresses the hopelessness (3 o clock) and you say to yourself, what? I have blown it already and lost her.

So you withdraw to yourself " (9 o clock). And then you get even angrier (3 o'clock) and that is the cycle that has overtaken the relationship and leaves you both alone (3 o'clock). And that brings tears for you (9 o'clock)." You say to yourself 'I have blown it, lost her. I will never please her, never have her love (6 o'clock). Is that it?"
SOCIAL SUPPORTS AND HUMAN CONNECTIONS: NEUROBIOLOGICAL SEQUELAE

Social supports and human connections, engaging in prosocial altruistic behaviors each facilitate resilience. The ability to demonstrate empathy and help others have neurobiological consequences. For example, the neuropeptides oxytocin and vasopressin have been found to increase trust, compassion and increase the reward value of social stimuli that are triggered by social activities, increase the reward value of social stimuli and further increase trust and compassion. Cortical “mirror neurons” have also been implicated in this regulation of “positive emotions” and can reshape the circuitry responsible for resilience. They play a role in facilitating social interactions by promoting shared understanding and empathy.

Compassion contributes to an increase in the level of endorphins, endogenous cannabinoids, endogenous morphine, dopamine, vasopressin, nitric acid, and oxytocin. In addition, the Autonomic Nervous System (ANS) engenders compassion, as compared to negative emotional distress. Human connection in the form of compassion also triggers an orientation response and accompanying heart rate deceleration tied to respiratory sinus arrhythmic, heart rate variability, and reduced startle responses and skin conductance (vagus nerve response), as well as triggering “mirror neurons.” Resilient individuals are better able to bond with others and attract social supports.

Low levels of social support have been linked to increased rates of depression, anxiety and PTSD. In a nine-year prospective study, individuals with no or few social supports had 1.9 to 3 times the risk of dying from a variety of illnesses including cancer, cerebrovascular and cardiovascular diseases, compared with the individuals who had optimal supports (Marta, 2012).

Among the elderly, loneliness is a strong predictor of early morbidity and has the same predictive power as smoking and lack of exercise.

Helping individuals increase their social supports and engaging in caregiving activities trigger the immune system to respond positively and stimulate the reward circuits along the medial forebrain bundle and engage dopaminergic neurons. Various hormones and neuropeptides like oxytocin and vasopressin facilitate social engagement and increase adaptation to stress by increasing empathy, eye contact, social cognition and problem-solving skills. Such positive attachment relationships buffer physiological stress responses.
FORGING RESILIENCE IN THE WAKE OF TRAGEDY

Froma Walsh (2018), in her book “Strengthening family resilience”, has provided several examples of how multisystemic family and community resilient-oriented interventions have been employed successfully in the aftermath of the terrorist bombing in Oklahoma City and the New York 9/11 attack; in the aftermath of Hurricane Katrina; and in reconciliation activities following civil wars; as well as in personal losses. A variety of shared empowering collective story-telling interventions have been implemented including community-based family group meetings; establishing compassion centers; candle light vigils; anniversary remembrance ceremonies; life-affirming activities like constructing “future trees”; outreach places of worship; journal writing activities designed to provide children and adolescents with opportunities to share their "Hurricane Katrina stories", highlighting not only the sad, bad and scary events, but also the helpful, brave and good things they experienced. What are the lessons learned that can be made into a "gift" to be shared with others?

Her descriptive accounts are bathed with RE-VERBS indicating the beneficial value of:

1. RE-establishing the routines and rhythms of life;
2. RE-organizing, RE-allocating one's roles and functions;
3. RE-storing order, meaning, and purpose;
4. RE-connecting, RE-engaging with social supports (family, kin and community resources);
5. RE-membering those who have been lost;
6. RE-affirming one's identity and RE-prioritizing goals ("Struggling wellness. Weathering adversity. Creating a possible legacy to pass along to a future generation");
7. RE-gaining spirit and RE-newing hope (mobilizing capacity and resources);
8. RE-authoring one's life (Strengthening RE-solve to RE-bound).

