EVOLUTION OF PSYCHOTHERAPY CONFERENCE, DEC. 2017

DON MEICHENBAUM’S PRESENTATIONS: SCHEDULE, OUTLINES AND HANDOUTS

I am scheduled to give eight presentations: (One Workshop, Two debates, One Clinical Demonstration, One Conversation Hour, and Panel and Discussion Presentations)

For additional Resources by Don Meichenbaum, please visit:

www.roadmaptoresilience.com

and

www.melissainstitute.org

On the Melissa Institute Website:

1. On The Home Page Click Resources Top Right
2. Scroll down to Author Index
3. Scroll to Meichenbaum and open papers

Finally, I am not a fan of Power Points. I have included in this File various presentation outlines and accompanying Handouts.

FOR FUTURE CONTACT, YOU CAN EMAIL ME AT dhmeich@aol.com
1. WEDNESDAY DEC. 13 3:20-6:20

Workshop Title “TREATMENT OF PATIENTS WITH SUBSTANCE ABUSE AND CO-OCCURRING PSYCHIATRIC DISORDERS: A CONSTRUCTIVE NARRATIVE APPROACH” (pp. 6-62)

PRESENTATION OUTLINE

a. Background Work.
b. Incidence and impact of co-occurring disorders.
c. The nature of the challenge: “State of the Art.”
d. Phase-oriented Integrative Treatment Approach
e. Case Conceptualization Model of Risk and protective factors.
f. A Constructive Narrative Perspective of Addictions; Role of “redemptive stories”
g. Treatment Options
h. How to implement integrative treatment and the Core tasks of treatment.
i. How to increase the likelihood of achieving “lasting changes.”
j. How to choose Residential Treatment Centers.

2. THURSDAY DEC. 14 8:30-10:30

Debate with Dr. Bessel van der Kolk

“THE NEUROBIOLOGY AND PSYCHOSOCIAL CORRELATES OF TRAUMA AND RESILIENCE: IMPLICATIONS FOR TREATMENT” (pp. 63-154)

PRESENTATION OUTLINE

a. Background Work.
c. What distinguishes RESILIENT individuals (75%) versus the 25% who develop PTSD and chronic disabilities.
d. A Constructive Narrative Perspective: We are all “Homo Narrans” or “story tellers.”
e. The neurobiology of trauma and resilience: Treatment implications.
f. Ways to bolster resilience (See www.roadmaptoresilience.com).
3. THURSDAY DEC. 14 10:15-10:45

Clinical Case Presentation (Video)
Discussant Bill O’Hanlon

“TREATMENT OF A SUICIDAL PATIENT WITH A LONG HISTORY OF VICTIMIZATION” (155-159)

PRESENTATION OUTLINE

a. Background work with suicidal patients.
b. Video Presentation.
c. Ways to cope with your patient’s suicide.
d. Discussant’s comments.

4. THURSDAY DEC. 14 2:15-3:45
Debate with Dr. Stephen Gilligan

“COGNITIVE VERSUS EXPERIENTIAL EMPHASIS IN PSYCHOTHERAPY” (pp. 160-232)

PRESENTATION OUTLINE

b. The role of Emotion in Cognitive behavior therapy.
c. Two Case Examples:

   Treatment of Individuals with Prolong and Complicated Grief and Traumatic Bereavement

   Treatment of Victims of Human Trafficking

d. A Search for Mechanisms of behavior change: The role of “story-telling”.
5. FRIDAY DEC. 15 8:00-9:00
   Discussion Hour with Scott Miller and Jeff Zeig

   TRAINING PSYCHOTHERAPISTS (pp. 233-237)

   PRESENTATION OUTLINE

   a. “How to spot HYPE and pseudo-scientific HOGWASH in the field of
      psychotherapy: A Consumer’s Checklist”.

6. FRIDAY DEC. 15 9:20-10:20

   Invited Address

   “WHY SOME PSYCHOTHERAPISTS ARE MORE EFFECTIVE” (pp. 238-279)

   PRESENTATION OUTLINE

   a. The “State of the Art” of Psychotherapy.
   c. The Core Tasks of Psychotherapy.
   d. How to achieve “lasting changes”.

7. FRIDAY DEC. 15 10:40-11:40

   Discussion Hour

   “EVOLUTION OF COGNITIVE BEHAVIOR THERAPY: ORIGINS, WHERE
   HAVE WE BEEN, WHERE ARE WE NOW, AND WHAT IS IN THE FUTURE?”
   (pp. 280-287)

   PRESENTATION OUTLINE

   a. Origins: The “untold” story of how Cognitive behavior therapy (CBT) emerged,
      “Interesting battles”.
   b. How CBT changed its Theoretical basis?
   c. The current “state of the art” of CBT: A critical appraisal.
   d. The future of psychotherapy, including CBT, using computer technology.
8. FRIDAY DEC. 15 2:30-3:30

Panel Discussion

“THE ROLE OF THE THERAPIST” (pp. 288-326)

PRESENTATION OUTLINE

a. “How to bolster resilience in psychotherapists: How to help the helpers”.
b. Individual, social and organizational interventions.
1. WEDNESDAY DEC. 13 3:20-6:20

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i. How to increase the likelihood of achieving “lasting changes.”
j. How to choose Residential Treatment Centers.

LIST OF HANDOUTS

1. Description of Phase-oriented Integrative Treatment Approach (pp. 8)
2. Generic Case Conceptualization Model (pp. 11)
3. Assessment Questions/Mindset-Self Talk/ and Patient Worksheets (pp. 13)
4. 12 Step AA Programs Checklist (pp. 46)
5. Treatment Recovery Checklist (pp. 52)
6. Consumer Guidelines for Choosing a Residential Treatment Center (RTC) (pp. 57)
7. References (pp. 61)
INTEGRATED TREATMENT OF PATIENTS WITH PTSD AND SUBSTANCE ABUSE DISORDERS

Donald Meichenbaum, Ph.D.

www.melissainstitute.org
www.roadmaptoresilience.com

1. Assessment Questions, Mindset/Self Talk and Patient Worksheets

2. Change talk examples

3. 12 Step AA Program Checklist

4. Post Treatment Recovery Strategies Checklist

5. Consumer's Guidelines for Choosing a Residential Treatment Center

6. References

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PHASE-ORIENTED INTEGRATIVE TREATMENT APPROACH

INITIAL PHASE

1. Develop, maintain and monitor therapeutic alliance. Use session-by-session Feedback-Informed Treatment and similar patient feedback measures.

2. Conduct Initial Assessment and conduct ongoing assessments
   a. Polysubstance abuse
   b. Comorbidity assessment from a life-span perspective
   c. Risk assessments toward self and others
   d. Assess for evidence of strengths and signs of resilience
   e. Assess from a Constructive Narrative Perspective: “Addictive and Redemptive Stories”, and Reasons for noncompliance

3. Use Three Tile-Lines:
   Time Line 1 - - History of Addictive and Co-occurring Disorders and Interventions
   Time Line 2 - - “In spite of” resilient behaviors
   Time Line 3 - - Focus present and future

4. Use Case Conceptualization Model (CCM) of Risk and Protective Factors: Have the patient fill this out. Maintain Progress notes using CCM.

5. Use Motivational Interviewing: Use the “Art of Questioning,”


7. Conduct Psychoeducation
   a. Discuss the impact of the use of substances: “Addictive Trap”
   b. Discuss the role of resilience - - “plasticity”: Use language of possibility (“As yet”, “So far”) and RE Active Verbs.
c. Use CLOCK Metaphor
   i. 12 o’clock - - external and internal triggers
   ii. 3 o’clock - - primary and secondary emotions
   iii. 6 o’clock - - automatic thoughts, thinking style, schemas and beliefs
   iv. 9 o’clock - - behaviors and resultant consequences

These contribute to a “Vicious Cycle.” Question “Toll, Impact, Price” patient and others pay. Consider ways to “Break the Cycle.”

d. Discuss ways in which PTSD and Substance Abuse go hand-in-hand ala Najavits.

8. Address ways Psychoeducation and Collaborative Goal-setting can be conducted on a Group basis: Use CLOCK metaphor and “Conversation Starters.”


PHASE II- SKILLS BUILDING AND CONSOLIDATION

1. Help the patient develop Intra-and Interpersonal Skills and ways to bolster resilience.
   a. Emotion self-regulation skills and “build and broaden” positive emotions.
   b. Identify Triggers and develop urge-surfing skills.
   c. Mindfulness and relaxation training.
   d. Interpersonal communication skills and social network associations.
   e. Refusal skills training
   f. Ways to bolster resilience
      (see www.roadmaptoresilience.com)

2. Incorporate Generalization Guidelines: Do not “train and hope” for transfer and maintenance.

3. Engage significant others, where indicated (e.g., Couples, Family and Peers involvement).

4. Discuss Role of 12 Step AA programs (See Checklist) and other possible programs such as SMART Recovery and Community-based supports.

5. Integrate spiritually and religiously-based interventions, where indicated.
6. Integrate skills and Treatment of Co-occurring Disorders such as PTSD.
   
a. Cloitre - - STAIR-MPE  
b. Ford - - TARGET  
c. Najavits - - SEEKING-SAFETY

Use various exposure-based interventions, Cognitive restructuring, Restorative Retelling (Gestalt “Empty Chair” Procedures).

7. Help patients develop SOBRIETY SCRIPTS and accompanying coping skills.

   PHASE III - - STEPS TOWARD DEVELOPING “LASTING CHANGES”

1. Conduct Relapse Prevention Training

2. Engage the patient in Self-attributional training (“Taking Credit”).
   
a. Use Patient Checklist  
b. Use Active Verbs that reflect meta-cognitive abilities.  
c. Put the patient in a “consultative” role: (Describe, Demonstrate, Teach, Own skills and express commitment and enumerate Reasons why and when and where to use coping skills. How to anticipate “high-risk” situations (triggers”), game plan and back-up plan.)

3. Have patient Revisit his/her Case Conceptualization and “retell” story.


   PHASE IV - - ACTIVE FOLLOW-UP PROCEDURES

1. Build in active follow-up Booster Sessions.

2. Focus on transition skills such as job skills and role responsibilities.

3. Help the patient reclaim a life worth living, and engage in meaning-making skills (“Making amends”; forgiveness skills toward self and others; altruistic behaviors (“Give to Get”), and the like.

4. Engage in Active Case Management.
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
3D. Impact

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

BOX 3: COMORBIDITY

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

BOX 4: STRESSORS

“Some of the factors (stresses) that you are currently experiencing that seem to maintain your problems are...or that seem to exacerbate (make worse) are... (Current/ecological stressors)
“And it's not only now, but this has been going on for some time, as evident by...” (Developmental stressors)
“And it's 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 were-note 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)
“And some of the services you can access are...” (Systemic resources)

BOX 7: SUMMARY OF RISK AND PROTECTIVE FACTORS

“What have I captured what you were 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 be informed by your past experience?”
“Moreover, if you achieve 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 plan. 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, 5B, 4C, 6B, etc) Maintain progress notes and share these with the patient and with other members of the treatment team.
ASSESSMENT QUESTIONS, MINDSET- SELF TALK AND PATIENT WORKSHEETS

The following illustrative list of questions are designed to help determine the patient’s reasons for seeking treatment, areas of concern that the patient and significant others have about the patient and the role that substance abuse plays.

Help Recognize the Problems

What difficulties have you had regarding drinking?
How has drinking stopped you from doing what you want?
In what ways have other people been harmed by your drinking?

Help Acknowledge Concern

What worries you about your drinking?
What do you think could happen to you?
In what ways does this concern you? Your family?

Help Generate Intention To Change

What reasons do you see for making a change?
If you succeed and it all works out, what will be different?
What things make you think you should keep on dri

Help Develop Optimism

What encourages you to think you can change?
What do you think will work for you, if you decide to change?
What is a positive example from your past of when you decided to do something differently?
How did you accomplish this goal?

This question can help bolster hope, the clinician can also use the MIRACLE QUESTION derived from Solution-focused therapy. In order to help the patient imagine what life would be like if his or her problems were solved, to nurture hope of change and to highlight the potential benefits of working for change.

“Suppose that while you are sleeping tonight and the entire house is quiet, a miracle happens. The problems that brought you here are solved. Because you are sleeping, however, you didn’t know that the miracle has happened. When you wake up tomorrow morning, what will be different that will tell you a miracle has happened, and that the problems that brought you here have been solved?”
Help Reinforce Commitment To Change

Since no one can decide for you and you are in a position to choose, let me ask:

“What do you think has to change?”
“What are you going to do?”
“How are you going to do it?”

What are some benefits of making such changes?”
“How would you like things to turn out, ideally?”
“How can I help you bring about such change?

The clinician can then add:

“Let me explain to you what I do for a living. I work with folks like yourself and I try to find out:

1. How things are in your life right now and how you would like them to be?
2. What have you tried in the past to bring about such change?
3. What has worked and what has not worked, so we can both be better informed?
4. Worked, as evident by? What were you most satisfied with that you could try again?
5. If we work together on your areas of concern, and I hope we can, how would we know if you were making progress? What would other folks in your life notice?
6. How would that make you feel? What conclusions or lessons would you draw as a result of such changes?
7. Permit me to ask, one last question. Can you foresee, envision what might get in the way of your bringing about such change?
8. Is there some way that you can learn to anticipate and plan for such possible barriers or potential obstacles?
MINDSET and SUSTAINING SELF-TALK of INDIVIDUALS with PSYCHIATRIC and SUBSTANCE ABUSE PROBLEMS

The following list provides examples of the types of “sustaining self-talk” and “self-generated narratives” that contribute and help to maintain addictive behaviors. They are summarized using the acronyms CLUBS and DEFENCES.

CLUBS

C - CONTROLLED By - Feelings of being controlled by
L - LOSS - Experiencing irrevocable loss and complicated grief
U - UNDESIREABLE - Label self and believe one is unwanted (thwarted belongingness)
B - BURDENED By - Feeling burden on others
S - SEPARATED FROM - Feeling detached, alienated from others, withdrawn and avoidant

DEFENCES

D -- DENIAL
E -- Self - EVALUATIVE Thoughts
F -- FATALISTIC Thoughts
E -- EVALUATIVE Thoughts about OTHERS
N -- NEEDS-based beliefs
C -- Illusions about CONTROL
E -- ENTITLEMENT feelings and beliefs
S -- SUBSTANCE-related STIMULATING and SATISFYING Thoughts

1. D -- DENIAL

Alcohol is legal. Everyone does it.
It is a natural substance.
This substance is not as bad as alcohol.
All my friends use.
A few (drugs, shots) won’t hurt.
Drinking (substance abuse) is a problem for some people, but not for me.
I am different from other people who use.
I can hold my X
I am not an addict, I am a social drinker.
No one will find out if I use.
I could drink and no one would ever know.
I know I should stop, but I don't want to (or need to).

2. E--Self-EVALUATIVE Thoughts

I hate myself
I'm inept (a failure, unlovable, boring, depressed, too anxious, damaged goods, broken, soiled goods, victimized).
I messed up my whole life.
I am my own worst enemy (critic, inner persecutor).
I berate myself. I loathe myself.

3. F-- FATALISTIC Thinking

I am HELPLESS.
I feel trapped, defeated
I need to punish myself. I have no other choice.
I do not deserve to be happy given what I did. I am so guilty and ashamed.
Nothing is going right in my life, I might as well use.
If I need help, then that means.....
The losses are too great.
I'll never get out of debt, I might as well get drunk.
What is the point of staying sober? It really doesn’t matter.
I am POWERLESS to stop.
I lack the will power, incapable of resisting. Too much work.
Drinking (substance abuse) has hijacked my life.
I am at the mercy of my urges.
My cravings are too strong; they make me use.
I will never be able to stop.
I am at the end of my rope.
I had one drink. Now I will never be sober.
Once a drug user, always a drug user
My life is a revolving door of treatment failures.
Nobody can help. There is no point in trying.
Everyone is going to die sometime.

I am USELESS.
I am a complete mess
Stopping won't do any good anyway.
I have wasted my entire life because of using alcohol/drugs.
I have blown it so many times, I might as well go all the way this time.
Once an alcoholic, always an alcoholic.
I worked so hard to stop and look what happened. I only got into more trouble.
I am stuck and I cannot get on with life.
I will never get out of this "vicious cycle".
4. E--EVALUATIVE Thoughts of OTHERS

This is my way of getting even (taking revenge).
My use will make her feel guilty (ashamed) for my fall.
I feel isolated (alienated, marginalized, rejected, abandoned, betrayed, manipulated, overwhelmed, taken for granted).

No one really cares if I use or not.
No one understands me.

People are untrustworthy. In order to be safe I have to use.
People who are against drugs don't really understand.

Only drug users will understand this and can be of help.
Only people who have been through what I have been through will understand my use.
I know you mean well, but you cannot be of help.

5. N--NEEDS-based Beliefs

I NEED X in order to (reduce, unwind such as take away my pain, drown my sorrows, self-medicate), take a time out, escape my bad thoughts, forget, survive.

I NEED X in order to (acquire some benefits) such as be creative, sexy, attractive, sociable.

I MUST use to have a good life. Drugs make my life worth living.

I CAN'T survive without them.

If I use X, then I will be able to improve my mood, boost my morale, endure life, take the edge off, handle my guilt, shame, loneliness.

Without X, I can't handle Y, tolerate, control, stand, cope.
Without X, I will mess up, be overwhelmed, be impotent.
Without X, my life is unbearable.
I can’t have fun or excitement if I don’t use.
I can’t fit in with others (my friends) if they use and I don’t.
Life is difficult. I need to escape for a while.

6. C--Illusions of CONTROL

I can test myself.
I can use just one more time. I am in control.
I am different from others who use.
I can stop anytime I want. I can control my use whenever I want to.
I can keep it limited this time.
I know how to handle my use.
As long as I am careful, using won’t be an issue.
I am more in control when I use.
I do not know if I control the drug or if the drug controls me.
I’ll never use again. I’ve got my problem under control.

7. E—ENTITLEMENT Thoughts: Permission-giving beliefs

I deserve X.
I cannot be happy without X.
I have quit everything else.
It is too much work to stop
Getting high is the only thing I have to look forward to.
It will be good to party tonight.
I will be able to be with all of my buddies. What will they think of me if I do not use. It is the only way to be accepted, being part of the group. It is the only form of pleasure and freedom I have.
I do not like being told what to do and not do by others. I am my own boss.
AA is for “quitters” and no one likes a quitter.
It is what everyone else does.

8. S—SUBSTANCE-related STIMULATING and SATISFYING THOUGHTS

It feels so good. I like the buzz.
I need a pick me up.
It makes me feel alive
Just the anticipation of the high is too great.
It will feel good to party tonight.
It kills the pain.
Have you ever used? If not, then don’t tell me I don’t benefit from this.
TYPES OF WORKSHEETS USED WITH SUBSTANCE ABUSE PATIENTS

(See Daley & Marlatt, 2006a,b; McCrady & Epstein 2009a,b; Meichenbaum 2009; Project Match, 1998 and SAMHSA TIPS - www.keys.samhsa.gov and T. Gorski www.cenaps.com and www.wpic.pitt.edu/accp/finds/locus.html)

SELF-RATING SCALE

HARMFUL EFFECTS WORKSHEET

FAMILY EFFECTS WORKSHEET

GOALS of TREATMENT WORKSHEET
  Goal Planning Worksheet: Domains of Recovery
  My Goal Sheet

THERAPY INTERFERING BEHAVIORS THAT CAN UNDERMINE/SABATOGE TREATMENT

STAFF ATTITUDES: MY PERSONAL VIEWS

DECISION MATRIX: PROS AND CONS OF CONTINUE USING VERSUS QUITING SUBSTANCE

POSSIBLE TRIGGERS: DRINKING AND OTHER SUBSTANCE USE
  Substance Abuse Triggers That Lead to Urges and Cravings

DAILY MONITORING WORKSHEETS

MANAGING THOUGHTS OF USING WORKSHEET AND COUNTERSTATEMENTS: ACRONYM “DEFENCES”

EMOTIONS WORKSHEET
  Steps To Emotional Wellness

SOCIAL PRESSURE WORKSHEET
  Interpersonal worksheet

RECOVERY NETWORK WORKSHEET
  Ways To Increase My Interactions With People Who Will Support My Abstinence

SELF-HELP PROGRAM WORKSHEET

RELAPSE WARNING SIGNS WORKSHEET
High-Risk Situations Worksheet
Lapse and Relapse Worksheet
Relapse Chain Worksheet: Use “Clock” Analysis

BEHAVIORAL SAFETY PLAN: RECOVERY-ORIENTED THOUGHTS
My Personal Safety Plan

PROBLEM-SOLVING WORKSHEET

MY ABSTINENCE PLAN

BALANCED LIFE-STYLE WORKSHEET: THE JOURNEY AHEAD

PLEASANT ACTIVITIES WORKSHEET

PATIENT CHECKLIST: WHAT I HAVE LEARNED AND WILL CONTINUE

PATIENT SATISFACTION MEASURE
SELF-RATING SCALE

Severity Level of My Problem
(1 = Mild, 3 = Moderate, 5 = Serious, 7 = Extremely Severe)

My Motivational Level to Quit Using Substances
(1 = Definitely Don’t Want To Quit, 3 = Some Desire To Quit, 5 = Strong Desire To Quit,
7 = Extremely Strong Desire To Quit)

My Confidence in My Ability to Stay Drug Free
(1 = Low Confidence, 3 = Some Confidence, 5 = High Confidence, 7 = Extremely High Confidence)

HARMFUL EFFECTS WORKSHEET

List of Problems Caused By My Substance Use
(Rank Order and Give Examples)

Medical/Physical Problems
Emotional/Psychological Problems
Work/School Problems
Family Problems
Recreational Problems
Legal Problems
Financial Problems

FAMILY EFFECTS WORKSHEET

List Your Family Members: How Has Your Substance Abuse Affected Each Family Member?

Spouse
Children
Siblings
Parents
Others- (Friends, Co-workers, Boss)

Indicate How Substance Abuse Has Affected Your Relationship With Each Member

1) Now for each indicate specific ways to improve these relationships
2) What might get in the way? How to anticipate and address each of these potential barriers?
3) How will you know if your efforts are working?
GOALS of TREATMENT WORKSHEET

1. Describe your primary goal for treatment at this time?

2. What form of treatment do you think would be most helpful at this time?

3. What treatment or other forms of interventions have proven most helpful in the past? What was it that made it most helpful?

4. What has proven most unhelpful in the past?

5. Describe what you hope to get out of treatment now?

GOAL PLANNING WORKSHEET

Domain of Recovery

Goal

Steps Toward Change

Domains
Physical
Emotional/Psychological
Family
Social/interpersonal
Spiritual
Other (Work, Financial)
MY GOAL SHEET

A **Goal** is something I want to get or something I want to have happen and I am willing to work for it.

My goal is:

The change(s) I want to make are:

The most important **reasons** for changing are:

The steps I plan to take are/or the **advice** I would give someone else to achieve this goal is:

How can I get started? What **small changes** can I make to begin with?

The ways other people can help me are:
**Person:** Possible ways they can help:

I will **know** if my plan is working if:

Who else would notice the change? What would he/she observe?

Some things that could **interfere** with my plan and some possible solutions are:
If my plan does not work, I will: ("I will be on the lookout for..."); “Whenever I see...I will do...”; “I will tell myself...”

What else do I have to do to increase the likelihood of achieving my goals?

a) Include reminders ("If...then" statements; “Whenever” statements)
b) Conduct a cost-benefit analysis (pros-cons, short-term, long-term benefits)
c) Share my plans with supporting others
d) Make commitment statements
e) Take credit for my efforts
f) Reinforce myself
THERAPY INTERFERING BEHAVIORS (TIBs) THAT CAN UNDERMINE/SABATOGE TREATMENT

(Obtain a History of Prior Treatment and Various Interventions)

Past TIBs (List examples such as not fully engaged or actively participating in treatment; Dropping out of treatment early; Being noncompliant; Not working my program)

Current TIBs

Identify a Current TIB and indicate your ACTION PLAN to address this, ahead of time.

STAFF ATTITUDES: MY PERSONAL VIEWS

1. The main reason my clients are addicted is because:
2. The best ways for my clients to deal with urges to drink (or cope with urges to engage in other addictive behaviors) are to:
3. In order for individuals to change their addictive behaviors they have to:
4. The goals of treatment for addictive behavior should be:
5. In order for individuals to change their addictive behavior they:
6. When my clients have multiple problems I think the best way to conduct treatment is:
7. As a result of participating in treatment, I would like my clients to tell themselves the following:
8. In order to help my clients from relapsing:
9. The best ways to help prevent the development of addictive behavior is to:

DECISION MATRIX: PROS AND CONS OF CONTINUE USING VERSUS QUITING SUBSTANCES

CONSEQUENCES

PROS and CONS: Short and Long Term

To Stop Using and Remaining Abstinent

<table>
<thead>
<tr>
<th>Immediate Consequences</th>
<th>Long-term Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>Negative</td>
</tr>
<tr>
<td>Positive</td>
<td>Negative</td>
</tr>
</tbody>
</table>

To Continue Using

<table>
<thead>
<tr>
<th>Immediate Consequences</th>
<th>Long-term Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>Negative</td>
</tr>
<tr>
<td>Positive</td>
<td>Negative</td>
</tr>
</tbody>
</table>
POSSIBLE TRIGGERS: DRINKING AND OTHER SUBSTANCE USE

Drinking Location/Settings

Drinking Times

Drinking Companions

Drinking Activities
   (What are you doing when drinking?)