Walsh observes that traumatic events can shatter an individual, family and community assumptive world of invulnerability, security, predictability, sense of trust, hopes and dreams. Recovery is a gradual process over time, even though some traumatic loses are never fully resolved. Nevertheless, multisystemic recovery efforts can help expand the vision of what is possible through shared efforts. Some communities, like some individuals, are more resilient than others, but resilience in all can be nurtured.
Jamie Pennebaker, and many follow-up investigators, have demonstrated the healing power of expressing emotions, the need to gain perspective, and the value of writing to heal. Wilson (2011), highlights that a story-prompting approach serves several functions, including helping individuals:

1. make sense of negative events and outcomes;
2. develop a framework within which to gain a more distant perspective from traumatic experiences and to better understand them;
3. change their personal narratives from a fragmented, jumbled, sensory-driven account into a more coherent, redemptive personal account;
4. engage in value-affirming story-telling and reduce the likelihood of engaging in a self-defeating cycle of negative thinking.

Engaging in writing exercises such as “step-back-and-ask why”, or write about “Your life in the future,” or write about a marital disagreement from a “third-person perspective,” have each been found to produce beneficial effects. Individuals tend to ruminate less, become more dispassionate, find meaning, overcome negative stereotypes, as a result of engaging in such writing exercises.

**ILLUSTRATIVE WRITING EXERCISES**

**Step Back and Analyze the Events From a Distance**

Instead of having the individual immerse oneself in the original experience, this writing procedure invites the person to take a “step back, in one’s mind’s eye, move away from the situation to a point where he/she is watching the event unfold from a distance.” Watch the event unfold from the perspective of a neutral observer, as opposed to a first person perspective. Focus on the “why” did you have these feelings?

Individuals are asked to write about this event for at least 15 minutes on three or four consecutive days. This writing exercise should be undertaken some time after the traumatic event has occurred.

Another writing exercise designed to help individuals develop a “best possible self”, requests that they write for 20 minutes on four consecutive days about “how everything has gone well as they possibly could, as if your life dreams have come true.”

Variations of this approach include asking individuals to write about important self-affirming values and “islands of competence” they possess. This writing approach has been described as requesting that they write “the rest of the story” of any strengths, or signs of resilience, that they evidence, “in spite of” the traumatic and victimizing experiences.
For more detailed descriptions of such writing exercises see the following references.

REFERENCES


**Psychotherapy “Hype” Checklist**

(1) Substantial exaggeration of claims of treatment effectiveness

(2) Conveying of powerful and unfounded expectancy effects

(3) Excessive appeal to authorities or “gurus”

(4) Heavy reliance on endorsements from presumed experts

(5) Use of a slick sales pitch and the use of extensive promotional efforts, including sale of paraphernalia

(6) Establishment of accreditation and credentialing procedures

(7) Tendency of treatment followers to insulate themselves from criticism

(8) Extensive use of "psychobabble"

(9) Extensive use of "neurobabble"

(10) Tendency of advocates to be defensive and dismissive of critics; selective reporting of contradictory findings, such as the results of dismantling studies

(11) Extensive reliance on anecdotal evidence

(12) Claims that treatment "fits all"

(13) Claims that treatment is "evidence-based" on the basis of informal clinical observations

(14) Inadequate empirical support: Limited reports or omission of treatment outcome information, such as patient selection criteria, drop-out rates, and follow-up data

(15) No proposed scientific basis for change mechanisms; proposed theoretical treatment mechanism lacks "connectivity" with extant science

(16) Repeated use of implausible ad hoc maneuvers to explain away negative findings
(17) Comparison of treatment with weak and "intent to fail" treatment groups, or with only partial (incomplete) treatment conditions

(18) Failure to consider or acknowledge potential allegiance and decline effects

(19) Failure to consider differential credibility checks across treatment groups;
    failure to consider the role of non-specific factors, such as the therapeutic alliance