Drinking Urges
   (What sets you off?)

Nature of Difficulties That Trigger Drinking
   
   Financial
   Social/Interpersonal
   Emotional/Psychological
   Family

SUBSTANCE ABUSE TRIGGERS THAT LEAD TO URGES OR CRAVINGS

(List People, Places, Events, Situations, Objects, Feelings, Thoughts, Memories, and Times of Day)

Level of Threat

(0 = No threat, 3 = Moderate Threat, 5 = Severe Threat)

<table>
<thead>
<tr>
<th>Trigger (Internal/External)</th>
<th>Rate (Level of Threat)</th>
<th>Coping Strategies</th>
</tr>
</thead>
</table>

DAILY MONITORING WORKSHEETS

Rate Intensity of Craving Daily
(Number the Days 1-31 per month)
(Rating 0 = None, 1 = Low, 3 = Moderate, 5 = Severe Craving)

Under Each Day Rate Craving

<table>
<thead>
<tr>
<th>Time of Day</th>
<th>Strength of Urge or Craving</th>
<th>Trigger</th>
<th>Type and Amount of Substance Use</th>
</tr>
</thead>
</table>
MANAGING THOUGHTS OF USING WORKSHEET

COUNTERSTATEMENTS-THOUGHTS

“DEFENCES”

D--DENIAL
E--Self- EVALUATIVE
F-- FATALISTIC
E--EVALUATE OTHERS
N-- NEEDS-based
C-- Illusions about CONTROL
E--ENTITLEMENT
S- -STIMULATING and SATISFYING

INCLUDE COUNTER THOUGHTS

Can you see the sequence of thoughts that convince you to use?

How can you challenge your addictive thoughts?

I know I am using addictive thinking when I start saying to myself…

Here is where this line of thinking will take me.

My ACTION PLAN is…
EMOTIONS WORKSHEET

Rate The Degree of Difficulty You Have In Dealing With These Feelings Without Using Substances
(0 = None, 1 = Low, 3 = Moderate, 5 = Severe)

List of Emotions

Choose Two Emotions

Some of My Calming Strategies are:

STEPS TO EMOTIONAL WELLNESS

1. Tune into Feelings
2. Name the Feeling
3. Locate the Feeling in your Body
4. Accept the Feeling
5. Letting Go (Allow feeling to melt away, dissipate or release)
6. Express the Feeling
7. Practice Containment (Hold your feelings in order to share and process them in safe place with a trusted person)
8. Check the relationship between my thoughts and feelings
   “When I say this to myself I tend to feel…”
   “What am I thinking that makes me feel this way?”
   “What is another way of thinking that could help me manage this feeling better?”
   “What can I do to recognize this feeling as soon as it occurs?”
   “How can I plan ahead to anticipate situations that are likely to trigger this feeling?”
   “Can I stay centered and in control and be aware of the rise and fall of my feelings?”
   “How do these feelings color the way I see things? Am I being ‘prejudiced’?”
9. Change my behavior in order to feel better.

   “Use my feeling management skills”
   “Take a time out before the feeling becomes unmanageable”
   “Use my relaxation/calming responses”
   “Procrastinate my self-defeating behaviors”
   “Ask for help”
   “What is another way to manage these feelings?”

SOCIAL PRESSURE WORKSHEET

Rate Degree of Difficulty You Have In Coping Successfully with Social Pressure
(0 = No Threat, 3 = Moderate Threat, 5 = Severe Threat)

<table>
<thead>
<tr>
<th>Social Pressure</th>
<th>Degree of Difficulty</th>
<th>Coping Strategies</th>
</tr>
</thead>
</table>

INTERPERSONAL WORKSHEET

1. Identify one aspect of the way you relate to others that you want to change (Be specific)

2. List several steps you can take to help you change this behavior.
RECOVERY NETWORK WORKSHEET

Identify People, Groups, Organizations that you believe can be helpful in your recovery, and the potential benefits of obtaining their assistance.

<table>
<thead>
<tr>
<th>People/Groups/Organizations</th>
<th>Potential Benefits</th>
</tr>
</thead>
</table>

What Potential Barriers Might Get in the Way of Your Accessing Their Help

<table>
<thead>
<tr>
<th>Potential Barriers</th>
<th>How To Overcome These Barriers</th>
</tr>
</thead>
</table>

ACTION PLAN

Repair Sobriety Supportive Relationships

Who are the people I have harmed by my addiction? (Make a list)

What did I do to hurt them?

What can I say and do to acknowledge/convey this hurt?

What can I do to repair the damage?

How can I make amends?

How can I prepare for possible rejection?

WAYS TO INCREASE MY INTERACTIONS WITH PEOPLE WHO WILL SUPPORT MY ABSTINENCE

Map Your Social Support Network (Provide Names) Indicate who can provide each type of support

Practical Support (Drive you, loan something you need)

Advice or Information

Companionship

Emotional Support (Share feelings encourages you)

Where do you have a lot of social supports?
Where do you have gaps in support?
What new people can you meet who do not use drugs?
How can you go about this?

Who can you support?
Who counts on you for support?
Is there someone you would like to begin supporting?

**SELF-HELP PROGRAM WORKSHEET**

1. Describe what it is like for you to ask for help and support.

2. What has been your experience with self-help programs? (Pros and cons)

3. List potential drawbacks (if any) in participating in self-help programs.

4. List potential benefits of participating in self-help groups.

5. What can you do (Action Plan) to get the most out of the self-group? What barriers might get in the way of your using a self-help group and how can these barriers be anticipated and overcome?

**RELAPSE WARNING SIGNS WORKSHEET**

<table>
<thead>
<tr>
<th>Relapse Warning Signs</th>
<th>Coping Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Feelings, Thoughts, Attitudes, Behaviors)</td>
<td></td>
</tr>
</tbody>
</table>

**HIGH-RISK SITUATIONS WORKSHEET**

<table>
<thead>
<tr>
<th>List High Risk Situation</th>
<th>Coping Strategies</th>
</tr>
</thead>
</table>
LAPSE AND RELAPSE WORKSHEET

Describe Main Reasons for Lapse

Describe Triggers (External/Internal - feelings and thoughts)

Do a Relapse Chain Analysis of Sequence that led to lapse. (*Use Clock Analysis*)

RELAPSE CHAIN WORKSHEET

Use “Clock” Analysis

<table>
<thead>
<tr>
<th>12 o’clock</th>
<th>3 o’clock</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triggers</td>
<td>Primary/Secondary</td>
</tr>
<tr>
<td>(External/Internal)</td>
<td>Feelings</td>
</tr>
<tr>
<td></td>
<td>(What did you do with all these feelings?)</td>
</tr>
<tr>
<td></td>
<td>“What thoughts or beliefs do you hold about your feelings?”</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>9 o’clock</th>
<th>6 o’clock</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Behaviors</td>
<td>a. Automatic thoughts, images, memories</td>
</tr>
<tr>
<td>“What did you do”</td>
<td>b. Thinking patterns</td>
</tr>
<tr>
<td>“What you did not do”</td>
<td>c. Core Beliefs/Values</td>
</tr>
<tr>
<td>b. Reactions from others</td>
<td></td>
</tr>
</tbody>
</table>
BEHAVIORAL SAFETY PLAN: RECOVERY-ORIENTED THOUGHTS
(Put on 3X5 Index Card)

MY PERSONAL SAFETY PLAN

- Remember my cravings will go down, like riding out a wave on the ocean.
- My positive thoughts can steer my ship over the waves of my cravings. I can learn to ride out the waves.
- I can call my sponsor (Include telephone number).
- I can call my best friend (Include telephone number).
- I can write in my journal.
- I can read from my favorite recovery book.
- I can work out and lift my weights

On the back of a 3x5 index card, come up with a saying or a prayer that gives you strength and helps you stay substance free.

Examples
“Lord help me to be the best possible person that I can be.”

“God, grant me the serenity to accept the things I cannot change, courage to change the things that I can, and the wisdom to know the difference”

PROBLEM-SOLVING WORKSHEET

Goal – Plan – Do – Check

1. Problem
2. Goal
3. Brainstorm for possible solutions (List Pros and Cons of Each Possible Solution)

<table>
<thead>
<tr>
<th>Solution</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short</td>
<td>Long</td>
<td>Short</td>
</tr>
<tr>
<td>Term</td>
<td>Term</td>
<td>Term</td>
</tr>
</tbody>
</table>

4. Pick a Solution and Generate an Action Plan
5. Check to see how it is working
6. Reevaluate
MY ABSTINENCE PLAN

Anticipate High-risk Situations
  (Generate a High-risk Hierarchy)
  How hard is each situation (0-10 Very Easy to Very Hard)

List Triggers (External/Internal)

Identify Chain of Events that Lead to Lapses
  (Consider Seemingly Irrelevant Decisions - - SIDs)

Ways to Cope with urges and cravings

Learn to Look Ahead for Trouble
  Safe Choices       Risky choices

Implement a Plan for People, Places and Situations

Plan for Handling Slips and Lapses

Plan for Not Letting Lapses Become Full-Blown Relapse
  (How Will I Get Support?)

List Alternatives to Using Substances

Possible Barriers to Doing Alternatives and Action Plan:

<table>
<thead>
<tr>
<th>ACTION PLAN</th>
<th>Difficulty Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triggers Plan</td>
<td>+/- Consequences</td>
</tr>
<tr>
<td></td>
<td>(1-10)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short Term</td>
<td>Short Term</td>
</tr>
<tr>
<td>Long Term</td>
<td>Long Term</td>
</tr>
</tbody>
</table>
BALANCED LIFE-STYLE WORKSHEET: THE JOURNEY AHEAD

SHOULDs LIST

Consider List in Various Areas of Your Life: Indicate “Wants” and “Shoulds”

Physical
Emotional/Psychological
Family
Social Relations
Work/School
Financial

OUT-OF-BALANCE AREA

MY CHANGE PLAN

POSSIBLE BARRIERS and GAME PLAN

PLEASANT ACTIVITIES WORKSHEET

Current Pleasant Activities

New Pleasant Activities

Action Plan to Increase Pleasant Activities

Possible Barriers And Game Plan

CREATE A WEEKLY SCHEDULE WORKSHEET AND INCLUDE PLEASANT ACTIVITIES (“WANTS”)
PATIENT CHECKLIST: WHAT I HAVE LEARNED AND WILL CONTINUE

As a result of participating in treatment, I have learned to do the following activities/skills: (Please give examples of each and then indicate the reasons why doing each activity is important and how it will help you achieve your goals). How confident are you, from 0% confidence to 100% confidence, that you can implement each of these activities? What barriers are you likely to encounter and how can you address these as they arise?

___ 1. Be on the lookout for triggers and setting events (people, places and things) such as the use of drugs or having urges/cravings that set me off. Bring these triggers into my awareness. (Give examples of such triggers).

___ 2. Notice warning signs of when I am getting upset. (For example, “I am becoming upset, angry, depressed, anxious, bored”), as evident by ...

___ 3. Conduct my “Clock Analysis in order to see the connections between my feelings, thoughts and behaviors.
   12 o’clock - - external and internal triggers
   3 o’clock - - primary and secondary emotions and urges and cravings
   6 o’clock - - automatic thoughts/images, thinking patterns underlying beliefs
   9 o’clock - - behavioral acts (what I do) and how others respond

___ 4. Take action to break my “Vicious Cycle” (Use my Clock analysis)

___ 5. Monitor my moods and accompanying thoughts. Keep my journal and check it regularly. Modify my beliefs that fuel my craving and behavior. Look at my Coping Flashcards as reminders of what I have to do differently.

___ 6. Reduce risk factors and make sure I spend my time in “safe” places with “safe” people. Work to keep myself out of trouble and away from temptations. Safeguard my environment so it is “unfriendly to trouble”.

___ 7. Remind myself why it is important to stay “safe” and free of trouble. Think about the consequences to me and others for my actions. Conduct a cost-benefit analysis of pros and cons, short-term and long-term (2x2 analysis). “Think through the drink” and consider consequences for myself and those I care for.

___ 8. Take responsibility for the choices I make. Recognize that the responsibility to change is clearly mine.

___ 9. Be able to “notice”, “catch”, “interrupt”, “anticipate/plan for”, “set positive/prosocial goals”, “reward myself”, “tell others/show others what I have learned”, and “take credit for changes I have made”.
10. Ask for help from “safe people” (family, friends, training team members) who will help me achieve my treatment goals. Make “healthy decisions” and develop meaningful relationships.

11. Develop and expand AA sober support network. Socialize with recovery people.

12. Learn how to have fun without substance abuse. Pursue hobbies, volunteer.

13. Give up resentments and choose to forgive others, as well as myself.

14. Implement my Safety Plan which includes the following specific steps (spell these out).

15. Anticipate the possible barriers and potential obstacles that might get in the way of doing my Safety Plan. Have a Game Plan in place to address each of these potential barriers/obstacles.

16. Create an “If...then” and “Whenever ...if” backup Safety Plan.

17. Use my Coping Cards as reminders to “jump start” my healthy thinking and Safety Plans.

18. Avoid high-risk situations and activities (people, places and things).

19. Challenge, test out and change my thoughts and thinking processes. Change what I tell myself and change my “internal debate”.

20. Catch myself when I am being demanding and impatient with others. Lengthen my fuse and learn how to “think before I act”. Increase my frustration tolerance. Reduce my “musts” and “shoulds”.

21. Accept my feelings and thoughts and learn how to “ride out” my cravings and the urge to hurt others or to hurt myself. Like an “ocean wave”, peak and then gradually come down.

22. Use my problem-solving skills. View perceived provocations, threats and disappointments as “problems-to-be-solved”, rather than as interpersonal insults and personal failures. Use my Goal-Plan-Do-Check protocol.

23. Use my self-soothing techniques so I won’t hurt others or won’t hurt myself. (Use my relaxation, mindfulness and distraction coping skills).
24. Look for the “Middle Road” and use my “I statements”, Negotiation Skills, and Cognitive Skills. For example, I can ask myself:

“What is the data and evidence to support my belief that...?”
“Are there any other explanations for what happened?”
“What does it mean if indeed...?”
“Can I ask myself the question that my trainer/counsellor would be discussing?”
“What are my goals in the situation and what are all the ways to achieve them?”
“Which alternatives are likely to keep me out of trouble?”
“Write this all down in my journal”

25. Remind myself of the reasons to do all of these activities and visit my “Hope Kit”. Remind myself of my “strengths” and “signs of resilience” and “survivor skills” that I have used in the past. Listen to the audiotape of my training sessions as a reminder.

26. Use my Future Imagery Procedures. Mentally rehearse how I can handle high-risk situations and ways to achieve my goals beforehand.

27. Cope with any lapses that may occur and view them as “learning opportunities”. These are “wake-up” calls to use my coping skills. They should awaken my curiosity so I can play detective/scientist and use my problem-solving skills. Use my Clock analysis to figure out what went wrong. (Give examples).


29. Make a “gift” of what I have learned and share it with others.

30. Take pride in what I have been able to achieve, “in spite of” possible temptations, social pressure, conflict with others and upsetting feelings (boredom, loneliness, humiliation, guilt, shame, anger). Take credit for changes I am bringing about. Build my self-confidence.

31. Recognize that I am on a “journey”, but not alone in creating a “Life that is worth Living”. Structure my daily activities with meaningful activities. Live up to my behavioral contract that I made with others and with myself. Remember that being a “person” is keeping your word and being a model for others. Maintain hope and demonstrate the “courage to change” and create a “positive lifestyle”. I have learned “to keep on keeping on.”

32. These are some things I learned from my treatment that I can use. In addition, I can also ______________.
33. Treatment tips that I would be willing to try: ______________________________

PATIENT SATISFACTION MEASURE

To what extent were the following aspects of treatment helpful? Rate each item below on the following scale.

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>A Little</td>
<td>Moderately</td>
<td>Very</td>
</tr>
<tr>
<td></td>
<td>Helpful</td>
<td>Helpful</td>
<td>Helpful</td>
<td>Helpful</td>
</tr>
</tbody>
</table>

List Treatment Features

1. Group Meetings
2. Individual Counselling Sessions
3. Etc.
CHANGE TALK

As a result of participating in treatment, the clients should begin to incorporate the following “language of change” into their narrative or “stories” and learn to use these phrases in an unprompted fashion. The clients should be able to employ the terminology of relapse prevention and offer multiple examples of each of these coping actions. They should be able to operate in a consultative mode being able to explain, teach and demonstrate these activities to others, and moreover, offer self-generated reasons why doing each of these activities is important to his/her recovery. As a result of treatment, the client should be able to indicate that “I can now...”

IDENTIFY TRIGGERS

Analyze “near miss” episodes, so I can learn from them
Catch myself before I fall off the wagon
Identify high-risk situations ahead of time
Increase awareness of unseen problems
Pinpoint triggers, tell tale signs, watch out for warning signs
Recognize when I am time-sliding back
See how I stir up my feelings and frequently fuel my feelings
Stay alert to my personal needs and people, places and things that put me at risk of using again
Troubleshoot events ahead of time
Turn off the CD in my head that leads to drinking (substance abuse)
Watch out for what activates my “hibernating” (dormant) beliefs that lead to my drug use

COPE MORE EFFECTIVELY

Avoid getting blind-sided
Avoid putting myself at risk
Avoid tunnel vision
Catch myself using “musts”, “shoulds”, “always”, “never”
Change my moods without using drugs
Change who I spend time with. Increase my association with non-substance abusing buddies.
Structure my daily activities
Check my 2 X 2 Grid of the pros and cons of using and not using drugs
Check my coping cards that I keep in my wallet/purse
Check out my beliefs
Come to grips with my emotions
Conduct a behavior chain analysis
Go for hugs, not drugs
Increase my tolerance for others
Increase ways to get positive “healthy” reinforcers or “perks” in my life
Maintain hope
Perform personal experiments
Plan ahead
Refocus on what is really important in my life
Rein in my feelings  
Remind myself of what “**I have**”, what “**I can do**” and “**Who I am**”, besides someone who has been a drug user.  
Seek help when I need it  
Start using my coping plans and back-up plans if I need them.  
Stop being my own worse critic  
Stop “catastrophizing”  
Stop deluding myself  
Stop giving myself a “snow job”  
Stop my self-defeating behaviors  
Stop putting myself down all the time  
Stop sabotaging my treatment plan  
Stop setting myself up for failure  
Take pride in what I have accomplished  
Teach (explain, demonstrate) what I have learned in treatment to others and offer reasons why I now do these things  
Use my Clock Analysis (**12 o’clock- internal and external triggers; 3 o’clock – primary and secondary emotions; 6 o’clock – thinking processes and beliefs; 9 o’clock – behavior and consequences**)  
Use my game plan and back up strategies to cope with my urges and cravings

The clients should be encouraged to offer **commitment statements** of specific ways (how, where, when) they will engage in each of these activities, **in spite of** barriers, pressures, obstacles to perform, and most importantly, they should be encouraged/challenged to provide the **reasons why** engaging in such behaviors are important to achieving their treatment goals.

A sign of the clients’ commitment statement is the desire to which their accounts (“stories”) include examples of **change talk verbs**. Consider the following list of verbs that reflect self-efficacy.
EXAMPLES OF “CHANGE TALK”: VERBS THAT REFLECT SELF-EFFICACY

A’s
ABSOLVE
ACCEPT
ACCESS
ACHIEVE
ACKNOWLEDGE
ACQUIRE
ACTIVATE
ADAPT
ADDRESS

B’s
BALANCE
BE AUTHENTIC
BECOME
BEFRIEND
BEGIN

C’s
CATCH IT
CAPACITY TO
CLARIFY
CLEANSE
CHALLENGE
CHANGE it
CHECK IT OUT
CHOOSE
CO-BUILT

D’s
DAMPEN
DECATASTROPHIZE
DECONDITION
DEEP insight into
DEFEND
DEFER judgement
DEMYSTIFY

E’s
EDIT
ELICIT
EMPOWER
EMBARK
EMPATHIZE
ENABLE

ADOPT
AFFECT
AFFIRM
ALIGN
ALEVIATE
ALLOW
ANEW
ANTICIPATE
APOLOGIZE

BE PRESENT
BLEND
BLINF SPOT
BOSS PTSD
BRAINSTORM

COLLABORATE
COME to terms with
CONCENTRATE
COMFORT zone
COMMITT to
CONCENTRATE
CONDUCT
CONFIDENT
CONFRONT

DESTRESS
DEVELOP ability to
DEVELOP X e.g. “coherent
narrative”, “Trust between
you and the healing process”
DIFFERENTIATE
DIGEST memories

ENLIST
ENSURE
ENVISION

APPLY
APPRECIATE
ARMED WITH
ASSERT
ASSURE
ATTAIN
ATTEST
AVOID

BREAK THROUGH
BREAKAWAY FROM
BRING
BUILD
BYPASS

CONSTRUCT
CONTAIN
CONTRAST
CONTROL
CONSULT
COPE with
CREATE a safe haven
CULTIVATE
CURIOUS about

DIRECT towards
DISENGAGE from
DISCUSS
DISUADE
DISPLAY
DRAW upon

ESTABLISH and maintain
EVOKE
EVOLVE
EXAMINE
EXERCISE
EXPRESS
<table>
<thead>
<tr>
<th>F's</th>
<th>FACE</th>
<th>FILTER out</th>
<th>FOCUS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FACILITATE</td>
<td>FIND peace, meaning, a lifetime alliance</td>
<td>FORGE</td>
</tr>
<tr>
<td></td>
<td>FEEL CENTERED</td>
<td>FINE TUNE</td>
<td>FORGIVE</td>
</tr>
<tr>
<td></td>
<td>FIGHT</td>
<td>FINISH the unfinished business</td>
<td>FORESEE</td>
</tr>
<tr>
<td></td>
<td>FIGURE out</td>
<td>FIX</td>
<td>FOSTER</td>
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<td></td>
<td></td>
<td>FLEE</td>
<td>FULFIL</td>
</tr>
<tr>
<td>G's</td>
<td>GALVANIZE</td>
<td>GET unstuck</td>
<td>GROW towards</td>
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<tr>
<td></td>
<td>GARNER</td>
<td>GO FORWARD</td>
<td>GUIDE</td>
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<tr>
<td></td>
<td>GENERALIZE</td>
<td>GONE AWRY</td>
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<td></td>
<td>GET BEYOND</td>
<td>GRAPPLE with</td>
<td></td>
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<tr>
<td>H's</td>
<td>HARM avoidance</td>
<td>HAVE corrective emotional experiences</td>
<td>HELP</td>
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<tr>
<td></td>
<td>HARNESS</td>
<td>HONOR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HARVEST full potential</td>
<td>HEAL</td>
<td>HOMEWORK</td>
</tr>
<tr>
<td>I's</td>
<td>IDENTIFY high risk situations, warning signs</td>
<td>INCORPORATE</td>
<td>INTRODUCE</td>
</tr>
<tr>
<td></td>
<td>IMPROVE</td>
<td>INVEST in</td>
<td></td>
</tr>
<tr>
<td></td>
<td>INCREASE capacity to improve situations, warning signs</td>
<td>INTEGRATE</td>
<td>INVITE</td>
</tr>
<tr>
<td>J's</td>
<td>JUMPSTART</td>
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(See Pages 127-129 and Pages 136 -137 in Meichenbaum's Roadmap to resilience book for further examples of how to use RE Verbs and Active verbs)

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<th>W’s</th>
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| Y”S     | YEARN FOR          |                    |                   |
12 STEP AA PROGRAM CHECKLIST

Donald Meichenbaum, Ph.D.

Alcohol Anonymous, (AA) is an International Program with 114,000 AA groups and a total of 1.9 million members who attend yearly. Since many Treatment Centers have adopted the AA sober support recovery program. There is a need for all therapists to be familiar with their 12 Step Program and their language and treatment culture. The following examples of 12 Step Activities can be blended with various cognitive-behavioral treatment approaches. (See Knack, 2008)

The therapist can use the following Checklist of AA Activities and accompanying AA Beliefs with clients. The therapist can ask clients to fill in the Checklist and discuss their answers to:

a. assess what AA activities clients have already engaged in and what AA beliefs they have embraced;
b. assess the reasons why clients have or have not engaged in these activities (possible barriers, lack of motivation, confidence, skills, opportunities) and how these obstacles can be addressed;
c. engage would-be participants to join AA and treatment, highlighting what new members may get out of some form of participation.

AA BEHAVIORS

How many of the following behaviors do you presently practice? Please put a check mark next to each behavior that you now do as a result of participating in the 12 Step AA Program.

_____ 1. Attend AA meetings (Beginner’s meeting, Big Book meetings, 12 Step meetings). How often per week? _____________________________________________________

_____ 2. I still attend AA meetings even though I have been sober.

_____ 3. Identify with presenters, but not compare myself to them. I recognize that the road one person takes to AA can be very different than another. Now, I do not feel so alone and different any more. I learn to listen for similarities than differences.

_____ 4. In AA there are many helpful tools such as meetings, 12 Steps, 12 Traditions, Slogans, the Big Book, learning from “Old Timers”, Having a sponsor, Being a sponsor. The parts of the AA program that help me the most are: __________________________________________

_____ 5. I work my program. I work toward progress, not toward perfection.
6. Be open, honest and helpful to others. As the saying goes, “To keep it, you have to give it away”. This is all about helping others by speaking and sharing at meetings, lend a listening ear. “Our spirit slowly starts coming back to life by dealing with honesty and tearing down barriers”. (H.O.W. Honest, Open and Willing)

7. Tell my story of “What it was like to be dependent on alcohol, what happened and what it feels like now”. The story I most want to talk about is about my recovery, namely, my pursuit of happiness, enjoyment, contentment and “how comfortable I am in my own skin”. I have a story to share of how I got to this point.

8. I am not into producing a drunk-a-log, rather we talk about solutions. The more we focus on the problem, the bigger the problem becomes. The more we focus on the solution, the solutions get bigger. I call upon my “Magic Magnifying Mind” when it comes to solutions

9. Surrender to a Higher Power (namely, a Spiritual Force, God, the power of my Group and the support of my sponsor.) Thus, I can regain control. I recognize that the Higher Power I choose may be different than the Power others choose.

10. Get a sponsor, a home group, get involved and begin working the Steps with the guidance of my Sponsor. My sponsor helped explain the 12 Traditions, Slogans and was there when I needed him/her.

11. Call my sponsor daily, or call another member or a sober person.

12. Increase my awareness and watch out for triggers. (Social pressure, interpersonal conflict, strong emotions such as anger, resentment, depression, loneliness, boredom).


14. Look at my beliefs (e.g., a sense of entitlement, viewing people as doing things to me “on purpose”) and see how these beliefs can contribute to my addictive behavior.

15. Recognize that trust does not come overnight. It has to be earned.

16. Learned to listen and then listen to learn.

17. Put my experiences into words and share my thoughts and feelings with my sponsor and with trusting others. As a result, I am building self-confidence and developing sound bonding skills.

18. Cut down on my self-criticism and perfectionism. I can learn to forgive myself.

19. Use my coping behaviors to manage threats to my self-esteem (pride, “ego”). Remember it will take time to learn to use my coping skills. Have faith “Faith can help move mountains, but you better bring along a shovel. You have to do the work”. 
20. I am learning to be comfortable with myself and I feel gratitude each day that I am sober.

21. Ride out and procrastinate (delay) my cravings and desire to use substances.

22. Before I take a drink (use substances), I can look at where my drinking has led me in the past and where it will lead me in the future. Never forget how far you have come.

23. Remember that one of the best tools to cope is the telephone. Call my sponsor or friend in the program to help me deal with my cravings and difficult times.

24. Think through the drink. Consider the consequences of my drinking. I follow the AA slogan Think…Think…Think.

25. Hang around with sober non-drinking buddies and family members. Firmly connect with a sober support network, especially at the beginning of the recovery journey. Stay around positive people, places and things to improve my safety. Right Fellowship.

26. Do a Moral Inventory on a regular basis. I check to see if I am treating people with kindness and respect and make sure that any defects that I have do not rear their head.

27. Make amends. Make a list of all the people that I have had a negative impact as a result of my drinking and begin making amends. I remember that a person does not have to accept my apology, but I have to give one in order to clear up some of the “wreckage of the past”.

28. Make a Gratitude List and follow through in showing my appreciation. I remember that the word “gratitude” is an Action Verb, where I have to show (demonstrate) positive behaviors and positive attitudes. I am developing the ability to practice of acceptance of myself and others.

29. Recognize signs of change and rehabilitation and “take credit” for this change. Use my “change talk” of “notice, catch, interrupt, game plan, backup plan, safety plan”. Recognize the benefits of the changes I have made. Continue my healing journey.

30. I recognize that the only requirement for AA membership is a desire to stop drinking.

31. My detailed safety plan includes: Being aware of what are my triggers; Knowing the “warning signs”; Having the telephone number of my sponsor on hand who I can call; Avoiding high-risk people, places and things; Sharing my Safety Plan with others; Making commitment statements, not only to others, but also to myself.

32. Keep coming back. Be there for the new folks coming through the door. By helping others, we are helped ourselves.
33. Share my journey of recovery with others. Make a “gift” of my experiences with others. I can sponsor others.

**AA BELIEFS**

Please put a check mark next to each belief or self-statement that you now hold, as a result of participating in the 12 Step AA program.

**I NOW BELIEVE THAT**

**Thinking Behaviors**

34. Addiction is 90% thinking and 10% drinking. “Stinking thinking is something I have to avoid”. “You can get mentally drunk, before you become physically drunk”. (Some say, 99% thinking and 1% drinking).

35. I can look at and begin to change my beliefs that contribute to my drinking (for example, my sense of entitlement and the “shoulds”, “musts”, and “wants” in my life).

36. I believe that we can learn to put alcoholism “to sleep”, but we can wake it up if I stop taking my AA medication.

37. I can be “right-sized” - - not have to be too perfect, nor “better than”. Comfortable with myself. Make positive changes to make life more comfortable for myself and for my loved ones.

38. Sobriety is not just “stopping drinking”; sobriety is peace of mind, contentment and happiness which comes from dealing with the wreckage of the past.

39. I can recognize that relapse is part of the illness of addiction.

40. I can tie my drinking to the trouble in my life and see the beliefs that support my addictive behaviors.

41. To be humble is not to think less of yourself, but to think of yourself less, and as a result have more of yourself to give to others.

42. I can recall my sponsor telling me, “If you want what we have, do what we do”. This stays with me.
I NOW BELIEVE THAT

Coping Behaviors

43. As the saying goes, “If you do the same thing over and over it will lead to the same results. If you want something different, then you have to begin to do something different”.

44. Alcoholic Anonymous may not open the gates of heaven, but it can surely open the gates of Hell and let you out.

45. The more you put into recovery, the more you will get out of it.

46. I believe that alcoholism is a “disease”, AA was the doctor and my working the program was my medicine.

47. I can remind myself to “take one day at a time”. “Easy does it!”, “One moment at a time”, “Yesterday is gone; tomorrow is not here yet; yet, all we have is today”. Yesterday is history, tomorrow is a mystery, and today is a gift and that is why we call it the “Present”.

48. I can remember that “This too shall pass”.

49. I can tell myself that having short-comings is a sign of being human. I can understand my vulnerabilities. I can forgive myself.

50. I can take responsibility for what I do.

51. I can consider my options. The program works if I work it, so if I work it, I am worth it. Sobriety gives us options.

I NOW BELIEVE THAT

Nurturing Hope

52. I can have HOPE. Hope deferred make the heart sick.

53. Change is possible: I do not have to continue as before. I can practice my AA principles and change will occur.

54. I can clean house. Clear away wreckage of the past.

55. Accept life on life’s terms.

56. I can see myself of value to others. Share experiences. Others can learn from me.
57. I can identify signs of resilience. I can give several examples of each of the following:
   - I can _______________
   - I have _______________
   - I am _______________

58. Other beliefs I learned include ____________________________________________
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________


POST-TREATMENT RECOVERY STRATEGIES

Don Meichenbaum, Ph.D. and Julie Myers, Psy.D.

The first months after substance abuse treatment can present challenges for the newly recovered. There are new tasks to face, new ways of relating to others, and often continued cravings for substances. But it is also a time of new awakenings, renewed purpose and hope, and learning new ways to cope with the challenges. In some respects, this period is like going on a “journey”, with multiples routes and various rates of recovery, with no one right way to cope or path to take and no one right amount of time to recovery.

People deal with these challenges in different ways. In the list below, you will find recovery strategies that others, like yourself, have used in their personal journey of recovery. This list is not meant to be a measure of how much you have recovered, but rather to reinforce the strategies you currently use and to help you discover new ways to move forward on your personal journey of sobriety.

We suggest that you look through the list and put a checkmark by the strategies that you have tried and find helpful. Then, choose some new items you would like to try, and if you find them helpful, add them to your toolbox of recovery strategies. If there are things you have found helpful that are not on this list, add them to the end of the list to share them with others!

We hope that reviewing this list will be a valuable opportunity to expand your repertoire of recovery activities and reinforce the ones you currently use. We thank you for taking the time to complete this checklist, and we wish you continued progress in your recovery.

MY RECOVERY STRATEGIES

I Can Reduce the Risk Factors That Lead to Relapse

___ 1. I recognize that substance use is driven by habits, external triggers and internal/emotional states, so I make a list of these and actively avoid those that might trigger relapse.

___ 2. I avoid high-risk situations that could lead to relapse. I limit contact with people, places and things that trigger urges, for example drinking/drugging-buddies, bars, and drug/alcohol paraphernalia.

___ 3. When I cannot avoid high-risk situations, I can have a plan in place of how I will deal with them, such as limiting time spent in the situation, having a trusted friend with me, etc. I anticipate barriers that might get in the way of my carrying out my Action and Safety Plans.

___ 4. I eliminate easy access to substances, such as deleting my drinking/drugging contacts on my phone and computer, removing all drugs/alcohol from my environment, etc.
5. I abstain from using all mind-altering substance, because I know that if I use these substances, I am at higher risk for relapse of my drug of choice.

6. I recognize that the “Seemingly Irrelevant Decisions” I might make can be the first step toward relapse. For example, agreeing to meet an old friend in a bar.

7. I limit interpersonal conflicts and strong emotional response, and I set boundaries with those who cause me stress or are unsupportive.

8. I practice my refusal skills to respond to the social pressures to use substances.

9. I engage in healthy, sober activities that are incompatible with using drugs or alcohol.

10. I keep recovery in the forefront of my mind to avoid complacency, and I try to engage in a positive “recovery activity” every day.

I Address My Urges

11. I recognize my warning signs of relapse and have a Safety/Action Plan in place to counter them. I stop the “vicious cycle” before it begins so I don’t get “blind-sided”

12. I have a list of urge-controlling techniques and refer to the list often. When I learn a new tool or strategy, I add it to my list.

13. I rate my craving intensity on a 1-10 scale and then watch the intensity rise and fall without judgment, like riding a wave. Or I allow the thought to just pass, without giving it power or too much attention since a thought is just a thought and doesn’t have to be cranked-up into an urge.

14. I track my urges in a journal to help identify their cause and remember how I handled the urge. I ask myself “What is triggering my craving?” I see these as problems-to-be solved, rather than as a command to use. I play “detective” and can have a compassionate curiosity and figure out what led to the relapse.

15. I write about my feelings, thoughts and stressors, tying them to action plans for recovery.

16. I know that I don’t have to give into immediate gratification, and I have other ways to feel good, indulge myself, or celebrate. I deserve sobriety.

17. I remind myself that I often used alcohol/drugs to avoid bad feelings, tough situations or withdrawal symptoms, and that I now have better ways to handle these without using.

I Take Care of Myself Physically

18. I try to lead a balanced life, with time for both work and play. I engage in leisure and social activities, learn new skills, spend time outdoor, help others, and engage in meaningful activities.

19. I use strategies to manage the physical triggers that affect my substance use, such as hunger, thirst, sleepiness, fatigue, stress, and pain.

20. I follow a schedule which helps make life feel both more manageable and pleasurable.

21. I get enough sleep, exercise, and good nutrition.
I eliminate or limit substances that affect my physical state. (Those who give up tobacco are shown to have better recovery progress. Caffeine can cause anxiety, which triggers use.)

I take medications that have been prescribed by my doctor and engage in alternative therapies that are helpful.

I recognize the physical signs of stress and have relaxation tools to manage them, such as slow breathing, muscle relaxation, mindfulness activities, meditation, exercise, music, etc.

I Manage My Emotions

I can label (name and tame) my intense feelings. I recognize the differences between my emotions and my thoughts and behaviors.

I can tolerate and accept uncomfortable emotions, recognizing them as normal feelings that will pass. “My negative feelings have gone away before. These too shall pass.”

I manage emotional triggers that lead to my substance use, rather than reacting to them. I use coping statements, positive self-talk, relaxation techniques, acceptance, spirituality, recite the Serenity Prayer, or other self-soothing tools.

I share my feelings with supportive others who do not judge, nor criticize me.

I recognize that the way I react to others affects how they react to me. My past may drive my reactions, but I am not a destined by my past. I am assertive but not reactive.

I Examine My Thoughts

I analyze the pros and cons of my using, and I know that the benefits of not using far outweigh the benefits of using, for myself and others, both in the short and long-term. I can remind myself of the consequences.

I pause to think before I act on my thoughts and feelings, thus leading to better outcomes. I take a “time out” when needed.

I can change my beliefs that contribute to my substance use, particularly the “should”, “musts”, “wants”, and preoccupation with “perfection”.

I use my CHANGE TALK to “notice”, “catch”, “interrupt”, “anticipate”, “plan for”, “set positive social goals”, and “tell/show others what I have learned”.

I use my Coping Cards to jump start my healthy thinking. For example, “It is normal for my body to crave alcohol/drugs since I used to use, but I can choose to resist my cravings.”

I recognize my automatic negative thoughts and challenge, test out and change these thoughts, avoiding “Thinking Traps”. I change my negative “Internal Dialogue” and the negative words I use for myself. I am less self-critical, use positive self-statements, and view perceived threats, provocations, losses and disappointments as “problems-to-be-solved”, rather than as insults and personal failures.
36. I “talk back” to the emotional part of my brain by engaging the “thinking” part of my brain. I can make better decisions when I do not let my emotions hijack my thinking.

37. I use my problem-solving skills and practice planning as a way to attain my short, mid, and long-term goals.

38. I recognize that lapses may be part of the recovery process and that a mistake or slip, should it occur, is a learning opportunity and it doesn’t mean I’m a failure. Instead, I accept the natural consequences of the slip and do not let a lapse become a relapse.

**I Reach Out to Others**

39. I create a list of people whom I can reach out to for encouragement when I am at risk of using. When I need help, I recognize who to turn to in order to get the kind of help I need: Emotional Support, Advice and Practical Support.

40. I increase my sober support network of family, friends, co-workers, and others.

41. I participate in self-help groups by attending AA meetings, NA meetings, SMART Recovery, Women for Sobriety, Secular Organizations for Sobriety, or other self-help groups.

42. I seek information and help by connecting to others via the internet (chat rooms, blogs, recovery websites, etc.), books about recovery, and inspiring movies.

43. I see my therapist, addiction counsellor, minister, or other helpful professionals.

44. I have a “sober mentor” or Twelve-step sponsor.

45. I am learning compassion and forgiveness of self and others. I am letting old resentments go.

46. I keep a Gratitude List and actively thank people in my life.

47. I remember that “Being humble is not thinking less of yourself, but thinking of yourself less.”

48. I make a GIFT of what I have learned to others and share my “story” of recovery.

49. I spend time in altruistic activities, knowing that generosity is for both the receiver and the giver.

**I Cultivate Hope and a Future Outlook**

50. I socialize with people who give me hope and encouragement.

51. I acknowledge the positive things I have gained by being sober, and I remind myself of how far I have come. I have faith in the future and remind myself that with sustained abstinence my brain will recover and my thinking processes will improve.

52. I take “credit” for the changes I have made, taking time and pause and honor my accomplishments. I recognize the personal strengths I have that are needed to sustain my recovery.

53. I take full responsibility for my recovery by taking charge of my life. I remind myself to “take one day at a time”
54. I know that I am of value, and I stop thoughts of helplessness, hopelessness, or low self-worth. I have found new direction and purpose in my life.

55. I use Future Imagery Procedures, mentally rehearsing how I can achieve my treatment goals.

56. I use my spirituality or religion to guide me.

57. I recognize that I am on a journey, but that I am not alone in creating a life that is worth living.

58. I remember that being a “responsible person” means keeping my commitments and being a model for others so that they too may have hope for the future.

59. I maintain hope and demonstrate the courage to change. I learned to “keep on keeping on.” If one method doesn’t work, try something else. The important thing is to keep working on my Recovery Plan.

60. Other coping strategies and activities I have used. Please list what else you have done so that we can share them with others. THANK YOU.
CONSUMER’S GUIDELINES FOR CHOOSING A RESIDENTIAL TREATMENT CENTER (RTC)

Donald Meichenbaum Ph.D.

I have often been asked by relatives, friends and colleagues, “How can I best choose a RTC for my loved one?” This article provides Guidelines that I encourage them to follow. Imagine what the impact would be if Directors of all TRCs would have to address these questions on a regular basis or post their answers to such Frequently Asked Questions (FAQs) on their Website?

To: Director of Treatment
From: A Concerned Parent (Spouse, Client, Employer, Referring Agency)

I am considering your Treatment Center for my family member. Before I decide on a placement, I would greatly appreciate your providing me with answers to the following questions so I can make an informed decision.

I gather that critical reviews of the treatment research literature indicate that the following factors have been found to be key predictors of outcome for clients with psychiatric and substance abuse disorders. They include:

a) the quality of the therapeutic alliance that is established and maintained between clients and treatment staff;

b) the degree of client engagement and active participation in treatment;

c) the client’s perception of improvement in training;

d) the inclusion of an active aftercare program that involves significant others (family members), supportive non-substance abusing peers and the development of a long-term Recovery Program;

e) the flexible implementation of a treatment package that incorporates regular feedback from outcome-driven results.

I would like to learn how your Treatment Center incorporates each of these treatment features. More specifically in terms of **Therapeutic Alliance**.

(1) How does your treatment program **develop** and **monitor** a therapeutic alliance with clients? How does your staff handle possibleimpasses or strains that may arise over the course of treatment?

(2) What specific client **feedback measures** about the quality of the therapeutic alliance does your staff regularly employ? For example, what specific Helping-alliance scales, client engagement/participation measures do you regularly obtain?
(3) Since **continuity of care** is so important, please share your **staff turnover data** and what you have done to address this issue?

(4) Since **client engagement** and active participation are critical to treatment outcome, what specific engagement strategies does your treatment center employ?

   a) Is your staff trained and certified in using Motivational Interviewing procedures?

   b) How does your staff engage clients in collaborative goal-setting and in developing a long-term Recovery Plan? (Could you please send me a copy of the Resident Handbook and of the Goal Sheets and Recovery Plan forms that clients are asked to fill out).

(5) What is your Treatment Center’s policy for involving family members (significant others) from the outset and keeping them informed throughout treatment? Policy toward visiting, phone call consultations, family therapy and the like).

In terms of **Assessment Issues**, I would appreciate your addressing the following questions.

(6) How **effective** has your Treatment Program been in helping clients become abstinent, or at least reducing their substance intake, and in developing a better quality of life? Please share what long-term outcome data you have collected (beyond testimonials). How do you go about collecting such follow up data on a regular basis?

(7) How do you intend to obtain **long-term data** from clients and from significant others. I would appreciate any reports on your treatment efficacy.

(8) I gather that the best assessment data in helping clients is to use ongoing outcome-driven feedback that is given to both clients and therapists in real-time. In this way both clients and therapists can adapt the treatment program in a flexible individualized fashion in order to reach agreed upon treatment goals. How does your treatment staff obtain such outcome-driven data and employ it in treatment? What specific assessment measures do your therapists employ and how is this information shared with all staff and the clients?

(9) How does your treatment team **assess** for the presence and history of **polysubstance use**, **comorbid disorders**, **risk to self and others**? How is this information incorporated into an integrated **Case Conceptualization Model** that informs treatment decision-making?

(10) How does your treatment staff assess for the “rest of the story”, namely, the client’s strengths, evidence of resilience, values, interests, talents, and how are these incorporated into the treatment plan? How does your staff explicitly nurture hope in clients, significant others, and staff?
(11) How does your staff employ a life-span perspective and assess for early victimization and trauma exposure? If such developmental events are identified, how do you incorporate this into the client’s treatment program? What specific trauma-focused interventions do you use and how do you integrate them with the treatment of substance abuse?

In terms of treatment issues I would appreciate your addressing the following questions.

(12) What is the weekly treatment schedule? Please indicate how each of these various activities have some evidence-based or empirical support for clients with comorbid disorders? How will engaging in these activities help with long-term recovery? Any evidence for this?

(13) How does your staff provide integrative (as compared to sequential or parallel) treatment approaches for clients with dual diagnosis? Has your treatment team adapted and been trained in any specific evidence-based integrative treatment procedures? Which programs?

(14) How do you ensure that your treatment staff communicate regularly and convey a similar treatment message to clients and significant others?

(15) Most importantly, when your treatment staff train clients on a variety of intrapersonal and interpersonal coping skills, how do you ensure that the staff has incorporated generalization guidelines designed to improve the likelihood of transfer and maintenance of the treatment effects? In short, what explicitly does your staff do besides “train and hope” for generalization and maintenance of treatment effects?

(16) What specific coping skills does your treatment team teach? How do you go about deciding which skills should be taught and nurtured (“tailored”) with which clients?

(17) When psychotherapies are provided, either individual, group or family, what specific approaches are used? Is this left up to the individual psychotherapist or is there one general psychotherapy approach at your Treatment Center? What is the psychotherapeutic approach and how do you evaluate its effectiveness?

(18) Given the high incidence of lapses and relapses, how does your treatment team incorporate relapse prevention training? How do you work with clients to develop and maintain a life of sobriety, a balanced life-style and a high quality of life that is drug free?

(19) How are your various treatment interventions culturally and gender sensitive? How do you incorporate the client’s cultural background, rituals and values into treatment? Do you conduct any gender-specific treatment programs? Please describe them.

(20) How do you incorporate spiritually-based interventions, such as 12 Step AA programs into your treatment program? How do you explicitly facilitate such AA programs in order to increase the likelihood that client’s will continue his or her participation, once he/she leaves the Treatment Center? Are such AA meetings on campus or off campus? How do you monitor the quality of these meetings? What percentage of the week’s activities are devoted to AA meetings?
(21) How do you incorporate psychotropic medications as part of your treatment program? How do you go about educating clients about their medication, systematically assess for possible side-effects and efficacy, and ensure that the client “takes credit” (makes self-attributions) about what the medication has allowed him/her to achieve in terms of their treatment goals? Since I raised the issue of medication, what is your Treatment Center’s policy about smoking and how do you handle clients who feel addicted to cigarettes?

(22) How does your treatment program conduct an assertive after-care program with follow up, as well as contact with recovery programs in the client’s natural environment? What specifically, do you do in the form of follow-up contracts, assessments and ongoing contacts? Moreover, are there any additional charges for such aftercare activities, or is this service included in the initial treatment fees?

(23) How do you explicitly address the needs of your staff at the individual, collegial and organizational levels in order to avoid burnout, vicarious traumatization and to ensure their professional development?

I realize that this is a long list of comprehensive questions, but I am sure you will understand my desire to make the best, most informed decision concerning our loved one. If you were in my shoes, I am certain you would want to thoughtfully address each of these areas of therapeutic alliance, assessment procedures, treatment effectiveness, and various features of the treatment program in order to make an informed decision.

Thank you for your careful consideration of each of these questions, and I look forward to meeting you and discussing a possible placement at your setting.
REFERENCES


2. THURSDAY DEC. 14 8:30-10:30

Debate with Dr. Bessel van der Kolk

“THE NEUROBIOLOGY AND PSYCHOSOCIAL CORRELATES OF TRAUMA AND RESILIENCE: IMPLICATIONS FOR TREATMENT”

PRESENTATION OUTLINE

a. Background Work.
c. What distinguishes RESILIENT individuals (75%) versus the 25% who develop PTSD and chronic disabilities.
d. A Constructive Narrative Perspective: We are all “Homo Narrans” or “story tellers.”
e. The neurobiology of trauma and resilience: Treatment implications.
f. Ways to bolster resilience (See www.roadmaptoresilience.com).

LIST OF HANDOUTS

1. Constructive Narrative Perspective on Trauma and Resilience: The Role of Cognitive and Affective Processes (pp. 64)
2. The Emerging Neurobiology of Resilience: Implications for Psychotherapeutic Interventions (pp. 99)
3. We Are The Stories We Tell: A Constructive Narrative Perspective of PTSD (pp. 113)
4. Ways To Bolster Resilience in Traumatized Clients (pp. 124)
5. Stress Inoculation Training (pp. 134)
6. Implications of TF-CBT With Children, Youth and Their Caregivers (pp. 149)
CONSTRUCTIVE NARRATIVE PERSPECTIVE ON TRAUMA AND RESILIENCE:
THE ROLE OF COGNITIVE AND AFFECTIVE PROCESSES

Don Meichenbaum, Ph.D.

Chapter included in the American Psychological Association Handbook of Trauma Psychology
In this chapter, I will discuss the following five propositions.

1) PTSD and related disorders such as post-traumatic depression, somatic reactions, dissociation, substance abuse disorders are essentially disorders of non-recovery. In the aftermath of traumatic experiences, some 75% of individuals will be impacted, but they go on to evidence resilience. People who initially evidence trauma-related reactions recover without treatment. In contrast, some 25% of victimized individuals develop persistent PTSD, co-occurring disorders and adjustment difficulties.

2) A major set of factors that distinguish these two groups of individuals is the nature of their autobiographical memories, or the “stories” they tell themselves and others.

3) Specific cognitive and mental-defeating thinking and accompanying affective hopelessness processes are predictors of the subsequent severity of PTSD, as well as predictors of responsiveness to treatment.

4) A Constructive Narrative Perspective (CNP) highlights the value of helping traumatized individuals develop “healing stories”, and accompanying coping processes. A CNP can inform resilient-oriented treatment approaches.

5) Any explanation of who develops PTSD and how they should be treated needs to incorporate the building blocks of resilience that are incompatible with the negative thinking processes that characterize individuals with persistent PTSD.
PTSD is Essentially a Disorder of Non-recovery

Most people (some 75%) who survive traumatic and victimizing experiences are impacted, but they go onto evidence resilience and do not need formal mental health interventions (Bonanno, 2004; Joseph, 2012; Reich, Zautra & Hall, 2010; Reivich & Shatte, 2002; Zoellner & Feeny, 2014). In contrast, some 25% of people exposed to traumatic events evidence persistent PTSD, co-occurring disorders and adjustment difficulties (Bonanno, Brewin et al. 2010; Friedman, Keane & Resick, 2014; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

Resilience is the normative response to experiencing traumatic and victimizing events. While traumatic experiences, either due to natural causes (disasters, illnesses), or due to intentional human design (some form of maltreatment, war, violence), or due to accidents and loss of resources, can have a profound impact, the majority of individuals are unlikely to evidence long-term psychiatric disorders and impaired social functioning. Most individuals, families and communities demonstrate the ability to “bounce back” and adapt to ongoing adversities (Meichenbaum, 2013a). In some instances, individuals are able to evidence posttraumatic growth (Calhoun & Tedeschi, 2006; Joseph & Linley, 2006; Southwick & Charney, 2012). In fact, Southwick and his colleagues (Southwick, Douglas-Palumbarc, & Pietrzak, 2014; Southwick, Litz, Charney, & Friedman, 2011; Southwick, Vythilingam, & Charney, 2005) have documented the neurobiological processes that accompany such resilient behaviors. A similar profile of resilience has been reported for children and youth who have experienced cumulative traumatic events (Masten, 2014).
The likelihood of such resilient recovery is strongest in the first three months and continues throughout the first year. After three months the slope of recovery tends to flatten. In contrast, approximately one quarter to one third of trauma exposed individuals do not recover with time (Brewin, Andrews & Valentine, 2000). The development of methods to reliably distinguish these, are critical to the understanding of PTSD and ways to conduct treatment.

**The Search for Distinguishing Factors**

Several meta-analytic studies have been conducted designed to determine the role of pre-trauma vulnerability, trauma-related and post-trauma factors in predicting the severity of subsequent PTSD (Brewin et al., 2000; Friedman et al., 2014; Masten, 2014). Pre-trauma factors have included prior trauma history, poor prior adjustment and psychopathology in the individual and family, and lower levels of SES and lower education, lower IQ and female gender.

One class of pre-trauma factors that has proven most predictive of the subsequent severity and chronicity of PTSD symptomatology is the cumulative exposure to different types of victimizing experiences, or what Kolassa et al. (2010) call the “building block effect.” A strong dose response of current and lifetime successive traumatization experiences correlates with the likelihood of the development and maintenance of PTSD and with the degree of symptom severity (Perkonigg et al. 2005). But overall, pre-trauma factors account for only a small amount of variance in predicting who does or does not develop PTSD (Bonanno et al., 2010; Friedman et al., 2014; Zoellner & Feeny, 2014).

Trauma-related factors have included the severity, duration and proximity of the traumatic events, perceived life threat, peritraumatic responses in terms of dissociative responses and hyperarousal reactions (Bryant, 2014; Hobfoll, 2002). Post-trauma factors have focused on
the perceived social support, degree of resources that were lost, and post-event hardiness (sense of control and mastery, commitment and perceived challenge). The lack of social support predicts PTSD better than prior history of trauma experiences, mental disorders and the severity of the traumatic events (Feeny, Rytwinski & Zoellner, 2014). The need to consider the impact of the loss of supportive ecological and socio-cultural resources has been highlighted by Hobfoll and de Jong (2014). For instance, they reported that in the aftermath of Hurricanes Andrew and Katrina that struck Florida and Louisiana, respectively, the best predictors were practical resource losses such as housing, employment, Insurance coverage, infra-structure and the length of time such basic needs were restored. Since no single class of factors predict PTSD, the question arises as to the mediating processes by which these various predictive factors, in concert, operate? What is the phenomenological impact of such variables as perceived life threat, or ongoing presence of psychological distress, or lack of perceived social supports? How do such experiences influence individuals’, families’ and communities’ traumatic memories and storytelling style?

PTSD is essentially a reflection of a particular set of autobiographical memories. Some traumatic or victimizing experiences have occurred and the individual has to tell a “story” about these events to someone else, and also to “the self”. We are each not only homo-sapiens, we are also “homo-narrans”, or “story-tellers.” As poignantly described by Stephen Joseph (2012, p.43):

Human beings are story-tellers. It is human nature to make meaning of our lives by organizing what happens to us into stories. We live our stories as if they were true. We tell stories to understand what happens to us and to provide us with a framework to shape new experiences. We are immersed in our stories.
A similar sentiment was offered by Kiser, Baumgardner and Dorado (2010) who observed that stories are used to organize, predict and understand the complexities of our lived experiences. Stories are for joining the past to the future. How individuals chronicle their experiences in terms of the content (“What happened?”), the affect (“How it felt?”), as well as the meaning (“Why this happened?”) will impact their reactions to traumatic and victimizing experiences. Vollmer, (2005, p. 418) observes: “Our tales are spun, but for the most part we don’t spin them, they spin us”. Stories shape memory. We don’t just tell stories, stories tell us.

As traced historically by Neimeyer and Stewart (2000), such a Constructive Narrative Perspective (CNP) has a long philosophical foundation as represented in the writings of Vico, Kant, Vaihinger, Korzybski, and found psychological representation in the writings of Bartlett, Bakhtin, Piaget, Alder, Kelly and Frankl. The cudgel of a CNP has been carried forward by Bruner (1986), Gergen (1994), Mahoney (1991), McAdams (1997, 2005), Sarbin (1986), Spence (1982) and White and Epton (1990). Each of these authors highlight that individuals actively construct templates, schemata, root metaphors, and mindsets that help them interpret the past, negotiate the present and anticipate the future. Individuals actively reconstruct the past, sculpt their memories, engage in meaning-making activities, and create workable fictions and stories that they can live by. Therapy is viewed as a co-constructivist activity that helps individuals imbue events with significance and meaning, integrating (assimilating and accommodating) their life experiences into a redemptive “healing life-story”. Lives are stories that help them organize their experiences.

The importance of such meaning-making CNP activities in the aftermath of traumatic victimizing experiences has been highlighted by a number of researchers (Courtois, 1999; Ehlers & Clark, 2000; Davis, Wortman, Lehman & Silver, 2000; Herman, 1992; Janoff-Bulman, 1992).
But what are the specific mediating features of such “story-telling” that have predictive value in
determining the severity and chronicity of PTSD versus the degree of resilience, and what are the
implications for treatment?

Cognitive and Affective Predictors of the Severity of PTSD

The stories we tell hold a powerful sway over our memories, feelings, behaviors,
identities, and they can shape our future. A number of researchers (Beck, Jacobs-Lentz et al.,
2014; Bryant, 2014; Dalgleish, 2004; Dunmore, Clark & Ehlers, 2001; Ehlers & Clark, 2000;
2006; Ehlers, Ehring & Klein, 2012; Ehring, Ehlers & Glucksman, 2008) have reported that
specific cognitive and affective processes predict the severity of subsequent PTSD, as well as
responsiveness to treatment. The following discussion summarizes the research and provides a
specific set of guidelines (or an algorithm) on what individuals need to do and not do in order to
develop persistent PTSD.

1. Dysfunctional cognitive responses and mental confusion during the acute phase of trauma
    exposure are associated with the development of Acute Stress Disorder and subsequent
    persistent PTSD. Dissociation and hyperarousal, emotional numbing, depersonalization
    and derealization at the time of the trauma have been found to be predictive of
    subsequent severity of PTSD (Bryant, 2014).

2. The use of negative catastrophic appraisals of the trauma and its aftermath contribute to
    the development and severity of PTSD. The tendency to pathologize natural
    psychological distress of intrusive and hyperarousal symptoms has a self-sustaining
    forward influence. Attempts to cope with such behavioral reactions by means of
    cognitive and behavioral avoidance and suppression or by engaging in safety behaviors,
and other maladaptive control activities (e.g., use of substances, participating in high-risk “adrenaline-rush” activities) are predictive of the severity of PTSD and feelings of hopelessness (Elhers & Clark, 2000, 2006).

3. Trauma survivors may evidence a mental defeating type of thinking, whereby their self-identity or the centrality of their autobiographical account or a “story-line” is that of being a “victim” who has little or no control over uninvited thoughts, feelings and circumstances. Making trauma central to one’s identity bodes poorly for survivors (Dunmore et al., 2001; Robinaugh & McNally, 2011).

“PTSD has stalked me for most of my adult life. The idea of PTSD, the spectre of it, has haunted me. Because I was in the military others assume I have PTSD and that fact alone has had a powerful debilitating effect on me.”

Lakoff and Johnson (1980) highlight the influence of metaphors, such as being stalked and haunted, as powerful influences in a person’s narrative. In the aftermath of experiencing traumatic events, language often proves to be inadequate in describing the perception of the event and accompanying feelings and reactions. In such circumstances, traumatized individuals use emotionally-charged metaphors to describe their experiences and its lingering impact. “I have lost a part of me. I am damaged goods.” “I am annihilated.” “I am a prisoner of the past.” “It was a psychological earthquake, a seismic event.” “My life is shattered.” “I am a pariah, a dead soul.” “I am stuck in moral quicksand.”

These metaphorical descriptions are not mere figures of speech, but rather they act as a cognitive transformative lens by which individuals perpetuate mental defeating thinking that contributes to the severity of PTSD (Joseph, 2012; Southwick & Charney, 2012).
4. Traumatic events violate fundamental pre-existing assumptions and beliefs about safety, trust, fairness, meaningfulness of life and worthiness of oneself (Janoff & Bulman, 1992; McCann & Pearlman, 1990). Such negative thoughts about one’s lack of control and the perceived unpredictability and randomness of life are risk factors for developing PTSD, anxiety disorders and contribute to reductions in the quality of life, and the accompanying disempowerment and disconnection from others (Beck et al. 2014; Herman, 1992).

5. A pervasive inflated sense of ever-present threats, an exaggerated perception of the probability of future dangerous events occurring, and the adverse effects of such events contribute to the severity and maintenance of PTSD. Such PTSD-prone individuals are frequently on the lookout for threats, even in ambiguous situations. They evidence a survival-based hypervigilance. (Brewin, Dalgleish & Joseph, 1996).

6. Following traumatic events individuals may evidence hindsight bias that contributes to attributions of inflated personal responsibility and characterological self-blame, with accompanying feelings of guilt, shame, humiliation, and moral injuries (Janoff-Bulman, 1992; Kubany, Haynes, Abueg, Brennan, & Stahura, 1996; Litz, Steenkamp & Nash, 2014) Unproductive ruminations can contribute to the development and maintenance of PTSD (Pearlman, Wortman, Feuer, Farber, & Rando, 2014). Such negative self-perceptions that one is incapable of healing and that no one will understand, nor can they be of assistance leads to a “loss spiral” that exacerbates the severity of distress (Saakvitne, Gamble, Pearlman, & Lev, 2000). Not sharing one’s “story” with others, keeping secrets and avoiding help also contribute to PTSD onset (Courtois, 1999; Courtois & Ford, 2012; Shipherd & Beck, 2005).
7. Following exposure to life-threatening traumatic events, individuals tend to have an overgeneralized memory and recall style that intensifies hopelessness and impairs problem solving. Traumatic memories tend to be fragmented, disjointed, vague and disorganized (containing gaps), primarily image-based, rather than occurring in a verbal form. They tend to be sensory-primed, emotionally-laden, and reflect an involuntary reliving of traumatic events, as if they were happening all over again (“nowness”). (Brewin, 2014; Brewin et al., 1996; Dalgleish, 2004; McNally, 2003). Ehlers and Clark (2000, 2006), in their cognitive theory of PTSD, propose that traumatic memories have poor elaboration and contextualization and lack a narrative structure that could be weaved into the fabric of one’s life story; not readily assimilated into one’s autobiographical memory. Such autobiographical traumatic memories contribute to PTSD severity, especially as expressed in re-experiencing symptoms. Inadequate encoding and processing of traumatic memories contribute to PTSD onset and severity. As van der Kolk and van der Hart 1995 (p.176) observe:

“Traumatic memories are unassimilated signs of overwhelming experiences which need to be integrated with existing mental schemas, and transformed into narrative language. It appears that in order for this to happen successfully, the traumatized person has to return to that memory often in order to complete [transform] it.”

8. Deficits in retrieving specific positive memories and the avoidance of seeing anything positive that could have occurred as a result of the traumatic events are predictive of the severity of subsequent PTSD (Brewin, 2014). A number of researchers have reported that
the presence of benefit-finding positive emotions and accompanying emotion-regulation skills (for example, altruism - making a gift of one’s experiences; forgiveness and gratitude exercises, self-soothing mindfulness and mentalizing activities) bolster resilience (Allen, Fonagy & Bateman, 2008; Folkman & Moskowitz, 2000; Fredrickson, 2011; Helgeson, Reynolds & Tomich, 2006; Tugade & Fredrickson, 2004). Nolen-Hoeksema and Davis (2004) observe that following any imaginable trauma, approximately 50% of those most directly affected report at least one positive benefit or life change that they link directly to their traumatic experience. The absence of engaging in such benefit-finding activities increases the likelihood of developing PTSD.

9. The use of some form of spirituality or religion is the major way that individuals in North America cope with traumatic events. Pargament and Cummings (2010) have reported that when individual’s view the experience of traumatic events as a sign of God’s punishment, or abandonment, accompanied by feelings of anger, they undermine resilience and contribute to self-sustaining PTSD. Moreover, when survivors relinquish control to a Higher Power or plead and await a form of miracle religious intervention, such coping strategies also exacerbate an individuals’ level of psychological distress. The loss of meaning and faith contribute to changes in self-identity. The experience of an ongoing “spiritual struggle” and the accompanying failure to use one’s faith as a means of coping contributes to the severity and duration of PTSD. The loss of what is called a “moral compass” and the belief that one is “soul dead” are features of a story-line that exacerbate distress (Litz et al., 2014; Steenkamp et al., 2011; Tick, 2007). On the other hand, as Meichenbaum (2008, 2013a) and Pargament and Cummings (2010) highlight being anchored to one’s faith and religion can act as a resilience factor.
In summary, these studies underscore the predictive power of negative cognitions that set the stage for subsequent PTSD, depression and the radiating effects on the quality of life. The degree of such negative cognitions correlate significantly with PTSD severity, even 6 to 12 months after traumatic events. Such a repetitive entrenched thinking style, mind set, or story-telling style have been found to be predictive of responsiveness to treatment. For example, there is evidence that individuals who engage in thinking styles characterized by mental defeating and hopelessness do worse in cognitive behavior therapy (Ehlers et al., 1998). The significance of the present narrative account of PTSD is further illustrated by Foa, Molner and Cashman (1995), who reported on treatment outcome studies with rape victims who received prolonged exposure-based interventions. They found that an analysis of the first and last sessions differed in the level of the client’s organized, coherent thought patterns and narratives with an accompanying expression of more positive feelings. The improved clients' narratives evidenced a decrease in unfinished thoughts and repetitions and a greater sense of personal agency. Such narrative changes correlated with symptom improvement in the form of trauma-related anxiety. Van Minnen et al. (2002) replicated these findings of narrative changes that accompany symptom reduction. In a dynamic interactive manner symptom reduction and narrative changes mutually influenced each other.

Table 1 provides an enumeration of what individuals have to do in the cognitive, emotional, behavioral and spiritual domains in order to develop PTSD. If there is any merit to this formula, then we can consider the implications for treatment.
On a Path Toward Resilience

Resilience is a process that reflects the ability to cope and adapt in the face of ongoing adversities and the ability to “bounce back” when stressors can become overwhelming (Meichenbaum, 2013a). It is important to keep in mind that resilience and post-trauma distress can co-exist. Moreover, individuals may be resilient in one domain, but not in other domains or at one time in their lives and not at other times. Resilience and the accompanying story-telling are fluid processes, as noted by Angus and McLeod (2004), Hickling (2012), Joseph (2012), Mair (1990), McMillen (1999), Meichenbaum (2013a) and Southwick and Charney (2012).

In contrast to the negative PTSD-engendering thinking patterns characterized in Table 1, individuals who evidence resilience tend to be more psychologically agile and flexible in how they tell their trauma stories and the accompanying account of the aftermath to others and to themselves. They are able to reframe, redefine, reauthor trauma narratives, and reclaim and reaffirm their self-identities. They are more likely to include in their trauma narratives what they did to cope and survive. They can share how they learned to regulate intense negative emotions (fear, guilt, shame, anger). In their story-telling they are more likely to include the “rest of their story” and what and how they have been able to accomplish goals “in spite of” experiencing traumatic events. They make reference to positive emotions, including the use of humor. Such narrative accounts have redemptive sequences in which bad traumatic events have good outcomes, as compared to contamination sequences where the reverse happens. They often comment on their sacrifices that they now believe were worth making and their desire to complete the “unfinished business”, and not let down others (like their buddies). Benefit-finding, or seeing the “silver lining”, characterizes resilient individuals’ narrative accounts that bolster realistic optimism and reflect accompanying “grit” (courage, dogged persistence, perseverance
and passion to pursue long-term goals). Resilient individuals often engage in meaning-making activities and undertake a survivor’s mission.

Resilient individuals’ accounts are more coherent with a plot line that includes a beginning, middle and end. They can slow down their accounts and break various experiences into manageable segments, connecting the dots and filling in missing gaps. They can tell and retell their stories without becoming overwhelmed. Such redemptive coherent stories nurture hope and strengthen self-confidence and provide access to new solutions. They may use their faith, religion, or sense of spirituality and values as anchors in their story-telling and as guides in their coping efforts. They may actually grieve, memorialize and even engage in restorative retelling and reconnecting with the deceased (Pearlman et al., 2014). Finally, resilient individuals are able to transform their trauma story into a narrative, where these landmark events can be placed in context alongside other life experiences. Resilient individuals, often with the help of others, are able to integrate their experiences into their larger autobiographical memories and let the “past be the past.” Resilient individuals resist allowing trauma stories and accompanying images to become dominant or central in their narratives in a way that can take away their sense of identity. They can disentangle themselves from the influence and lingering impact of traumatic events. Traumatic circumstances are a landmark event in their autobiography, but not the defining feature. Many resilient individuals choose to share their stories with trusted others, making a “gift” of their lessons learned. They establish and nurture a social supportive network as they transform from being a “victim”, to a “survivor”, to becoming a “thriver.” This personal journey helps them cope with transitional stressors, viewing them as challenges, rather than as overwhelming barriers and threats.
Calhoun and Tedeschi (2006) and Meichenbaum (2006) have proposed that some resilient individuals may go onto evidence post-traumatic growth consisting of:

1. enhanced interpersonal relationships with family and friends and an increased sense of empathy and compassion for others and for themselves;
2. changed view of themselves as evident in a greater appreciation of self-efficacy, wisdom, coupled with a greater sense of vulnerabilities and limitations;
3. altered philosophy of life with a fresh appreciation for each day and a reevaluation of what really matters in life.

Table 2 summarizes the narrative features of resilient individuals. These features convey the “change talk” and “language of possibilities” that characterize resilient individuals. In my recent book, Roadmap to resilience, I include a list of authors and movies (for example, an HBO film Alive Day Memories) that document such resilient story-telling.

**Valuable Lessons To Be Learned From Working With Native Populations**

I have had the good fortune of working with Native populations, both in the U.S. and Canada, who reinforced my view that all forms of psychotherapy are a collaborative co-constructivist narrative enterprise. They also demonstrated the power of story-telling and rituals as healing activities.

There is wide heterogeneity among the 565 Federally recognized Tribal Nations and marked variability in the incidences of victimization, substance abuse, domestic violence, suicide and the like across tribes. In general, more “traditional” tribes who offer a greater sense of belongingness and support, and who have more resilient-oriented group activities have less
PTSD and accompanying comorbid disorders and adjustment difficulties (Indian Heath Services, 2011).

Common to each of the Native populations is the power of an oral tradition of cultural story-telling. As Heavy Runner and Morris (1997) observe:

> Stories may be told over and over again. In essence, we grow up with our stories. When Native elders want to make a point, they tell a personal story and leave their audience to make the necessary connections and understand how the story illustrates and illuminates the issue in question.

The use of such a narrative approach gets translated into ceremonial healing activities such as Talking Circles, Native spiritual acceptance and purification ceremonies, use of a Medicine Wheel and Sweat Lodge activities designed to restore harmony and enhance healing and Canoe Journey ventures designed to forge a new path. They also have a ceremonial procedure whereby so-called “wounded warriors” can share their experiences and convey the lessons they have learned to members of the community.

From a Constructive Narrative Perspective, each of these ceremonies reflect a way to formulate redemptive healing stories. But as Nebelkof and Smith (2004) highlight, any healing attempts with Native populations should convey empathy for the historical tragic treatment they received. It is the intergenerational transmission of “stories” that needs to be addressed. The memories of history, the recollections and remembrances, the stories that are passed on guide the present and future behaviors. Lewis Mehl-Medrona (2011) has described the healing powers of such Native story-telling.
Psychotherapists Are Good Story-Tellers

From a constructive narrative perspective, psychotherapy is a co-constructed activity, whereby therapists help clients reframe and reinterpret their presenting problems and symptoms in a more productive and hopeful manner. In order to accomplish these goals, psychotherapists provide a “rationale” prior to any interventions. These treatment rationales or “stories” usually occur as some form of psychoeducation framed in “metaphorical” terms. Therapists encourage, cajole, and engage their clients to replace the negative stress-engendering metaphors that they bring into therapy (“Being haunted by PTSD”, Being “damaged goods”, “A prisoner of the past”), with hopeful redemptive healing metaphors.

Consider some of the following examples of the ways psychotherapists tell stories to their clients. Wells (1997) offers the following “healing” metaphor:

“Just like your body, your mind is equipped with a means of healing itself. If you have a physical scar, it is best to leave it alone and not keep interfering with it as this will only slow down the healing process. So it is with your mind after trauma. Your intrusive thoughts and symptoms are like a scar, and it is best to leave them to their own devices. Do not interfere with them by worrying or ruminating in response to them, or by avoiding or pushing thoughts away. You must allow the healing process to take care of itself and gradually the scar will fade.”

A somewhat different rationale, using a dysfunctional “alarm” metaphor has been offered by Ford (2013), who explains to clients with PTSD that there is an “alarm” in their brain that can get stuck in the “on position” by trauma. This alarm is designed to help them stay alert and protect them. Trauma doesn’t damage the brain, but instead could over-activate a perfectly
healing and useful part of the brain. This alarm center is connected to the memory and filing centers right next to it in the brain and these centers work with a third area at the front of the brain (“the thinking center”) to figure out how to handle stress. With teamwork, the alarm center can be reset so it wouldn’t keep going off. Therapy can teach clients how to realign the alarm and not get stuck in the “Red Zone.” Psychotherapy helps clients with PTSD learn admirable ways to escape a vicious cycle and improve the “teamwork” across these three centers.

van der Kolk and van der Hart (1991) offer examples of how victimized individuals were helped by asking them to alter the memory and meaning of traumatic events in some way. For example, a therapist had a Holocaust survivor imagine a flower growing in her assignment place in Auschwitz. Dolan (1991) had child sexual abuse victims engage in adult mastery imagery exercises of how they can reimagine the abuse scene, but this time comforting and helping the “younger self”.

Goulding and Goulding (1979) use a similar imagery-based Redecision Therapy to help childhood sexual abuse clients not only comfort their younger self, but to share (construct) a story of their feelings that have been “buried” and their impact, toll, and cost to self and others that resulted from keeping traumatic events a secret. Another way that psychotherapists have helped clients alter their narrative is to use the Gestalt therapy “empty chair” procedure, whereby clients engage in a dialogue with an imagined other, as in the case a deceased loved one when treating clients who are experiencing Prolonged and Complicated Grief Disorders (Pearlman et al., 2014), or experiencing moral injuries in conjuring up a discussion with a moral mentor (Litz et al., 2014).

Foa et al. (1995) describe how prolonged exposure is like peeling back “layers of an onion,” and how like a wound in the body, trauma memories need to be treated before they
become a spreading infection. Elbers and Clark (2002) convey to clients that traumatic memories need to be refiled as in the instance of a messy cabinet that will not close, until the traumatic memories are put in order.

Such guided-imagery based interventions are designed to introduce flexibility into client’s memorial images (narrative accounts). “By imagining such alternative scenarios many patients are able to soften the intrusive power of the original unmitigated horror” (van der Kolk and van der Hart, 1991, p. 410).

Whether it is in the form of providing therapy rationales (telling stories) about “unhealed scars”, “faulty alarms”, “peeling onions”, or “disorganized cabinets”, or using imagery-based and empty-chair procedures, psychotherapists (like Native healers) are in the business of story-telling. From a CNP, what is critical is not the scientific validity of these metaphorical explanations, but the credibility and plausibility of the offered accounts. In many instances, psychotherapists may use the resilient-engendering metaphors that clients offer.

As Zoellner et al. (2014) observe:

“Finding meaning after trauma exposure means finding a truth that the survivor can live with about what happened and moving forward with it. We are not passive recorders of our experiences, but are active participants in our memory. We have the ability to shape what we remember, to better control the retrieval of memories of a particular event, no matter how well stored the memory.”

Through story-telling clients can learn to control their traumatic memories and metaphorically “rewire their brains.”
Treatment Implications of CNP of PTSD

From a CNP perspective, psychotherapy with traumatized clients is a co-constructive enterprise that helps them develop a resilient-oriented narrative, or “healing story”, with accompanying enhanced coping skills. To accomplish these treatment goals, core psychotherapeutic tasks should be implemented.

1. Establish a nonjudgmental, supportive, trusting, collaborative relationship with clients, so they feel safe and secure to share their trauma story and capable to tolerate any intense negative emotions that may be elicited. The therapist is a “fellow traveler” who bears witness to the emotional pain and suffering the clients may have experienced. By means of the use of a compassionate curiosity and Socratic questioning, the therapist can not only have the client relate the trauma narrative, but also the “rest of their story” of what they did to survive and cope. The therapist should also address the developmental trajectory of any co-occurring disorders that accompany PTSD. This quality of the therapeutic alliance accounts for a significant larger portion of treatment outcome variance then do the specific treatment interventions. The therapeutic alliance is the cornerstone of effective therapy (Meichenbaum, 2013b, 2014).

2. Assess the nature and context of the thought processes of individuals with PTSD and their implicit theories about the causes of their presenting problems and what it will take to change. Therapists can use a variety of expressive interventions to solicit and to change the client’s trauma narrative (art expression, journaling, imagery-based approaches). Such procedures will help clients organize and streamline their trauma memories. Stories are a pathway through which coping efforts emerge. Clients will come
to see that their lives are a “story in progress”, so they can find a workable account they can live with.

3. Conduct psychoeducation using credible “metaphorical” terms (psychotherapists story-telling) that engage the clients in treatment. It is the between session reduction in self-reported distress that predicts greater reduction in PTSD symptom severity. (Forbes et al. 2010). There is a need to monitor on an ongoing basis the client’s real-time feedback that alerts psychotherapists to potential treatment failures on a session-by-session basis. Such feedback permits the psychotherapist to individually alter and tailor the intervention to the clients’ needs, and thereby strengthen the therapeutic alliance (Lambert, 2010).

4. Engage the client in collaborative goal-setting that nurtures realistic hope, self-confidence, strengthen a future optimistic orientation, and other positive emotions. The therapist should bathe the social discourse with the language of possibilities and reinforce “change talk”, using motivational interviewing procedures.

5. Bolster the client’s intra- and interpersonal coping skills in order to address present-focused transitional stressors (Meichenbaum, 2013a).

6. Provide clients with practice in effortful, purposeful retrieval of traumatic memories so they can learn to voluntarily manage their mental processes. Clients need to learn how to “mentalyze” and control what is remembered and when and how these memories are shared with others. Help clients sculpt and transform their memories and develop “healing stories” that can be incorporated and contextualized into their autobiographical narrative. As Allen et al. (2008) observed, there is a need for clients to “keep the mind in mind”.
7. Help clients engage in benefit-finding, meaning-making activities that helps them develop new “possible selves”, and that puts them on a path of resilience. Involve and have the clients invite supportive others to be part of this journey. Where indicated, encourage clients to use their faith, values and sense of spirituality as resilient-engendering adjunctive tools. Help clients piece together an emergent life and to live the story they are now creating.

8. Encourage clients to create their own healing tales and that this collaborative restorying process is the heart of successful psychotherapy and contributes to resilient-engendering healing activities.
TABLE 1

HOW TO DEVELOP PTSD

1. In the acute phase of trauma exposure dissociate, become emotionally numb and hyperaroused.
2. Engage in negative-catastrophic appraisals and pathologize natural distress reactions.
3. Engage in cognitive and behavioral avoidance, suppression and high-risk safety behaviors that exacerbate distress.
4. Use mental defeating type of thinking, including emotionally-charged metaphors and fall into various “thinking traps.”
5. Focus on shattered beliefs about safety, control, trust and self-worth.
6. Be hypervigilant and magnify your fears.
7. Experience an inflated sense of personal responsibility and engage in hindsight bias that engenders guilt, shame, humiliation, disgust. Most importantly, do not let go of your anger that undermines emotional processing.
8. Engage in unproductive rumination and contrafactual thinking, worst world scenarios and upward social comparisons. Focus on “hot spots” and “stuck points.”
9. Have an overgeneralized memory that lacks narrative structure, thus contributing to poor problem-solving and hopelessness and helplessness. Fail to integrate traumatic narrative into one’s autobiographical memories.
10. Fail to retrieve specific benefit-finding positive memories. Do not see anything positive that would have resulted from the trauma experience.
11. Do not employ your religious faith and spirituality; experience a “spiritual struggle”.
   Question the meaningfulness of life and experience a “soul wound.”
12. Delay or fail to access help. “Clam up” and do not share your trauma story with supportive others. Isolate yourself, withdraw and detach from others.

**TABLE 2**

**HOW TO DEVELOP RESILIENCE**

1. Be psychologically agile and flexible in how one tells and retells the trauma story without becoming overwhelmed. Control to whom and when one shares the trauma story with supportive others and to yourself.

2. Mentalize or become an observer of one’s mental and emotional processes. Be self-reflective and voluntarily monitor and manage memories.

3. When telling one’s story incorporate redemptive sequences of bad events that have good endings. Engage in benefit-finding (“silver lining” thinking).

4. Incorporate the language of possibilities, becoming and change talk when recollecting memories. (For example, use verbs of personal agency such as “nurture”, “catch”, “interpret”, “plan”, and RE-verbs such as “retell, restory, reclaim, reframe, reconnect”, and give examples of each activity.)

5. Be sure to include in your telling to yourself and others the “rest of the story” of what you did to cope and survive. Include examples of “In spite of” behaviors and outcomes.

6. Integrate and contextualize your trauma memories into autobiographical accounts. Offer a coherent narrative that has a beginning, middle and ends. Use a narrative structure that fills in the missing gaps. Actively “sculpt” your memories so the trauma events are landmarks but not the full account.

7. Engage in memory-making activities and undertake a survivor’s mission.
8. Make a “gift” of your trauma experience so others can benefit from your experience. Share your story, highlighting the lessons learned.

9. Develop “possible selves” that build and broaden positive emotions, but that are realistically optimistic. Formulate SMART goals that are Specific, Measureable, Attainable, Realistic, and Timely.

10. Develop a “healing story” that corrects misconceptions, clarifies interpretations, and incorporates personal attributions (“taking credit” self-statements of what you did to change with the help of others). Create a “positive blueprint” that incorporates your values and faith.

11. Seek out and employ a social network who will support your journey to resilience.

12. Avoid doing those behaviors described in Table 1 on How to develop PTSD.
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THE EMERGING NEUROBIOLOGY OF RESILIENCE: IMPLICATIONS FOR PSYCHOTHERAPEUTIC INTERVENTIONS

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Impact of Acute and Chronic Stress

1. Prolonged Stress and accompanying negativity are taxing to the body and can take a toll called **Allostasis**, which refers to changes in the biological system. **Allostatic load** refers to changes in biological functioning from cumulative effects of chronic stress. **Resilience** is the capacity to minimize allostatic load (Feder et al., 2011; Malta, 2012).

2. One of the responses to chronic stress and threat perception is to stimulate the HPA system (hypothalamic-pituitary-adrenal axis) which coordinates the body’s response to stress. Exposure to chronic stress leads to excessive cortisol exposure that increases vulnerability to a variety of physical diseases (hypertension, immunosuppression, cardiovascular diseases) and mental disorders (anxiety, PTSD and depressive disorders). (Handwerger, 2009).

3. More specifically, chronic stress alters 5HT receptor functioning and affects secretion of Dopaminergic (DA) brain regions that are associated with reward sensitivity and approach behaviors. The dopamine-related reward circuitry includes the nucleus accumbens, amygdala, ventral striatum and anterior cingulate cortex.

4. Findings of neuroimaging of individuals with PTSD have revealed structural and functional abnormalities in the amygdala, hippocampus, anterior cingulate cortex, medial prefrontal cortical pathways, neuroendocrine systems and polymorphisms in genes associated with norepinephrine functioning. These neurobiological alterations can contribute to the development of conditioned threat responses, hyperarousal, insomnia, anger/aggression and dissociative behaviors.

5. The amygdala is the engine that mobilizes threat responses. It receives input about threat cues and activates the release of corticotrophin-releasing factor (CRF) and norepinephrine (NE) in the brain and the secretion of the peripheral nervous system stress hormones. In addition to the amygdala, the stress circuit includes the hippocampus, hypothalamic-pituitary axis (HPA) and the brain stem locus coeruleus (LC). The amygdala has been called the brains “smoke alarm system”.

6. Excessive release of NE and CRF during memory encoding prevents memories from fading and conditioning responses from extinguishing contributing to the development of PTSD re-experiencing symptoms and also disables the hippocampus which is critical in developing episodic memories. This contributes to fragmented, sensory-driven memories. Such poor contextualization of traumatic memories and accompanying sensitivity to threat-related cues undermine the integration with neutral autobiographical contextualized memories and the retrieval of positive recollections. This contributes to such symptoms as a restricted range of positive emotions, avoidance, loss of interest, withdrawal, estrangement, self-referential thinking and to the perception of others as being unsupportive.
7. Research on the cumulative impact of early childhood stressors, (abuse, neglect, exposure to family and community violence, inadequate parental care) as reported in the Adverse Childhood Experiences ACE) studies by Edwards et al (2005), indicate that the experience of three or more of such adversities can result in long-term far-reaching effects such as various disorders (cardiovascular and autoimmune diseases), and to a poor health-related quality of life, as well as, to behavioral difficulties such as substance abuse, depression, suicide attempts, teen pregnancy. As Vander Kolk (2014), observes, “the body keeps score.”

The research by Caspi, DeBellis, Moffitt, Perry, Pynoos and Yehuda indicate that traumatic adverse events can influence neurological development. These changes in the developing brain are further exacerbated if accompanied by poverty (overcrowding, noise, substandard housing, exposure to violence, family turmoil, separation from parents) and other forms of extreme stress that can be “toxic”. For example, children from poverty have 6% less brain surface and a less voluminous hippocampus and a compromised brain circuitry, relative to children from higher SES levels.

Consider the following findings of the impact of ACE on children’s development.

- Physical abuse and neglect, but not sexual abuse have been associated with the reduction in the volume and activity levels of major structures of the brain, including the corpus callosum (midsagittal area of connective fibers between the left and right hemispheres) and the limbic (emotional regulation) system, including the amygdala and hippocampus.

- Trauma has been found to affect the HPA Axis (Hypothalamic Pituitary Adrenal axis) contributing to its hypersensitivity to cortisol and can contribute to an increased vulnerability to depression.

- Trauma exposure can contribute to increased sympathetic nervous system activity which is especially evident under conditions of stress (e.g., increased heart rate and increased blood pressure). This may be manifested as exaggerated startle responses.

- Among children who have been abused, there is a greater likelihood of cerebral lateralization differences or asynchrony. For example, abused children are seven times more likely to show evidence of left hemisphere deficits. This can contribute to the failure to develop self-regulatory functions, especially language and memory abilities. **Self-regulatory processes** are internalizing organizing functions that filter, coordinate and temporally organize experience. Self-regulation includes attentional controls, strategic planning, initiation and regulation of goal-directed behaviors, self and social monitoring abstract reasoning, emotional regulation and interpersonal functioning. Trauma has the
most impact when its onset occurs during early childhood and is recurrent or prolonged.

- Early and prolonged victimization impacts the communication between the Prefrontal Cortex (PFC) (“upper portion of the brain”) and the amygdala (lower part of the brain). The PFC is normally in balance with the amygdala response to life stressors. This “top-down” regulation of executive skills can be compromised by perceived threats and stressors. The bottom-up emotional processes can “hijack” the PFC.

- Trauma exposure results in elevated levels of circulating catecholamines and in abused boys it also results in elevated growth hormone.

- Trauma exposure can have a negative impact on the development of attachment behaviors. For example, abused teenage girls are more likely to hide their feelings and have extreme emotional reactions. They have fewer adaptive coping strategies and have problems handling strong emotions, particularly anger. Moreover, they have limited expectations that others can be of help. They show deficits in the ability to self-soothe and modulate negative emotions. They show evidence of problems with behavioral impulsivity, affective lability, and aggression and substance abuse. For example, Kendall et al. (2000) found that in a twin study, the twin who had been exposed to childhood sexual abuse had consistently an elevated risk for drug and alcohol abuse and bulimia when compared to the unexposed twin. Sexual abuse also contributes to increased susceptibility to sexually transmitted disease and can compromise the immune system.

- In order to compensate for the deficits that arise from multiple victimization experiences and to bolster resilience, special efforts are needed to bolster the abused and neglected children’s and youth’s self-regulatory systems and to provide them with “cognitive and emotional prosthetic devices” that can help in their development (e.g., metacognitive supports of planning, monitoring, language, memory, as well as social supports).

More specifically, the neurodynamics of early cumulative child maltreatment results in:

a. accelerated loss of neurons;
b. delayed myelination;
c. abnormalities in developmentally appropriate pruning;
d. inhibition of neurogenesis;
e. chronically elevated cortisol levels and increases in NE over time;
f. changes in brain structure;
g. less integration of the left and right sides of the brain’s hemispheres;
h. smaller left frontal lobes and to hippocampus shrinkage;
i. elevated risk of dysregulated HPA function;
 j. hyperarousal;
 k. shorter telomere length which impacts the integrity of DNA.

In summary, stress hormones damage brain structures when stress is early and prolonged. The resultant damage impacts various stages of development.
THE NATURE OF RESILIENCE

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 well-being of a group to which individuals belong. Sights and sounds of nature, collective rituals, 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 orbitomedial 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).
The research on neurobiology of resilience underscores the value of conducting psychoeducation on neuroplasticity (the power of the human brain to change and repair itself) and the potential recovery from experiencing traumatic and victimizing experiences. The therapist can help clients learn a variety of skills and engage in activities that bolster positive emotions and improve resilience and health (Ray, 2012).

When discussing with clients the lingering impact of traumatic and victimizing experiences, the therapist can convey examples of how the body “keeps score” and the enduring impact on the clients' brain and behavior. The good news, however, is that the brain is a remarkable resilient organ and clients have the potential ability to reverse this process. Clients can learn to capitalize and build upon what is called neuroplasticity, and moreover, even begin to “turn on” and “turn off” the genes in their body (neurogenesis).

The therapist can say: “Let us begin by having you better appreciate the possible impact that traumatic and victimizing experiences may have on your brain and behavior. Traumatic events and losses can lead the lower part of your brain that is the emotional center to:

“hijack; overwhelm; flood; overshoot; ramp up; exceed; trigger action pathways; overactivate and have a spiraling, cascading snowball effect; prime or kindle; shorten your fuse; and undermine and shut down the upper part of your brain, the frontal lobe executive control center.”

When conducting this psycho-education, the therapist should choose one or two of these illustrative verbs to describe the impact of traumatic and victimizing experiences and accompanying losses. Do not overwhelm the client. The therapist should then solicit personal examples from the client that reflects that activity.

“Can you give me an example of how you did X?” (Choose one of the following).

“Magnified your fears; time slide back to your old ways of coping that once worked for you; went into a kind of autopilot mode of survival; engaged in safety behaviors; were hypervigilant and constantly on the lookout for possible threats; repeatedly conducted a kind of after action analysis in the form of ruminating; had difficulty sleeping; sought an adrenaline-rush by engaging in high-risk behaviors; used booze or drugs to self-medicate?”

The therapist can convey to the client that he/she noticed, and wondered if the client also noticed, these behavioral patterns and “What is the impact, toll and price that resulted?” After discussing such consequences and how they may interfere with achieving the treatment goals, the therapist can convey that the therapy can help the client learn how to: (Choose one)

“regulate, modulate, control, strengthen, regain, restore, reprogram, reshape, re-right myself, re-establish, re-define, mobilize, adapt, calibrate, blunt, improve their error detection skills; soothe, down-regulate, label and tame emotions, surmount your fears, orchestrate, get accustomed, accepted, organize your traumatic memories into a narrative account, develop coherent redemptive
stories that have a beginning, middle and ending, note what you have done to survive, contextualize and put the landmark traumatic events into a larger autobiographical account.”

The therapist can highlight that attention and increased awareness are the key first steps in the ability of the brain to repair itself. The client can learn how to “talk back” to the amygdala or the lower part of the brain and take charge once again. For instance, clients can learn emotion-regulation skills and they can come to tell themselves (and others):

“I can rewire my brain.”

“I can talk to my amygdala (the alarm center) and train my emotional brain.”

“Not allow my amygdala to hijack my frontal lobes.”

“I can use the upstairs part of my brain to calm down the downstairs part of my brain.”

“My positive emotions can re-shape my brain.”

“Positive relationships that I have can switch on and off different gene contributions and leave a positive chemical signature on my genes that affect my brain development.”

“By being kind I can raise my level of oxytocin which curbs stress-induced rises in heart rate and blood pressure and that reduces feelings of depression. Being kind protects my heart.”

“I can reduce my heart rate by 6 to 10 beats per minute by taking slow deep (diaphramatic) breaths.”

“I remind myself that my brain is not fixed, nor static. It is highly plastic and flexible. It can repair itself, with my help.”

“As with other parts of my body, I need to use my brain or lose it.”

“If I don’t stimulate my brain, my brain cells will die and be pruned away.”

“I have the capacity to bend, but not break.”

“I can see the big picture and find the silver lining, and develop a new normal.”

“I can get myself to do what I do not feel like doing and get myself out of my comfort zone.”
INTERVENTION STRATEGIES THAT BOLSTER RESILIENCE

(See Meichenbaum’s Roadmap to Resilience book for examples)

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.
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WE ARE THE STORIES WE TELL: A CONSTRUCTIVE NARRATIVE PERSPECTIVE OF PTSD

Donald Meichenbaum

We are each not only “homo-sapiens”, but also “homo narrans”, or story-tellers. As psychotherapists we get paid to listen to our patients’ stories. In the aftermath of individuals experiencing traumatic and victimizing events, whether they occurred in the recent past, or a long time ago, most individuals will be impacted, but some 75% will evidence resilience, the ability to “bounce back, and cope with ongoing adversities. In contrast, some 25% of traumatized individuals get “stuck” and may develop PTSD, Complex PTSD, co-occurring disorders and adjustment difficulties (Bonanno, 2004; Calhoun & Tedeschi, 2006; Reich et al. 2010).

PTSD is essentially a disorder of non-recovery. PTSD reflects a particular form of autobiographical memory. In order to receive the diagnosis of PTSD or Complex PTSD, some traumatic or victimizing events have had to happen and individuals have to tell others, as well as themselves, a “set of stories” about “What happened?”; “What impact it had at the time?”; and “What lingers from those events at the present time?”

How do the “stories” that the 75% resilient group differ from the 25% who get stuck and develop PTSD, Complex PTSD, and other co-occurring clinical disorders? Moreover, what are the implications for conducting psychotherapy with such patients? How can psychotherapists help patients develop “healing and redemptive” stories and the accompanying adaptive coping skills?

A Constructive Narrative Perspective of PTSD

As poignantly described by Stephen Joseph (2012):

“Human beings are story-tellers. It is human nature to make meaning of our lives by organizing what happens to us into stories. We live our stories as if they were true. We tell stories to understand what happens to us and to provide us with a framework to shape our new experiences. We are immersed in our stories.”

The stories patients tell hold a powerful sway over their memories, feelings, behavior, identity, and shape their future. Patients don’t just tell stories, their stories tell them. A number of researchers have elucidated the characteristics of the narrative of individuals who develop PTSD versus those who evidence resilience (Courtois, 1999; Fredrickson, 2011; Ehlers & Clark, 2000; Joseph, 2012; McAdams, 1997; Shipherd & Beck, 2005; Southwick & Charney, 2012). For example, the cognitive and affective processes experienced during the early onset of traumatic
events is predictive of the development of Acute Stress Disorders and the subsequent severity of PTSD (Brewin, 2014). Ehlers and Clark (2000) reported that the engagement of negative, “catastrophic” thinking processes in the aftermath of experiencing traumatic events contributes to the development and severity of PTSD and their lack of responsiveness to treatment. Such “negative” ideation has a self-sustaining forward influence.

Table 1 provides a detailed summary, or algorithm/formula on ways to develop persistent PTSD, Complex PTSD, and co-occurring disorders. Doing these behaviors will increase the likelihood of falling into the 25% clinical group.

**Insert Table 1 Here**

The prolong exposure to traumatic and victimizing experiences and the accompanying “negativity” enumerated in Table 1 can take a bodily toll, and impose what is called an Allostatic Load on biological functioning. As van der Kolk (2015) observes, the “body keeps score” for trauma victims who develop diagnosable clinical problems. These bodily sequelae may include both structural and functional brain alterations, activation of neurotransmitters’ communication systems (dopaminergic, cortico-releasing factors, norepinephrine and nervous system stress hormones such as cortisol, and the like). As a result, such increased vulnerability can lead to a variety of physical and mental disorders.

The challenging question is what is the “Resilient” group doing, and not doing, that results in their managing and tolerating the impact of traumatic events? What are the “in spite of” behaviors they engage in that act as protective factors? Before addressing this question, it is important to keep in mind that resilience and post trauma stress can coexist. It is not an either-or proposition. Moreover, individuals may be resilient in one domain, but not in a separate domain, or at one time in their lives, but not at other times in their lives.

In my book, “Roadmap to Resilience” (Meichenbaum, 2013a), I discuss how traumatized individuals can bolster their resilience in six domains (physical, interpersonal, emotional, cognitive, behavioral and spiritual).

The building-blocks for such resilience-engendering behaviors include accessing and using social supports who can provide emotional, informational and practical support, when requested. Resilient individuals also “give to get.”

Another building block is the ability to reappraise, reframe and to engage in meaning-making activities, including calling upon one’s faith, religion and sense of spirituality; one’s values and “moral compass.” The ability to use goal-directed problem-focused coping of taking direct-actions when stressful events are potentially changeable can increase neuro transmission in the mesolimbic dopaminergic pathways that increase pleasurable feelings and stimulate reward centers such as the ventral striatum. Dopamine release in the brain leads to “openness of
experience”, exploratory behaviors in the present, mindful thinking, “here and now”, as compared to replaying over and over past traumatic events.

Another building-block that resilient individuals evidence is building and broadening the use of positive emotions such as optimism, acceptance, forgiveness, gratitude, humor, love, and a sense of awe with nature that contributes to altruistic behaviors (“making a gift of one’s experiences to others”). Such positive emotions reduce physiological arousal and alters the individual’s focus of attention, allowing for more flexibly inclusive, integrative perspective-taking, endless positive reappraisal of challenging situations, fosters problem-solving coping, and facilitates the inclusion of ordinary events with meaning. Repeated positive emotional responses to negative events, expands and builds psycho-social relationships and behavioral responses. In short, the ability to engage in non-negative thinking, as described in Table 1, results in trauma-exposed individuals changing the “stories” they tell others and that they tell themselves. They are able to “uncouple” the intense negative emotions from the memories of past traumatic events. They are able to embed and contextualize these landmark emotionally-charged events into a life-story autobiographical account. They can now change their relationships with others, themselves, their bodily reactions, and memories.

Implications for Conducting Psychotherapy with Traumatized Individuals

The task for psychotherapists is how to help their traumatized patients move from the 25% group to the 75% resilient group. In the effort to achieve this objective, trauma psychotherapists have a plethora of options as they can choose from an array of Acronym-based interventions. Each psychotherapeutic approach has its own unique Acronym such as DTE, VRE, CPT, EMDR, DBT, TF-CBT, SIT, ACT, STAIR-MPE, and others. How shall the psychotherapist select from these treatment alternatives and other options?

Reviews of the treatment outcome studies have seriously challenged the proposition that any one Acronym form of treatment is more effective than any other. No one treatment approach is the “winner of the race” and should be embraced and advocated (Duncan, 2010; Lambert, 2007; Meichenbaum 2013b; Wampold, 2006).

Rather than select one specific treatment approach to bolster patients’ resilience, it would be more judicious to consider what these varied Acronym-based psychotherapeutic approaches have in common that contribute to their success. What are the core tasks of psychotherapy that contribute to positive treatment outcomes?

The following list enumerates the psychotherapeutic features that are common to each of these Acronym-based interventions.

1. Each treatment approach establishes and monitors the quality of the therapeutic alliance. The psychotherapist works to create a supportive trusting, nonjudgmental, compassionate, genuine relationship, so patients feel safe and secure to share their trauma
stories and capable to tolerate any intense negative emotions that may be elicited. The psychotherapist is a “fellow traveler” who bears witness to the emotional pain and any suffering the patients may have experienced. But the therapist does more by probing for the rest of their patients’ stories, namely what did they do to survive and achieve “in spite of” their traumatic, victimizing experiences. In this way psychotherapists “pull for” evidence of the patients’ strengths and resilience that can be built upon.

In fact, research indicates that the therapeutic alliance accounts for more of the treatment outcome, than does the specific treatment intervention. The specific treatment accounts for no more than 15% of the variance of treatment outcomes. In comparison, the quality of the therapeutic relationship accounts for three times the variance in treatment outcomes (Duncan, 2010).

As Sperry and Carlson (2013) observe,

“It is the therapist and not the treatment that influences the amount of therapeutic change that occurs. Relationship skills or developing a therapeutic alliance is the cornerstone of therapeutic excellence.”

The patients’ evaluation of the quality of the therapeutic relationship on a session-by-session basis is the best predictor of treatment outcome (Lambert, 2007).

2. Psychotherapists engage their patients in collaborative goal-setting that nurtures hope and bolsters future optimistic orientations and their related positive emotions.

3. Psychotherapists conduct psycho-education and provide a treatment rationale prior to introducing specific treatment interventions. In short, effective psychotherapists are “good story-tellers”. They may characterize treatment as a way to “rewire the brain”; “fix a faulty alarm system”; “organize trauma memories like rearranging a messy cupboard”; “peel back layers of an onion”; “treat unhealed wounds”; “finish the unfinished business”; and the like. These metaphorical treatment descriptions provide a framework to engage patients actively in treatment. What is critical about these therapists’ metaphorical “stories” is not their scientific validity, but their plausibility and credibility to their patients.

As Zoellner and Feeny (2014) observe”

“Finding meaning after trauma means finding a truth that the survivor can live with about what happened and moving forward with it. We are not passive recorders of our experiences, but are active participants in our memory. We have the ability to shape what we remember, to better control the retrieval of memories of a partial event, no matter how well stored the memory”.
Brewin (2014) proposed that the mechanisms by which various treatments of traumatized patients operate is not the reduction of negative trauma-based memories, but the increased ability to retrieve and integrate positive autobiographical memories. Psychotherapy provides the context and opportunity for patients to “restory”, “reclaim”, “renew” their lives and develop the accompanying intra-and interpersonal coping skills.

4. Each Acronym therapy approach provides patients with repeated practice in effortful, purposeful retrieval of traumatic memories, so they can learn to voluntarily manage their mental processes and learn to “uncouple” debilitating accompanying emotional reactions. Patients learn how to “mentalize” and control what is remembered and when and how these accounts are to be shared with others. Psychotherapists help their patients sculpt and transform memories and develop “healing stories” that can be incorporated and contextualized into their autobiographical narrative. Psychotherapists may use writing, art expressive and imagery-based procedures, Gestalt empty-chair exercises, restorative retelling procedures, distraction and mindfulness activities to help patients develop a sense of agency in their lives.

These procedures help patients organize and streamline their trauma memories so they are coherent, with beginning, middle and have redemptive endings. Stories are a pathway by which coping efforts emerge. In this way they can generate “healing” stories as a “story in progress”; so they can find a workable account that they can live with (McAdams, 1997; Meichenbaum 2017a; Vollmer, 2005).

Psychotherapy can be viewed as a type of “narrative repair”, as a benefit-finding, meaning-make collaborative approach that helps patients develop new “possible selves”, and that puts them on a path of resilience. Elsewhere, I have described other specific interventions that psychotherapists can employ to help their patients shift from the 25% group to the 75% group of resilient individuals (Meichenbaum, 2013a,b; 2017a,b). Also, please visit www.RoadmaptoResilience.com; www.melissainstitute.org; http://mindsetce.com; or contact me at dhmeich@aol.com.
HOW TO DEVELOP PTSD AND COMPLEX PTSD

1. Engage in self-focused “mental defeating” type of thinking, viewing oneself as a “victim”, as compared to being a “survivor”, if not a “thriver”. See yourself as lacking the ability to control “uninvited” thoughts and feelings.

2. When telling others and yourself “stories” of traumatic events and their lingering impact use dramatic metaphors that convey continual vulnerability, unloveability, and unworthiness. (“I am a prisoner of the past.” “I am damaged goods.” “Entrapped”, “A pariah”. It is like living in a room with no lights on”)

3. Hold erroneous beliefs that the world is completely unsafe, unpredictable, that people are untrustworthy and that life has lost its meaning; and moreover, you are a “burden” on others.

4. Ruminate and dwell on “hot spots”. Preferably, keep your trauma story a secret and do not share your account with potentially supportive others. Delay or avoid seeking help.

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

6. Engage in avoidant behaviors and deliberately suppress trauma-related thoughts that as a result have a “boomer-rang” effect, likely to lead to more emotionally-charged intrusive ideation and hyper-arousal.

7. Have an “overgeneralized” memory that is disjointed, fragmented, disorganized, sensory-driven and lacks coherence, thus undermining problem-solving and intensifying a sense of hopelessness.

8. Fail to view landmark traumatic events as a “slice of life” that can be embedded and contextualized into a larger autobiographical “life-story”. Fail to retrieve “positive” memories.

9. Engage in “thinking traps” such as increased sense of personal responsibility for what happened; have a “hindsight bias” and do “Monday quarter-backing”; conduct social comparisons with others; be hypervigilant; “catastrophize”; and engage in emotional reasoning that magnifies fears, exacerbates guilt, shame, humiliation, disgust and grief.

10. Hold onto anger that undermines emotional processing. Engage in a “spiritual struggle” with God, or with others or with the “system”. View such provocations as deliberately done “ on purpose”, and strike out toward others, or toward oneself.

11. Fail to engage in any meaning-making activities such as turning your traumatic experiences into a “gift” that you can share with others, or turning your “emotional pain” into a transformative activity. Do not use your religion, faith, or spirituality as a coping mechanism.
resource. Abandon your “moral compass”. Instead, choose solutions designed to reduce your emotional pain that exacerbates your level of distress such as using substances to self-medicate, or engaging in re-enactment behaviors.

12. Avoid experiencing any positive emotions such as realistic optimism, acceptance, compassion, gratitude, forgiveness, perseverance/graft, or fail to see any potential benefits that might have arisen from experiencing traumatic events. Broadening and building on such positive emotions can influence the structure and function of the brain reflecting “neuro-plasticity”.

13. Engage in a variety of safety and risk-taking behaviors that increase the likelihood of further (re)victimization. Inadvertently, unwittingly, and perhaps unknowingly, make choices and behave in ways that exacerbate your distressing situation and condition.
Footnote: DTE = Direct Therapy Exposure; VRE = Virtual Reality Exposure; CPT = Cognitive Processing Therapy; EMDR = Eye Movement Desensitization and Reprocessing; DBT = Dialectical Behavior Therapy; TF-CBT = Trauma-focused Cognitive Behavior Therapy; SIT = Stress Inoculation Training; ACT = Acceptance and Commitment Therapy; STAIR-MPE = Skills Training in Affective and Interpersonal Regulation followed by Modified Prolong Exposure.
Donald Meichenbaum, Ph.D. is currently research Director of The Melissa Institute for Violence Prevention, Miami and one of the founders of Cognitive behavior therapy and he was voted “one of the ten most influential psychotherapists of the 20th century.”
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WAYS TO BOLSTER RESILIENCE IN TRAUMATIZED CLIENTS: IMPLICATIONS FOR PSYCHOTHERAPISTS

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My mother, Florence, always had a special way of telling her stories about the events in her life. She would regularly include in her accounts a detailed description not only of what happened to her, but also of her accompanying feelings and thoughts before, during and after each event. Moreover, she incorporated in her tales an accompanying editorial commentary about her maladaptive stress-engendering thoughts and feelings, as well as what different, more positive, goal-directed feelings, thoughts and behaviors she should have chosen.

“So, I thought Selma, the woman I worked with for years, insulted me in front of my friends. I started to get mad and on the subway ride home, I was getting down on myself, but then I told myself, ‘Why make myself feel worse?’ and changed what I said to myself. ‘It was much better to let it go, for now. I can give her feedback on Monday. I don’t think she did it on purpose.’”

One evening, while eating dinner with my mother, it dawned on me that my entire professional career had been a validation of her style of story-telling. My research and clinical career has been spent teaching a broad range of clinical populations (e.g., schizophrenics, children, adolescents and adults who have impulse disorders of anger control and aggressive behaviors, substance abuse, depression, and the like), how to talk to themselves differently, and more helpfully - - to become, in short, more adaptive “story tellers”, like my mother.

Recently, in my capacity of being Research Director of the Melissa Institute for Violence Prevention (see www.melissainstitute.org), I have focused my clinical work on people who have been traumatized, including returning service members, victims of violence, natural disasters and injuries. Following any form of what DSM characterizes as life-threatening criterion A traumatic events, 75% of exposed individuals will be affected, but they go onto exhibit resilience, and in some instances post-traumatic growth. In contrast, approximately 25% will develop PTSD, Complex PTSD, comorbid psychiatric disorders, and challenging adjustment difficulties.

If we could determine what differentiates these two groups, then we could develop more informed and effective treatment approaches for all forms of life stressors, including traumatic events. Could part of what contributes to resilience be the way individuals tell themselves and others “stories”? Could my mother’s kitchen table accounts hold any hints worthy of examination?

Keep in mind that PTSD is essentially a reflection of an autobiographical memory of something perceived to be stressful and traumatic, that has occurred in the past. Now, these trauma-exposed individuals have to tell others, as well as themselves, a “story” in which they will draw conclusions and implications about themselves, the world and the future.

As I noted in my recent book, “Roadmap to resilience” (www.roadmaptoresilience.org), human beings are not only homo-sapiens, they are “homo-narrans”, or story tellers. It is human nature to manufacture the meaning of our lives by organizing what happens to us into stories. We tell the stories to understand our experiences and provide a framework for integrating them into our autobiography. We live our stories as if they were true, and are immersed in them throughout our lives.

Research by a number of investigators such as Briere, Ehlers and Clark, McAdams, McNally, and Neimeyer, have identified the key characteristics of traumatic autobiographical memories and distress-engendering story-telling styles. In the aftermath of profound trauma exposure, memories tend to be made up of fragmented, distorted, sensory-driven images and
thoughts, that are triggered by the sights, sounds and smells and similar reminders. Traumatized individuals who develop PTSD tend to have an overgeneralized recall style with jumbled traumatic memories, lacking a coherent time-line which intensifies hopelessness, and impairs problem-solving. The story-telling of these people tends to be stuck on “hot spots” - the worst, most painful and horrifying aspects of trauma- which keeps them from integrating traumatic events into an autobiographical memory or narrative. They may show a “narrative breakdown”, as they continue to search for answers of “what is going on and why.” For example, they tend to engage in what is called “contra-factual” thinking of continually asking “Why” questions for which there are no satisfactory answers, and engage in “Only if” type thinking of trying to undo the traumatic events.

Consider the client who, in an attempt to stop a home break-in, had accidentally shot and killed her nine year old daughter Vicki. Vicki’s mother’s account was “stuck” at the point of the tragic shooting - - the sound of the gun going off, the sight of her daughter’s fallen body, the smells and feel of Vicki’s blood. In the aftermath of such horrific events, one does not “cure” PTSD. There are no treatments that can magically take away the emotional pain and the accompanying guilt, shame, anger and grief, but the therapeutic challenge is how to help such clients continue their life journey and help them transform their losses and pain into a life, still worth living.

I asked Vicki’s mother if she would be willing to do something that would be very painful and that she should feel free to say no to my request. I said:

“I would be both privileged and honored to get to know more about your daughter Vicki in order to better appreciate the magnitude of your loss. Would you be willing to bring into our next session a family picture album that includes pictures of Vicki?”

Why did I make such a request? Because, her memory of Vicki was stuck at the moment that the gun went off. The review of the picture album was designed to help her retrieve positive memories to balance the horrific traumatic memories of Vicki. I wanted Vicki’s mother to embed the tragic events into a larger biographical narrative. I was trying to help her become “unstuck” from her habitual way of ruminating. Research indicates that various forms of trauma treatment are mediated by their ability to help victimized clients retrieve positive memories and that there is a need to have at least three positive to each negative emotion to facilitate the recovery process. Posttrauma distress and resilience can co-occur and therapists need to help traumatized clients tip the balance.

As you can imagine, the session of reviewing Vicki’s picture album was remarkably emotional. Through painful tears, I asked her to indicate what she saw in Vicki that was so special? She responded that what impressed her most about Vicki was that “she was wise beyond her years”, and gave several examples of Vicki’s perceptiveness, maturity and compassion for others. She offered anecdotes of Vicki’s infectious personality and ways she could make the family laugh. I then asked her, “If Vicki, who was wise beyond her years, was present now, and could curl up into your loving arms and look into your woefully sad eyes, what advice, if any, would Vicki, who was wise beyond her years offer?” After a long pregnant pause filled with more tears, she answered with one word, “Hope.” She then went on to elaborate with examples of how the family had overcome previous illnesses and crises.
Thus, I was using the absent other Vicki, as a means to alter her narrative. And, if she killed herself, as she was contemplating, what would happen to the memory of Vicki? Vicki’s memory would die with her.

“What is it that Vicki saw in you that made your relationship so special?” She answered poignantly with an account of their intimate sharing of daily events. Out of such gentle discovery-oriented probes, that elicited the “rest of the story”, Vicki’s mother eventually transformed her tragic loss and emotional pain into a personal mission of making a “gift” of her experience to other parents. She took on the task of educating parents of school children on the dangers of keeping guns in the house and she became an advocate for gun safety locks. By using the “art of questioning” and reflective listening, the therapy moved Vicki’s mother from a state of complicated grief to transforming her loss into a “gift” to share with others. For example, here are illustrative questions that helped Vicki’s mother get “unstuck” and undertake meaningful activities. They do not take away the pain or loss, but they facilitate the recovery process.

“Let me see if I understand where you are now”

“This loss has forced you to think about…?”

“So there is a part of you that is still grieving for Vicki, but there is another part of you that is carrying Vicki’s story forward?”

“Some people who have experienced tragic losses have said that they changed in some positive ways by being forced by life to face very difficult traumatic situations? Have you noticed any changes in yourself?”

“Given how horrible this event was, is there any possibility of anything valuable coming from it?”

“Are you saying that hope is a function of a struggle?”

“It sounds like one of the things you are discovering about yourself is…?”

“It is like knowing part of yourself that you have not known before.”

“Do you see yourself differently, now that you are going through all of this?”

“What words would you have used to describe yourself before this tragic event, and what words would you use to describe yourself now?”

“So where does this leave you now?”

“Let me see if I understand what you are committing yourself to doing now?”
Out of such social discourse, over the course of three months of weekly sessions, Vicki’s mother came to embrace Elie Weisel’s, the Holocaust historian adage that “one should never forget.”

“Whoever survives a test
Whatever it may be
Must tell the story
That is one’s duty.”

Vicki’s mother was actively constructing templates of meaning that helped her interpret her past, negotiate the present and anticipate her future. She was developing a sense of authorship over her life story. She was freeing herself from the dominant traumatic narrative, and in her parent presentation, recruiting an audience to share her life story. What was initially encoded in an emotionally intense unelaborated, unintegrated, primitive montage of memory fragments and images unordered with no discernible timeline, was being transformed through her presentations to sympathetically supportive parents, into a coherent structural narrative. Her newly constructed life story helped her reduce her level of distress and grief. Therapy helped Vicki’s mother find a workable account that gave meaning to her tragedy and that will continue to change.

In contrast, clinical research has found that the 25% who keep traumatic events alive evidence persistent distress and adjustment difficulties do not readily share, nor transform their “stories”. In fact, in my Roadmap to resilience book, I suggest an “algorithm” of the cognitive, emotional, interpersonal, behavioral and spiritual characteristics that seem to correlate with the development of persistent PTSD and related adjustment problems. Such people tend to be self-focused and engage in “mental defeating” types of thinking that maintain a “victim”, rather than a “survivor” or “thriver” mindset. They also often spend a great deal of time in rumination, contra-factual thinking (“why me”, “only if”), avoidant thinking and behaviors like keeping traumatic experiences a “secret” and not seeking help. In addition they often fail to memorialize those who have been lost and have a “spiritual struggle” and see God as having punished, abandoned and betrayed them. Many I’ve seen remind me of the Biblical character Job, crying out against what they regard as an injustice of what has happened to them repeatedly asking “Why?” questions, for which there were no satisfying answers. For instance, clients who evidence persistent PTSD are prone to convey:

“I am a prisoner of the past.”
“I am a walking time bomb.”
“These thoughts and feelings just happen. They arrive like unannounced guests.
“The depression just comes.”
“I am a born loser.”
“You can’t trust anyone. There is no place that is completely safe.”
“No one will understand what I have been through.”
“What is the point of continuing? I am a burden on others.”
“God could have prevented this from happening. I have lost my faith.”
If there is any merit in the algorithm for developing persistent PTSD and the value of a Constructive Narrative Perspective I advocate, how can therapists help traumatized clients develop coherent “healing stories” and compensatory coping behaviors in several domains (emotional, cognitive, interpersonal, behavioral, and spiritual)? How can therapists help their clients develop narratives with redemptive sequences that bolster hope, strengthen self-confidence and nurture meaning-making activities? How can therapists help clients view trauma as only one part of their lives, rather than the defining aspect?

This is more than a clinical exercise. History, current events and literature is filled with remarkable examples of individuals not only recovering from sometimes almost unimaginable suffering, but drawing from their traumatic past the strength and inspiring deeds. In my “Roadmap to Resilience” book and the accompanying website (www.roadmaptoresilience.org), I have included examples of resilience-engendering behaviors from Viktor Frankl, Nelson Mandela, Maya Angelou, Romeo Dallaire, Christopher Reeve, Michael J. Fox, and Terry Waite. Consider the following accounts of “true grit” and coping strategies:

“A 17 year old suicidal patient was hospitalized for 26 months, at times confined to an isolated secluded room because she engaged in self-injurious behaviors (burning her wrists with cigarettes, slashing her body and head banging). She writes, “I had to tell my story. I owe it to others. I cannot die a coward. One night I was kneeling in prayer, looking up at the cross, and the whole place became gold and suddenly I felt this shimmering experience, and I just ran back to my room and said ‘I loved myself’. It was the first time I remember talking to myself in the first person. I felt transformed.”

These are the words of Dr. Marsha Linshan who developed Dialectical Behavior Therapy for victimized suicidal Borderline Personality Disorder patients, as cited in the New York Times, June 23, 2011.

Another example of a redemptive story involves the tale of a five year old child who watched helplessly as his younger brother drowned. In the same year, glaucoma began to darken his world and his family was too poor to afford medical help that might have saved his sight. Both of his parents died during his teens. Eventually, he was sent to a State Institution for the blind. Because he was African American he was not permitted access to many activities, including music. Given the obstacles he faced, one could not have predicted that he would become a renowned musician. His name is Ray Charles.

Finally, consider the recent account offered by a mother whose son was murdered in the Newtown, Connecticut school shooting. She told how she had her dead son cremated and how she placed his urn on her bedroom night table. She indicated that each morning she greets him by kissing the urn of ashes and prays that at night when she slept, he will visit her in her dreams with their happy moments. This gives her strength to continue and work for gun control legislation.

Each of these accounts highlight ways individuals transform their traumatic life experiences into productive life narratives. For many traumatized individuals, they may need the assistance of a psychotherapist to change their life stories and bolster their resilience. As psychologists who conduct narrative research highlight:
“We don’t just tell stories, stories tell us. They shape our thoughts and memories and even change the way we live our lives.”

A Constructive Narrative Treatment Approach for Client’s with PTSD, Complex PTSD and Comorbid Psychiatric Disorders. 

The first and most critical task for psychotherapists is to establish a nonjudgmental, respectful, sensitively attuned, trusting relationship with the traumatized client, and with significant others, where indicated. This relationship has to be culturally, developmentally and gender sensitive. For example, when treating returning service members, there is a need to understand and appreciate military culture. Therapist also must be able to “stand close” to the suffering of the client - - fully empathise with his or her feelings - - without being overwhelmed. The treatment goal should be to empower the client and place him or her “in charge”, by conveying that he or she can disclose as much, or as little, as he or she wishes.

The most valuable clinical tool that the therapist has is the “art of questioning”, especially using discovery-oriented Socratic questions of a “What” and “How” variety, rather than “Why” questions. I often say something like the following to clients, speaking in a slow deliberate pace, pausing between questions:

“Let me explain what I do for a living. I work with clients, like you, and try to find out how things are going right now and how you would like them to be?

How can I best help you identify and work on your treatment goals?

What have you tried in the past? What worked (as evident by)? What did not work? What did you have difficulty following through with? What, if anything were you satisfied with that you think we can build upon?

If we work together and I hope we can, how would we know that you were making progress? What, if anything, might others notice was changing?

Permit me to ask one last question, if I may? Can you envisage, foresee any things that might get in the way of our working to achieve your treatment goals that you mentioned?”

Note that every question that I asked is a “What” and “How” question. I also solicit from the client, his or her ideas of what is causing current distress and presenting problems, and what he or she believes is needed to change.

In order to tap the client’s “story”, I lead from behind and use the “art of questioning” as a means of soliciting the client’s narrative, at a safe and comfortable pace. But, I do not only tap the story of the traumatic and victimizing events. I also probe for the story of survival and any signs of strengths and resilience. A Constructive Narrative psychotherapeutic perspective probes for the “rest of the story”, of what the client has accomplished “in spite of” the traumatic events. The social discourse is filled with the language of possibilities, becoming and resilience. A goal
of psychotherapy is that the client take the psychotherapist’s voice with him or her (as I took my mother’s voice with me). I ask clients the following question:

“Do you ever find yourself, out there, in your everyday life, asking yourself the kind of questions that we ask each other right here?”

In this way the psychotherapist models and helps a client incorporate a style of thinking and a resilient mindset embedded with actionable personal agency “change talk” verbs such as “notice, catch, interrupt, choose, plan, change”, and with phrases such as “so far”, “as yet”, which underscore an ongoing process with a future. Over the course of treatment the client is asked to give examples of how to implement “Re”-verbs - - “RE-author, RE-story, RE-write, RE-vise, RE-frame, RE-interpret, RE-claim, RE-connect, RE-build, and RE-plenish” his or her life? The psychotherapist is a fellow traveler on the client’s personal journey helping him or her construct new life stories that are imbued with RE verbs and examples of specific ways to implement each RE activity.

Moreover, it is critical to have the client offer the reasons why engaging in each of these activities will help him or her achieve short-term, intermediate and long-term treatment goals. There is also a need to develop a game-plan and back-up plan on how such potential obstacles can be addressed. There is a need to solicit public commitment statements from clients for engaging in behavioral change. Such collaborative goal-setting is an effective way to nurture the client’s hope and encourage him or her to create a “healing story” that builds a sense of purpose and meaning. A major treatment goal is to help the client generate an explanation that he or she can live with and reduce the endless search for meaning. Treatment is designed to help the client re-organize traumatic events into meaningful acts to give back to others. Therapists can use a variety of psychotherapeutic procedures to accomplish these objectives including psychoeducation, journaling, acceptance and exposure-based interventions, Gestalt empty-chair procedures, skills training with role enactments, emotionally-focused couples’ treatment and spiritually-based interventions. What is common across each of these diverse interventions is that each helps traumatized clients engage in “personal experiments” that “unfreeze” and “dislodge” the stories they brought to therapy.

Each intervention, regardless of what theoretical perspective is designed to encourage clients to integrate their trauma experiences into coherent autobiographical accounts, in which traumatic events are landmarks, but not the defining elements of their accounts.

Changes in storytelling and in the willingness to share and make a “gift” of the lessons learned, as compared to keep the trauma story a secret, provides access to social support and ways to undertake “pass forward” meaningful activities. The client’s ability to generate a coherent narrative helps to reduce distress and hypervigilance, increase a sense of personal control, and lessen feelings of chaos and unpredictability.

Trauma is only one part of an individual’s life, rather than the determinant aspect. Effective trauma therapy helps clients learn to let the “past be the past”. Clients can learn to disentangle themselves from the lingering impact of traumatic events. It is not that bad things happen to good people, per se, that is critical. Traumatic events, in one form or another, will happen to most people living in North America. Rather, it is the “story”, the conclusions that one draws about the future that determines if chronic disabilities or resilience will prevail.

In trauma therapy, no matter what form it may take, clients engage in a narrative healing process. It is like having dinner with my mother!
Implications for Psychotherapists

1. **Remember the relationship.** Research has repeatedly shown that the therapy relationship is the most important single factor in therapy, regardless of treatment type. This is especially true for traumatized clients, who must feel safe, supported, respected and empowered to tell their stories at their own pace if therapy is to succeed. The therapist needs to keep tabs on the therapeutic alliance and solicit real-time feedback, address any therapy-interfering beliefs and behaviors and immediately address any “ruptures” in the therapeutic relationship.

2. **Ask artful and compassionate questions.** The psychotherapist should use the “art of questioning” and demonstrate “compassionate curiosity” to solicit the client’s multiple stories of victimization and survival. The client should be encouraged to give voice to any emotions of suffering, despair and related feelings of grief, shame, guilt, anger, and the like. Keep in mind that post trauma distress and resilience can coexist.

3. **Be alert to “Toxic” Stories.** The therapist should probe for the presence of any “toxic” conclusions and implications about the client’s self, the world and the future that linger from the trauma experience in order to help the client co-construct more healing stories with redemptive features. You should be sensitive to any “hidden stories” about prior victimization experiences – before the traumatic events under consideration- that undermine the normal recovery process. [Address at the outset of treatment any distressing presenting problems like sleep disturbance, physical pain, substance abuse, risk-taking behaviors, suicidality in an integrated manner that considers the interconnections between PTSD and comorbid psychiatric disorders.]

4. **Get the whole story:** There is a need to solicit the “rest of the story” of what the client was able to accomplish “in spite of” the traumatic experiences. The core of recovery is the narrative construction on which coping rests. The psychotherapist needs to provide an attentive, non-judgmental setting in which the client can experiment with (“try on”) a new story and extend it to everyday experiences. Help the client move from viewing him or herself as being a “victim”, to becoming a “survivor”, if not a “thriver”. The therapist can ask “hinge questions” that open the gate of possibilities.

   “How did going through this ‘seismic event’ change you?”
   “How did this change the direction of your life?”
   “Has anything at all positive come from this event?”
   “How did going through this traumatic event shake up your belief system, your life pattern?”
   “Where does this leave you now?”

5. **Foster more coherent, resilient-building stories.** The psychotherapist can help the client co-construct and revise his or her account in a way that integrates and processes traumatic memories, as well as the disturbing thoughts and feelings arising from them, into more coherent autobiographical accounts. In this process the client can begin coming to terms with losses and transform emotional pain into something positive that can be shared with others.
These revised narratives foster a sense of meaning and nurtures a resilient-engendering mindset. Examples from clients include:

“I am much stronger that I ever expected.”
“I am not who I used to be.”
“If I lived through this, I can live through just about anything.”
“I had to live with my major suffering and losses. Now little things don’t get to me anymore.”
“I can make a gift of what happened to me and my family to others.”
“I can live with my not understanding and not having all the answers.”
“I have developed a good enough explanation and I stopped searching for meaning.”
“I have learned how not to distress myself.”
“I am in the midst of discovering....”
“I am on a journey and I can begin to write a new chapter.”
“My faith has saved me.”

6. **Help the client develop a “tool-kit” of coping behaviors.** It is easier and more effective to add positive behaviors, rather than eliminate negative ones. Therefore, besides learning to create “healing stories”, the client needs to develop a coping “tool kit” of both direct-action proactive problem-solving and emotionally palliative accepting coping behaviors. The therapist should help the client become aware of and build upon capacities for resilience, in order to develop more social supports, soothe negative emotions while increasing positive ones, become more cognitively flexible and optimistic, undertake meaning-making activities either individually or as part of a group activity, and practice his or her faith.

7. **Prevent revictimization.** The therapist should help the client avoid revictimization by exploring past victimization experiences, identifying high-risk situations, and attending accompanying warning signs, and developing escape and safety behaviors. In addition the therapist and client should consider any potential barriers that might undermine the recovery process and the possible impact of anniversary effects that can be anticipated and addressed.

8. **Help the client appreciate his or her “new self”.** Finally, help the client more fully appreciate a changed sense of self, a new philosophy of life, rearranged priorities and improved relationships with loved ones. Ensure that the client “takes credit” for specific changes that he or she has made in these areas.

As my mother reminded me, “A psychotherapist is an instructor in the art of story-telling and helps clients construct more adaptive narratives”. She would comment that “If I had difficulty achieving these treatment goals, have them visit with me for dinner?”

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STRESS INOCULATION TRAINING: A RESILIENCE-ENGENDERING INTERVENTION

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In the aftermath of traumatic and victimizing experiences, such as combat exposure, sexual victimization, and various forms of losses, most individuals are impacted, at least in the short run, but some 75% have the ability to “bounce back”, handle ongoing adversities, and evidence resilience (Bonanno, 2004). In some instances, such resilient individuals go onto experience posttraumatic growth (Tsai et al., 2017).

In contrast, some 25% of trauma victims develop PTSD and co-occurring physical and mental disorders such as depression, anxiety, anger, prolong and complicated grief, moral injuries and substance abuse disorders (Adler et al., 2011). These same percentages substantially hold up for returning service members. As Litz et al. (2016) report, some 10% to 20% of the two million troops who served in Iraq and Afghanistan experience significant mental health difficulties. For at least half of those affected, the disorder shows a chronic course in veterans that can become a disabling condition. Most returning service members resume “normal” lives and are well-adjusted (Moore & Barnett, 2013). In general military deployment has had positive meaning on their lives.

For example, among aviators shot down, imprisoned and tortured for years by the North Vietnamese, 61% said that this ordeal had beneficial psychological effects of increasing their self-confidence, tenacity and helped them develop a greater appreciation for things and relationships in their lives. They took pride in their service. Southwick and Charney (2012) studied 250 American Prisoners of war who were imprisoned for up to 8 years and subjected to torture and solitary confinement. Years after their release they had lower than expected incidence of depression and PTSD. They manifested various forms of resilience.

Like returning service members, the military families are generally resilient and are a healthy robust group. Most spouses of returning service members report that deployment had strengthened their marriages (Riviere & Merrill, 2011).

Any psychotherapeutic intervention designed to treat returning service members who fall into the 25% group, should be informed by what members of the 75% group are doing, and not doing, that contribute to their resilience. A number of authors have enumerated the variety of coping skills and resilient-engendering behaviors and attributes that characterize trauma-exposed individuals who constitute the 75% group (Adler et al., 2011; Penk & Ainspin, 2005; Reich et al., 2008; Southwick & Charney, 2012; Tsai et al., 2017). The identified building blocks of resilience include:

1. The ability to establish and maintain a supportive social network. Resilience rests fundamentally on relationships that are non-judgmental and supportive.

2. Such strengths may derive from a variety of human and social capital resources including having a “Charismatic Mentor”, and role model, from the past, or the present, whom one can garner strengths. Such social support can take various forms including emotional, practical and informational (colloquially known as “heart, hand and head”).

3. The ability to establish and maintain a “Resilient Mindset” that views oneself as a “survivor”, or even as a “thriver”, instead of a self-identity of being a “victim”, bolsters resilience. Having a realistic optimism (benefit-finding and benefit-remembering); a sense of personal control, tenacity, “grit”, cognitive flexibility, and a
future-oriented problem-solving approach, each strengthens resilience. A Resilient Mindset includes the ability to reframe, reappraise, renew, reauthor any lingering effects of traumatic experiences (Brooks and Goldstein, 2003). As Southwick and Charney (2010, p. 25) observe:

“Optimism serves as the fuel that ignites resilience and provides energy to power other resilience factors.”

4. Another key feature of resilience is learning how to adaptively face one’s fears, so as not to engage in either cognitive, emotional and behavioral avoidance. How to accept negative emotions such as sadness, grief, guilt, shame, anger as being “normal” and to be expected reactions to the experience of traumatic events contributes to the healing process. It is not that individuals experience negative emotions, but what one does with such feelings that is critical to adaptation (Meichenbaum, 2016).

5. The ability to develop and employ a variety of emotion-regulation skills such as self-soothing, distraction, mindfulness, acceptance, as well as interpersonal skills enhance resilience.

6. As noted, positive emotions fuel resilience. These may include forgiveness and compassion toward self and others, gratitude, joy, empathy, love, humor, each of which have both neuro-biological and psycho-social effects on the structure and function of the brain. Various fMRI and biochemical studies indicate how various stress hormone levels, amygdala and frontal lobe functions, and heart rate variability, are impacted by the ability to “broaden and build” positive emotions (Feder et al., 2011; Fredrickson, 2001; Southwick et al., 2011).

7. The ability to undertake meaning-making pro-social activities of transforming one’s experiences into an altruistic “gift” to others (“give to get”) fosters resilience. The ability to maintain a “moral compass” and use one’s faith, religion and sense of spirituality also sustains resilience (Litz et al., 2016).

8. Finally, resilient individuals are prone to stay fit by engaging in physical activities like exercise, sleep hygiene, good nutritional habits, and help-seeking behaviors, and by avoiding high-risk activities and safety behaviors that may inadvertently, unwittingly, and perhaps, unknowingly undermine resilience.

Elsewhere, I have enumerated specific practical ways to bolster resilience-engendering behaviors in six domains (physical, interpersonal, emotional, cognitive, behavioral and spiritual) (Meichenbaum, 2012).

Although, resilience and post-trauma stress can coexist, and individuals can be resilient in one domain of their lives and not in other areas, or at one time in life and not at other times, the research findings indicate that PTSD is essentially a disorder of non-recovery. Most returning service members are able to successfully transition from the “war zone” to the “home zone”. As one soldier observed,
“From being in combat you realize how much more important your friends, family and battle buddies are and you realize how much life should be treasured.” (Alder et al. 2011, p.4).

“I feel now that it (combat) has made me a better and stronger person. I know now that I can deal with some fucked up shit and get through it.” (Alder et al. 2011, p.11).

A second set of conclusions is that the array of coping strategies that resilient individuals employ interfere with and preclude a “victim” mentally-defeating mindset. Resilient individuals engage in a variety of activities that result in non-negative thinking.

Table 1 describes what returning service members need to do, and not do, in order to develop chronic PTSD and accompanying adjustment difficulties. As I highlighted, (Meichenbaum, 2017), PTSD patients are not only homo-sapiens, but they are also “homo-narrans”, or “story-tellers”. Stress inoculation training (SIT) proposes that what distinguishes the 75% resilient group versus the 25% group who develop long-term adjustment challenges is the nature of the “stories” that they tell themselves, and that they tell others, and the accompanying coping strategies and skills that such narrative accounts engender. PTSD is a reflection of a set of autobiographical memories (or “stories”) of the recent, or distant past, that trauma-exposed individuals generate. As Ehlers and Clark (2000) highlight, individuals who develop PTSD tend to have overgeneralized memories and they maintain a recall style that intensifies hopelessness, increases avoidance behaviors, and impairs problem-solving. In addition, they have difficulty remembering specific positive experiences and their current memories are fragmented, sensory-driven, and they fail to integrate traumatic events into a coherent autobiographical memory, nor develop a redemptive “healing story”. As Brewin (2014) and Joseph (2012) propose, various treatment approaches for individuals with PTSD are effective insofar as they help victimized individuals retrieve and integrate positive autobiographical memories with landmark traumatic accounts, rather than merely getting rid of, or habituating and desensitizing individuals to traumatic memories.

SIT treatment, which focuses on bolstering resilient-engendering behaviors and coping skills, helps patients “reauthor” their personal accounts and helps them get “unstuck” and attend to the rest of their stories of what they have been able to accomplish “in spite of” of their traumatic experiences. What are the survival and coping skills that they bring with them into therapy that can now be used to address the “unfinished business” in their lives and help them achieve their treatment goals? A Case Conceptualization Model of risk and protective factors can be used to inform the assessment and treatment decision-making process (see Meichenbaum, 2009).

SIT is tailored to the individualized needs of patients on the basis of their presenting symptoms, address any specific therapy-interfering behaviors, attend to the presence of comorbid problems and to their treatment goals. In order to achieve these objectives, SIT includes three phases: (1) an initial conceptualization and psycho-education phase; (2) a skills-oriented acquisition and rehearsal phase, and (3) an application relapse prevention and follow-through phase. SIT is designed to be flexibly delivered over eight to fourteen sessions, but SIT has been applied on a group format, as well as on a preventative basis to address stressful events (Meichenbaum, 2007). SIT is not a prescribed session-by-session protocol.
Table 2 provides a detailed description of the core psychotherapeutic tasks incorporated in each of the three phases of SIT.

**Phase I: Conceptualization and Psycho-education**

The first Phase of SIT is designed to prepare the patient for treatment and includes a non-didactic educational component from which he/she can better understand the nature and origin of this stress. The therapist uses Socratic questioning and motivational interviewing procedures to engage patients in the treatment process and works collaboratively to develop treatment goals that nurture hope. The psychoeducation process also includes a discussion of the neurobiological correlates of resilience and pulls for the “rest of the story” of any patient resilient survival skills and strengths. Self-monitoring is used to help patients better appreciate the interconnections between their feelings, thoughts, and behaviors and the accompanying reactions from others. Various “myths” about stress and coping are also addressed. The language of possibilities, (“As yet”, “So far”, and “Change talk”) are built into the psychotherapeutic discourse. Journal writing can facilitate this process.

**Phase II: Skills Acquisition and Rehearsal**

Following the collaborative identification of short-term, intermediate, and long-term SMART treatment goals (Specific, Measureable, Attainable, Relevant and Timely) with the patient, a variety of intra- and interpersonal coping skills are taught, or strengthened. In order to address issues of hyperarousal, irritability and heart rate variability, a variety of relaxation and tactical breathing exercises are included in SIT. In order to address issues of negative debilitating affect a variety of emotion-regulation, distress tolerance, self-soothing skills are included. The patient may be encouraged to participate in acceptance, mindfulness, meditation, and behavioral activation (exercise) activities. SIT also highlights the benefit and ways to broaden and built on positive emotions that have salutary benefits. To address issues related to a “victim” mindset, SIT includes a variety of active cognitive skills such as cognitive restructuring, guided self-dialogue, problem-solving, and where indicated, the patient turning to his/her faith, sense of spirituality or religion in order to reclaim a “moral compass.” A variety of interpersonal skills including how to avoid revictimization are also incorporated.

Consistent with the constructive narrative perspective and emphasis on altering the stories that the patient tells to oneself and to others, SIT therapists may employ the Gestalt “empty chair” procedure of imaginal dialogue with significant others. For example, see the Adaptive Disclosure procedures of Litz et al., (2016) designed to address clinical issues of moral injuries, or Shear et al., (2005) use of the empty-chair procedures with patients who experience prolong and complicated grief.

In the aftermath of trauma exposure, individuals may experience a wide range of emotions, well beyond fear and anxiety that warrant more than exposure-based interventions. SIT is sensitive in tailoring the intervention to the patient’s specific emotional needs which may include guilt, shame, anger and grief. For instance, cognitive-behavioral interventions of Kubany (1995) on guilt; Smucker and Dancu (1999) on shame; Novaco and Chemtob (2002) on anger and rage, Shear et al., (2005) on grief are employed. Such emotions interfere with the processing and integration of traumatic memories.
Where comorbid disorders such as substance-abuse (SUDs) and PTSD co-occur, a variety of integrated treatment approaches may be employed.

One of the strengths of SIT is its flexibility to individualize treatment, rather than employ a fixed treatment protocol.

In summary, in Phase II of SIT patients are taught how to change stressful situations, when possible, and the accompanying emotional reactions. Both problem-focused instrumental and emotion-focused palliative coping skills are taught.

**Phase III: Application, Relapse Prevention and Follow-through**

In the final phase of SIT, the therapist guides the patient in using imaginal situations and coping responses in actual stressful situations. The patient is exposed, in-session, to graded stressors via imagery and engaged in behavioral rehearsal in order to prepare them to handle potential triggers and stressful events. These in-session rehearsal and applications are supplemented by graded in vivo experiences and practice of the coping strategies.

Relapse prevention procedures are incorporated that help patients anticipate any potential high-risk stressful situations, and develop their “game plans” for coping. Self-efficacy is bolstered by the therapist asking “How” and “What” questions that pull for internalized self-attributions (“Taking credit” self-statements).

Treatment sessions are gradually faded out, and booster and follow-up sessions are offered that may focus on involving significant-others in training, peer and internet supports, self-help groups, and on-going therapeutic coaching contacts, where indicated.

The SIT is designed to not only help patients develop a sense of mastery over their stress reactions by teaching a variety of skills and then providing opportunities to practice them, but also to help and challenge them to change their “stories” and develop a “resilient” mindset.

**Evidence for SIT**

The initial research evaluating the efficacy of SIT began with civilian populations who evidenced a variety of clinical problems including issues of anxiety disorders, anger-control, pain management, and having to manage stress reactions resulting from either medical procedures or stress-related occupations (teachers, athletes, high-risk professions) (Meichenbaum, 1985, 2007).

SIT has been applied to the treatment and prevention of PTSD. Two randomized controlled trials included women with sexual assault-related PTSD (Foa et al., 1991, 1999). They compared Prolong Exposure (PE) versus a reduced version of SIT. In the Foa et al. trials, they intentionally removed the third application phase of imaginal and in vivo exposure in order not to overlap with the exposure elements of PE. Even with this modification to SIT, the SIT proved effective in reducing PTSD symptom severity at follow-up.

SIT has been employed on a preventative basis with Marines as a form of pre-deployment intervention. Hourani et al. (2016) developed what they call a PREST program that consists of educational and skills-oriented modules followed by an application phase using exposure to video multimedia combat-related scenes. The SIT-based intervention yielded positive benefits in terms of the Marines’ arousal response and in the incidence of PTSD.

SIT is a comprehensive, holistic, omnibus, individualized treatment approach that incorporates a number of skills-based interventions and narrative therapy procedures, each of which has demonstrated efficacy with both civilian and military populations. For example,
various forms of relaxation training (breathing retraining, emotion-regulation procedures); mindfulness training and acceptance-based procedures; cognitive and narrative therapy procedures such as imaginal dialogue and spiritually-based interventions have been found to be effective forms of intervention.

There is a need for further research to determine the relative efficacy of present-centered skills “here and now” training interventions versus “then and there” emotional processing approaches like Prolonged Exposure and Cognitive Processing Therapy that have patients tell and retell their traumatic accounts versus the combination of these two approaches. As Schnurr et al. (2003) highlight in their major VA comparative outcome study, it is still an open question as to what is the best treatment approach to use with returning service members.

Two findings stand out, however. First, a great deal can be done in pre-deployment and at the organizational level (military leadership, unit cohesion and morale, mental health services and the like) to bolster resilience. Second, the field of intervention has progressed to recognize the need to tailor interventions in accord with the dominant emotional needs of the service member. Anxiety and fear which respond to exposure-based interventions is only one of a variety of approaches that is included in SIT. Other types of treatment approaches are tailored to the emotional and behavioral needs of patients.

As noted, “one treatment approach does not fit all.” This maxim is at the heart of SIT.

CASE EXAMPLE

Shanise T is a 30 year old African-American veteran of Iraq, where she served two tours of duty. She presented with a clinical profile of Complex PTSD and co-occurring disorders of depression with suicidal ideation and substance abuse disorders (alcohol, marijuana).

The initial sessions of SIT focused on establishing a non-judgmental, empathic, trusting relationship with a Caucasian male psychotherapist. (No female psychotherapist was available). The therapist conveyed to Shanise that she was “in charge” of the content and rate of self-disclosure and that her feedback would be obtained on a session-by-session basis (i.e., feedback-informed treatment ala Prescott et al., 2017). This was critical since Shanise had dropped-out of two previous treatment programs.

The pre-military history revealed that she was an only child, whose father and grandfather had served in the military. She had always dreamed of following in their footsteps. While her upbringing was “normal”, at the age of 17 she was gang-raped that left an indelible mark. Soon thereafter, she joined the military, hoping that this would prove to be a “healing process”.

In the military, she experienced sexual harassment and another attempted rape. In addition, she had to deal with combat experiences, including the death of her best female buddy. Shanise felt that she was somehow responsible for this death due to her negligence.

“It was my fault.”
“I could have prevented this.”

As a result, she experienced prolong and complicated grief, guilt, shame and anger at the military system. Her thinking style reflected hindsight bias that exacerbated her level of distress. As she stated:
“My soul is dead!”

She had been raised as a member of an Evangelical born again church and often used religious terminology to describe her plight. She broke away from the church raising the consternation of her family. She felt no one could understand what she had been through, and no one could be of help. Feelings of hopelessness and purposelessness contributed to a “Victim Mindset.”

In addition, she had occasional panic attacks and she used substances as a form of self-medication. She was unable to reconnect with her boyfriend and was frequently absent from work as a computer instructor.

The SIT treatment consisted of 12 sessions, initially twice a week, and then weekly. The primary focus was on ensuring Shanise’s safety in terms of her suicidal ideation, accompanying substance abuse, and the belief that she was a “burden” on others, and felt estranged. Care was taken to ensure she did not have access to weapons. In order to nurture hope and a future-orientation, the assessment process focused on collaborative goal-setting. The psychotherapist used Socratic questioning of “What” and “How” questions to develop SMART treatment goals.

“What would you like to change most in your life?”
“How would you like things to be different?”
“What kind of help do you think you need?”
“What do you think would be most helpful, right now?”
“If we could work together, and I hope we can, how would you know if treatment was successful? What would you see change? What would other folks who know you notice?”

These questions were followed by motivational interviewing, and psycho-education about the nature of the treatment, and information about PTSD, grief, guilt, especially the role of hindsight bias, and a “victim” mindset.

In addition, the psycho-education process also focused on the “rest of the story” of her “in spite of” resilient behaviors.

“How did she come to the decision to join the military after her rape experience?”
“What did she do to get through boot camp?”
“What strengths did she inherit from her grandfather and father?”
“What lessons, if any, did she take away from her church experiences that are still with her?”
“What did she like most about her good buddy who died in combat?”
“What did her buddy see in her that led to this special friendship?”
“If your friend were here right now, what would she be saying to you?” (Use of imaginal dialogue of the absent other to elicit strengths)

Phase II of SIT (Session four) began with the psycho-education about the interconnections between Shanise’s feelings, thoughts and behaviors, namely, use a CLOCK metaphor that contributes to a “vicious cycle” (12 o’clock - - external and internal triggers; 3 o’clock - - primary and secondary emotions; 6 o’clock - - thinking processes; 9 o’clock - - behaviors and
reactions of others). Shanise self-monitored when such a “vicious cycle” occurred that reflected as a “stuckness” problem. The discussion highlighted what Shanise is presently doing to “break” the “vicious cycle” such as use avoidance behaviors, self-medicate using substances, dropping out of treatment, and how these are self-sustaining behavioral patterns.

In collaboration with the therapist, Shanise was able to develop and practice a variety of intra- and interpersonal coping skills such as breathing retraining to control panic attacks; acceptance, yoga and mindfulness training to control rumination and hindsight bias; behavioral activation (exercise) to address depression; cognitive restructuring to focus on a “victim” mindset; social skills to renew relationship with her boyfriend and with the choral group at her church, and to use the Internet to connect with other vets.

When asked, what she had learned in the five coping skills training sessions, she stated that she had learned how to:

“Talk back to my amygdala so it cannot hijack my thinking brain.”
“I can rewire my brain by exercising.”
“I can let off steam and take a breather.”
“I can make myself smile. It makes me feel better.”
“I can use my CLOCK analysis and break my vicious cycle.”
“I can tell myself the rest of the story and call upon positive memories.”

Phase III of SIT (remaining three sessions) worked on Shanise performing in vivo exposure-based activities that focused on her facing her fears and developing a “resilient” mindset. Ways in which Shanise could “broaden and build” on positive emotions and activities by reconnecting with others like her boyfriend, friends from church, her family and Internet Chat rooms, was part of the healing process. Shanise undertook a meaning-making mission of making a “gift” of her experiences for others. She became a “helper” to other female veterans who had gone through similar experiences, transforming her emotional pain.

The empty-chair exercises with her deceased buddy was pivotal in her deciding that she was not responsible for this death and that her friend would want her to have a life worth living. As Shanise observed:

“I learned to let the past be the past, including the sexual assaults.”
“I can share my story, and the rest of my story with others.”
“I was trained to keep going, even when the going got tough.”
“Disbelieving is hard work.”
“I survived for a purpose.”
“I just visited the parents of my best buddy who died. It was a healing experience for both them and for me.”

Phase III ended with the inclusion of relapse prevention procedures and self-attributional training (Shanise “taking credit”) for changes she was able to bring about. The last two sessions were spaced apart by two weeks and follow-through contact of three and six month follow-up were included.

In summary, this case illustrates how much preparation must occur before any skills are trained and that a major treatment goal of SIT is to bolster the patients’ resilience and to help them develop a resilient mindset and a positive self-identity.
# TABLE 1

**What Individuals Need to Do (And Not Do) In Order To Develop Chronic PTSD**

1. Engage in self-focused cognitions (story-telling) that reflect a “victim” mindset. See oneself as continually vulnerable, mentally defeated, and ruminate about the negative future implications of trauma exposure. Engage in contrafactual thinking and hindsight bias, worst world scenarios, and upward social comparisons.

2. Incorporate into one’s stories emotionally-charged metaphors that undermine resilience. (“I am a prisoner of the past.” “A pariah.” “Emotionally dead. The right side of my brain is frozen.”)

3. Hold beliefs that the world is unsafe and that people are untrustworthy, and that life is purposeless, and things are not going to improve. Moreover, view oneself as a “burden” on others and feel estranged from others and demoralized.

4. Engage in catastrophic ideation with accompanying feelings of self-blame, guilt, shame, unresolved anger and grief that undermines emotional processing. Feel “stuck” and focus on “hot spots.”

5. Be continually hypervigilant and avoidant at both the cognitive and behavioral levels. Clam up and keep trauma experiences a secret. Engage in safety-behaviors like using substances and engage in high-risk “adrenaline rush” behaviors that sustain and exacerbate distress.

6. What not to do.
   a. Access social supports, nor seek help.
   b. Engage in benefit-finding and benefit-remembering.
   c. Develop a coherent-narrative that has a redemptive “healing” story.
   d. Undertake meaning-making activities, nor use one’s faith/religion

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<table>
<thead>
<tr>
<th>TABLE 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What Individuals Need to Do (And Not Do) In Order To Develop Chronic PTSD</strong></td>
</tr>
<tr>
<td>1. Engage in self-focused cognitions (story-telling) that reflect a “victim” mindset. See oneself as continually vulnerable, mentally defeated, and ruminate about the negative future implications of trauma exposure. Engage in contrafactual thinking and hindsight bias, worst world scenarios, and upward social comparisons.</td>
</tr>
<tr>
<td>2. Incorporate into one’s stories emotionally-charged metaphors that undermine resilience. (“I am a prisoner of the past.” “A pariah.” “Emotionally dead. The right side of my brain is frozen.”)</td>
</tr>
<tr>
<td>3. Hold beliefs that the world is unsafe and that people are untrustworthy, and that life is purposeless, and things are not going to improve. Moreover, view oneself as a “burden” on others and feel estranged from others and demoralized.</td>
</tr>
<tr>
<td>4. Engage in catastrophic ideation with accompanying feelings of self-blame, guilt, shame, unresolved anger and grief that undermines emotional processing. Feel “stuck” and focus on “hot spots.”</td>
</tr>
<tr>
<td>5. Be continually hypervigilant and avoidant at both the cognitive and behavioral levels. Clam up and keep trauma experiences a secret. Engage in safety-behaviors like using substances and engage in high-risk “adrenaline rush” behaviors that sustain and exacerbate distress.</td>
</tr>
<tr>
<td>6. What not to do.</td>
</tr>
<tr>
<td>a. Access social supports, nor seek help.</td>
</tr>
<tr>
<td>b. Engage in benefit-finding and benefit-remembering.</td>
</tr>
<tr>
<td>c. Develop a coherent-narrative that has a redemptive “healing” story.</td>
</tr>
<tr>
<td>d. Undertake meaning-making activities, nor use one’s faith/religion</td>
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</tbody>
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TABLE 2
Phases of Stress-inoculation Training

Phase I - - Conceptualization and Psychoeducation

Establish, maintain and monitor the therapeutic alliance using ongoing session-by-session patient-informed feedback.

Establish a warm, nonjudgmental, respectful, trust-engendering treatment environment. Be sensitive to ethnic and racial differences.

Assess for prior history of victimization, intergeneration transmission of trauma, address safety issues from the outset and throughout treatment (e.g., suicidal behaviors, possible access to weapons, engaging in high-risk behaviors and the possibility of revictimization).

Use a Case Conceptualization Model of risk and protective factors. Tap the patient’s implicit theory of presenting problems and treatment needs.

Address any potential therapy-interfering behaviors and patient concerns around “stigma” and barriers to treatment engagement such as compensation and entitlement issues that can act as interfering “secondary gains.”

Use Motivational Interviewing and Collaborative goal-setting procedures. Establish SMART treatment goals (Specific, Measureable, Attainable, Relevant, Timely).

Conduct psycho-education in a non-didactic fashion about the nature of PTSD and treatment.

Use Timelines to solicit patient “strengths” in the past and present, namely, “in spite of” behaviors and achievements. Elicit the “rest of the story” that influence the relative retrievability of different positive memories. Journaling and writing can enhance adjustment.

Conduct psycho-education about how positive emotions and activities can change brain structure and function. Highlight ways to bolster patient resilience. Prepare the patient for Phases II and III of SIT.

Normalize symptoms and prioritize and address any presenting symptoms and maladaptive behaviors (e.g., sleep disturbance, avoidance behaviors, substance abuse, “victim” mindset).
Phase II: Skills Acquisition and Rehearsal

Begin with a discussion of how patients inadvertently, unwittingly, and perhaps unknowingly contribute to and can exacerbate their presenting problems. Use a CLOCK metaphor to help the patients appreciate the interconnections between their feelings, thoughts and behaviors - - a self-sustaining “vicious cycle.”

a. 12 o’clock - - appraisal of external and internal triggers
b. 3 o’clock - - primary and secondary feelings
c. 6 o’clock - - automatic thoughts, thinking style and developmental schemas and beliefs
d. 9 o’clock - - behaviors and reactions from others

Help the patient appreciate ways they can “break the cycle” by using intra- and interpersonal coping skills.

Teach emotion-regulation, mentalizing, cognitive reframing and active behavioral coping skills.

Do not “train and hope” for generalization and maintenance of coping skills, build into treatment generalization guidelines (See Meichenbaum, 2017).

Tailor interventions according to the dominant emotional needs of the patient (fear, anxiety, guilt, shame, anger, grief, moral injuries) and provide integrated treatments for the presence of any co-occurring disorders such as PTSD and substance abuse. Where indicated, use imaginal dialogue (Gestalt empty-chair procedures).

When indicated incorporate the patient’s faith, religion and spirituality. Help the patient make a “gift” of trauma experience and undertake meaning-making activities.

Phase III: Application, Relapse Prevention and Follow-through

Challenge, cajole and encourage the patient to practice coping skills, both in session (imaginal rehearsal, role playing), and in vivo settings as identified by means of a planful graduating (“inoculating”) hierarchal fashion.

Ensure that patients “take credit” for behavioral changes. Nurture a personal agency self-attributional style of mastery of stress (Being a “boss of PTSD”).

Focus on psychosocial rehabilitation and on improving social relationships, social reintegration vocational/educational functioning, and daily routine and leisure activities. Help patients reengage life.

Use Relapse Prevention procedures and follow-through interventions such as ongoing coaching, booster sessions and involvement of significant others in treatment.
Throughout all Phases of SIT solicit patient-informal feedback on a session-by-session basis, and adjust treatment accordingly.

**Resources on Stress Inoculation Training (SIT) and Related Interventions**

1. Google Stress Inoculation Training to read various Websites and papers that describe SIT. Also, see video application of SIT in training military personnel.

2. Visit [www.roadmaptoresilience.com](http://www.roadmaptoresilience.com) for a description of ways to bolster resilience and [www.melissainstitute.org](http://www.melissainstitute.org) for follow-up articles including treatment manuals on Prolong and Complicated Grief, Ways to integrate spirituality and psychotherapy, and Ways to bolster resilience in LGBTQ youth.


5. Meichenbaum conducts workshops on SIT ([dhmeich@aol.com](mailto:dhmeich@aol.com)).
REFERENCES


IMPLEMENTATION OF TF-CBT WITH CHILDREN, YOUTH AND THEIR CAREGIVERS

(See Allen & Kinniburgh, 2014; Allen & Johnson, 2012; Blaustein & Kinnibergh, 2014; Cary & McMillen, 2012; Cohen et al., 2009, 2012; Creed et al., 2014; Grasso et al., 2011; Hays, 2009).

1. TF-CBT has been applied effectively with children who have experienced a variety of multiple traumatic events including child sexual abuse, maltreatment, exposure to domestic violence, natural disasters and those who experience traumatic grief. It has been employed with children who have developmental disabilities and where there is also comorbid disorders such as depression, grief, substance abuse. Ollendick et al. (2008) indicate that the presence of comorbid disorders did not diminish treatment outcomes.

2. TF-CBT has been applied to children ranging from ages 3 to 18. The treatment is usually conducted on a weekly basis over a few months, ranging from 8 to 24 weekly sessions.

3. Children with supportive caregivers who are involved in treatment exhibit greater benefit from mental health interventions than children whose caregivers are not involved in treatment. The parent’s level of distress and engagement in parallel and conjoint sessions are predictive of treatment outcome.

4. TF-CBT has been altered in both a developmental manner using cognitive-behavior play therapy procedures and in a culturally-sensitive fashion. (See Cohen et al. 2012 and examples by Bigfoot and Schmidt, 2012 for Native American populations and deArellano et al., 2012 for Latino populations).

5. The therapist in TF-CBT structures sessions such that there is a focus on skill building and a direct discussion and processing of the traumatic and abusive experiences. Treatment addresses the impact of multiple traumas that may have co-occurred. There is a need to triage for basic needs and ensure ongoing safety. Trauma that is more severe in duration, perceived as life-threatening, and where the closer the relationship between the victim and the perpetrator, each contribute to more significant psychopathology. Abused children are more at risk for experiencing future episodes of maltreatment, bullying in schools, and other forms of traumatic events and revictimization.

6. The development, maintenance and monitoring of the therapeutic alliance with the child, youth and caregiver are central and critical to treatment effectiveness. There is a need for the therapist to be empathetic, genuine in developing a therapeutic relationship that engenders respect and
trust, so clients feel heard, valued and respected. The therapist can use reflective listening skills, humor, and nurture hopefulness throughout.


8. The components of TF-CBT have been summarized in a mnemonic PRACTICE.

   P – Psychoeducation and parenting skills
   R – Relaxation
   A – Affect expression and regulation
   C – Cognitive coping
   T – Trauma narrative development and processing
   I – In vivo gradual exposure
   C – Conjoint parent-child sessions
   E – Enhancing safety and future development

9. TF-CBT uses a Phase-oriented intervention flow-chart.

   Sessions 1-4 PRAC
   Sessions 5-8 TI
   Sessions 9-12 CE

10. Treatment usually entails individual sessions with the child and parallel sessions with the caregiver. The same therapist sees both the child and the caregiver and later conducts joint sessions when sharing and processing the trauma narrative.

11. Psycho-education is an ongoing process throughout the entire course of treatment and it takes various forms. For the child it may take the form of storybooks, games, role playing discussions, puppet play, and the like. These activities are designed to help normalize the client’s experiences, educate about the nature and impact of abusive events and bolster safety skills. Allen and Kronenburg (2014) list a variety of children’s story books that can be used with titles such as “The way I feel”, “Double dip feelings”, “Brave Bart”.

12. There is a parallel psycho-education intervention for caregivers that educate about the incidence, impact of abuse and neglect. Parent training skills and the use of PRAISE are highlighted. There is need to sensitively consider the caregiver’s level of distress, self-blame, and where indicated, history of abuse.

13. There is a need to elicit the story of abuse from the child or youth using the “art of questioning”, or re-enactment puppet play, drawing, and the like. For example, the therapist can ask:

   “Tell me more about…”
“I wasn’t there, so tell me about…”
“I want to know all about…”
“So X began touching your…”

Address avoidance behavior in a supportive fashion.

14. Help the child and youth tell and write out, draw their account in a chronological order - - like chapters in a book, or panels in a cartoon book. Use thought bubbles to elicit accompanying thoughts and feelings.

15. Help the child develop, practice and teach various coping skills:

Relaxation using belly breathing, cool air techniques. Raggedy-Ann, cooked spaghetti metaphors, Guided imagery, Dream catcher activity.

Affect Modulation – name and tame feelings, increase vocabulary for feelings, use Feeling Chart, SUDs Ratings, Guessing games, Emotional Bingo, role playing, Thought Bubbles, assertive and safety skills. Have the child teach these skills to his/her caregiver, and develop a “Coping Plan”. (Put the child in Consultative Mode and have his/her “take credit” for changes - - self-attributional training and relapse prevention procedures in order to enhance the likelihood of generalization and maintenance - - “lasting changes”.

16. The development and sharing of a trauma narrative with the caregiver is a critical feature of TF-CBT. Help the child to tell his/her trauma story over several sessions. Discuss and role play with the caregiver how to be accepting and supportive during the conjoint session. The need to be a role model and ways to enhance the child’s safety in the future (NO, GO, TELL).

17. Prepare the caregiver for the conjoint session of sharing the trauma narrative.

Explore what the caregiver knows about the abusive events.
Consider the caregiver’s emotional reactions and own history of victimization.
Role play caregiver parent-child interactive discussion of trauma narrative.
With the child’s permission have the child share artwork, narrative written stories with the caregiver.

18. In the context of preparing the caregiver for the conjoint session, explore the history and current victimization of the caregiver. In about 40% of the cases of child sexual abuse and maltreatment there is also evidence of Domestic Violence. The lingering effects of such abuse in the caregiver can undermine the treatment of the child.
19. Address any specific additional clinical issues such as grief work using Restorative Retelling procedures, Meaning-making activities, and the presence of sexualized and acting out behaviors.

20. Terminating Therapy

Review skills learned and progress achieved.
Build in Relapse Prevention training. Help bolster skills and confidence in meeting future challenges and any possible setbacks.
Fade out the treatment sessions and build in follow-up contacts and booster sessions.
Highlight the caregiver’s role as a therapeutic resource for the child.
Celebrate the child’s and caregiver’s Therapy Graduation.
REFERENCES


3. THURSDAY DEC. 14 10:15-10:45

Clinical Case Presentation (Video)
Discussant Bill O’Hanlon

“TREATMENT OF A SUICIDAL PATIENT WITH A LONG HISTORY OF VICTIMIZATION”

PRESENTATION OUTLINE

a. Background work with suicidal patients.
b. Video Presentation.
c. Ways to cope with your patient’s suicide.
d. Discussant’s comments.

LIST OF HANDOUTS

1. Order Information for the Missy Video (pp. 156)
2. Coping with Your Patient’s Suicide (pp. 157)
Cognitive-Behavioral Therapy with Donald Meichenbaum is a demonstration of arguably the most frequently used therapeutic approach by one of its co-founders. Dr. Meichenbaum uses cognitive-behavioral therapy with a constructive-narrative perspective in which he looks at the stories patients tell about themselves and considers ways that the patient could develop a different, more positive story. In this session, Dr. Meichenbaum works with a young woman who is depressed and anxious and has attempted suicide seven times. She has undergone multiple traumas in her life, including rape and several suicides in her immediate family. Dr. Meichenbaum accentuates the patient's strengths, skills and support system. Then he gently confronts the patient by helping her to see that, although one of her strengths is her willingness to forgive others, she has not been able to forgive herself for the things she has done.

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COPING WITH YOUR PATIENT’S SUICIDE

Donald Meichenbaum, Ph.D.

The first patient I ever treated as a graduate student at the Veteran’s Administration hospital in Danville, Illinois died by suicide. While my supervisor and fellow clinical students tried to reassure me that his death was not my fault, nor due to my clinical incompetence, I felt “deep down” that his suicidal death was a reflection of my inexperience. This incident caused me to wonder if becoming a clinical psychologist was the correct occupational choice.

In the 40 years since this initial clinical episode, I have had three other clients die by suicide being either one of my clients, or the client of a trainee I was supervising.

In fact, clinicians often have to treat suicidal clients. Consider the following findings:

- Full time psychotherapists will average up to 5 suicidal clients per month, especially among those clients who have a history of victimization and substance abuse;
- 1 in 2 psychiatrists and 1 in 7 psychotherapists report losing a client to suicide;
- 1 in 3 clinical graduate students will have a client who attempts suicide at some point during their clinical training and 1 in 6 will experience a client’s suicide;
- 1 in 6 psychiatric clients who die by suicide while in active treatment with a health care provider;
- Work with suicidal clients is considered the most stressful of all clinical endeavors. Therapists who lose a patient to suicide, experience such a loss as much as they would the death of a family member. It can become a career-ending event.
- Such distress in psychotherapists can be further exacerbated by the possible legal actions. 25% of family members of suicidal patients take legal action against the suicidal patient’s mental health treatment team (Bongar, 2002; Kleespies, 2017).

What can psychotherapists do in the aftermath of the suicidal death of his/her patient?

In a paper entitles “35 years of working with suicidal patients: Lessons learned”, I summarize the “Dos and “don’ts” of working with suicidal patients and the need to Document, Document, Document risk and protective factors and accompanying interventions in progress notes (Meichenbaum, 2005). The American Association of Suicidology has offered the following advice on “What to do if you lose a patient to suicide. These include both Procedural and Psychosocial steps to follow. I have inserted some additional suggestions.

1. Procedural (Immediate) Steps

A. Notify your supervisor and supportive colleagues. B. Notify the Director of your Service. C. Contact the Hospital Attorney. D. Consider contacting the client’s family members and ask whether you should attend the client's funeral, only with the family member’s permission.

2. Meeting your emotional needs.

A. Seek support from your supervisory, colleagues and significant others. B. Attend to your needs to “mourn”, in any form, this may take. C. Monitor any stress-engendering self-blame,
hindsight bias thinking processes. D. Use cognitive strategies to cope with the emotional aftermath of the client’s suicide. Engage in the mindful path of self-compassion (Gerber, 2009).

3. Education (later with supervisor, colleagues or review groups).

A. Review progress notes. B. Write a case summary of the ongoing risk assessment and the course of treatment interventions. C. Enumerate the lessons learned and share this with interested and supportive others. Make a “gift” of your clinical experience with others, transforming the loss into a “teachable experience”.

A number of clinicians have offered ways to bolster the psychotherapist’s resilience, and nurture post-traumatic growth in the aftermath of a client’s death by suicide. See Hernandez et al., (2010), Norcross and Guy (2007), Pope and Vasquez (2005), and Wicks, and Maynard (2014). Elsewhere (Meichenbaum, 2006, 2014, 2017), I have discussed ways to bolster resilience in psychotherapists and ways to “help the helpers”.

Finally, find ways to work with others to reduce suicide.
REFERENCES


4. THURSDAY DEC. 14 2:15-3:45
   Debate with Dr. Stephen Gilligan

   “COGNITIVE VERSUS EXPERIENTIAL EMPHASIS IN PSYCHOTHERAPY”

   PRESENTATION OUTLINE

   b. The role of Emotion in Cognitive behavior therapy.
   c. Two Case Examples:

      Treatment of Individuals with Prolong and Complicated Grief and Traumatic Bereavement

      Treatment of Victims of Human Trafficking

   d. A Search for Mechanisms of behavior change: The role of “story-telling”.

   LIST OF HANDOUTS

   1. Treatment of Individuals with Prolong and Complicated Grief and Traumatic Bereavement (pp. 161)
   2. Ways To Treat Victims of Human Trafficking: Core Therapeutic Tasks (pp. 219)
TREATMENT of INDIVIDUALS WITH PROLONG and COMPLICATED GRIEF AND TRAUMATIC BEREAVEMENT

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TABLE OF CONTENTS

Complicated Grief versus Traumatic Bereavement

Incidence of Complicated Grief

The Nature of Prolong and Complicated Grief Reactions: Use of a CLOCK Metaphor

1. Assessment Procedures
   1. Guided Interview and “Art of Questioning”
   2. Self-report Measures
   3. Self-monitoring procedures
   4. Risk Assessment: Past and Present (Suicidality)
   5. Coping with Grief Checklist

Appendix XX.1 Strategies for Coping with Grief Checklist

Need for Ecological Assessment: Other Losses

Evidence-based Principles and Practices for Clients with PCG and Traumatic Bereavement

Treatment Guidelines and Outcome Studies

Core Tasks and Processes of Grieving

Implications for Psychotherapy

Examples of the Core Tasks of Psychotherapy
   1. Establish, Maintain and Monitoring the Psychotherapeutic Alliance
   2. Conducting Psychoeducation: Examples
   3. Restorative Retelling Procedures
   4. Exposure-based and Supplemental Interventions
   5. Addressing Bereavement Specific Issues
   6. Self-attributional Training or Helping Clients “Take Credit” for Changes

References

Internet Websites
COMPLICATED GRIEF versus TRAUMATIC BEREAVEMENT

There is value in drawing a distinction between individuals who experience Prolonged and Complicated Grief versus Traumatic Bereavement in response to the loss of a loved one or for someone for whom an individual has a strong attachment relationship. Survivors are likely to experience deaths as traumatic if the loss is sudden, unexpected, untimely, often violent, and perceived as preventable, unjust, and resulting from an intentional human act. If the death involved violence or mutilation, or if the survivor believes that his/her loved one suffered during his/her final moments, then there is a high likelihood of mental anguish, an overwhelming sense of loss and difficulty accepting the death. They often struggle making sense of what happened and may experience guilt, self-blame, manifest preoccupation with the circumstances of the death and the deceased experience of suffering. Such shocking deaths may cause survivors to question their faith and experience “spiritual struggles.” (Pearlman et al., 2014). In addition, individuals who experience traumatic bereavement with accompanying PTSD are likely to experience intrusive thoughts, avoidance behaviors, cognitive and mood alterations, physiological arousal, loss of meaning, affect dysregulation, impaired concentration and being consumed by memories (rumination). They are prone to disengage from the present in favor of yearning for the deceased and focusing on the past. They evidence an avoidance of engaging in pleasurable activities and social contacts.

In terms of Prolonged and Complicated Grief, Prigerson et al., (2009) have proposed a Prolonged Grief Disorder (PGD) that is associated with intense, unremitting and disruptive impact on central roles and relationships and that contribute to enduring mental and physical health problems and that are slow to resolve and will persist if left untreated. At least 6-12 months following the loss, the individual with PGD experiences intense yearning or longing for the deceased, either daily or to a disabling degree, as well as 5 or more of the following symptoms on a daily basis, or to a disabling degree:

- feel stunned, dazed or shocked by the death; avoid reminders of the reality of the loss; have trouble accepting the death; have trouble trusting others; feel bitterness or anger related to the loss; experience difficulties moving on with life; experience confusion about one’s role in life or a diminished sense of self; feel that life is unfulfilling, empty or meaningless and feel numb (absence of emotion) since the loss.

In addition, they may also experience heightened levels of suicidal thinking and behaviors, impaired social functioning and more days of work missed.

The intense yearning for and preoccupation with the deceased, the accompanying pangs of grief in response to the evocation of the “echoes of the past”, the avoidance of loss reminders, social isolation and avoidance of seeking help can contribute to difficulties with occupational and social functioning, self-care behaviors, poor health, impaired sleep, contribute to substance abuse, and in some instances, contribute to suicidal thoughts and acts. (See Pearlman et al., 2014 - - pp. 42-43 – for a list of common responses to the death of a loved one).
Bereaved individuals with Complicated Grief are more likely to seek professional services than individuals without Complicated Grief.

Thus, the circumstances of the death can influence the nature of the bereavement process, and the type of treatment approach that should be employed. Survivors of natural deaths rarely encounter the problems and challenges that bring about great distress for survivors of traumatic deaths.

**INCIDENCE OF COMPLICATED GRIEF**

The incidence of Complicated Grief varies depending on the circumstances of the death (e.g. traumatic death due to violence, homicide/suicide), death of a child (as high as 30% to 50%), or whether the death was expected due to natural age-related causes. Some healthy individuals do not show significant distress, nor impaired functioning even shortly after a recent loss (Wortman and Silver, 1989). Most bereft people advance through bereavement without any residual problems (Parkes, 2011).

For most individuals (75%), over time the severity of their grief reactions subside and they grieve adaptively over a period of a few months and evidence resilience (Bonanno, 2002, 2004; et al. 2005; Clayton et al., 1968; Currier et al., 2008; MacCallum & Bryant, 2013). Wortman and Boerner (2007, 2011) have reported that while most survivors improve symptomatically, but they may still have difficulty finding meaning after a sudden traumatic loss, than after a loss stemming from natural causes. Neimeyer and Sands (2011) indicate that the inability to find meaning is a significant predictor of post loss adjustment.

Anywhere from 5% to 20% of bereaved individuals evidence Prolonged and Complicated Grief (PCG) reactions and Complicated Spiritual Grief reactions, chronic depression and related adjustment difficulties. Psychiatric outpatients who are bereaved evidence a higher incidence of PCG (Hensley, 2006).

During the first weeks past the loss, grief-related reactions are normal (Clayton et al., 1968; Pearlman et al., 2014).

- 70% of bereaved individuals report depression, sleep disturbances
- 85% experience bouts of crying
- 50% evidence diminished interest in usual activities, loss of appetite, difficulty concentrating, withdrawal, and a sense of insecurity

Such behavioral patterns of grieving occur across cultures, but there are marked variability in expression.

For a discussion of the controversies concerning the inclusion of Complicated Grief in DSM-V see Boelen & Prigerson, 2013; Jordan & Litz, 2014; Pearlman et al. 2014; Prigerson et al. 2001; Prigerson & Jacobs, 2001; Rando et al. 2012; Shear et al., 2011; and Wakefield, 2013. DSM-V has introduced the diagnostic category of Persistent Complicated Bereavement in the Appendix.
The diagnosis of Prolonged Grief Disorder (PGD) will be used in the International Classification of Diseases (ICD-11) (Maercker et al., 2013).
THE NATURE OF PROLONGED COMPLICATED GRIEF REACTIONS

Complicated Grief Reactions consist of a variety of components including how survivors perceive and appraise interpersonal, intrapersonal (reminders), situational triggers and the emotions they elicit, as well as the accompanying automatic thoughts, images, beliefs, schemas which contribute to how survivors behave (what they do and do not do) and how others react. This interconnective chain can occur in a variety of ways and can lead to a downward “loss spiral”, or can lead to a “recovery process”. The following CLOCK metaphor can be used to summarize and educate clients about the mourning process.

Use of a CLOCK Metaphor to Summarize Complicated Grief Reactions

12 o'clock - External and Internal Triggers

3 o'clock - Primary and Secondary Emotions

6 o'clock - Automatic thoughts and images, Thinking Processes, Schemas and Beliefs

9 o'clock - Behavior and Resultant Consequences

12 o’clock - External Triggers
- Circumstances of the death
- Reminders of death, losses
- Other people’s losses act as triggers
- Memorial events, routines

**Internal Triggers** – Reminders such as an anniversary and situational reminders (holidays, special times and events)
- “Echoes of other losses”.

3 o’clock – Primary and Secondary Emotions and The Survivor’s Attitude About Emotional Expression

Initially, stunned, shocked, disbelief, confused, emotionally numb, angry, enraged, sad, anxious, bitter, psychologically hyperaroused, devastated, sense of unreality about the loss, dissociated, disgusted, guilty, shamed, humiliated.

This may be followed by feelings of longing, yearning, emptiness, loneliness, fear that something else bad is going to happen, powerlessness, helplessness and hopelessness, separation distress and depression, “emotional anesthesia” and feelings of unreality.

6 o’clock – Automatic thoughts and images, thinking processes, schemas and beliefs

Initially, a sense of disbelief depending on the circumstances of the death, rumination on circumstances of the death, difficulty accepting the loss, disbelief, denial of the loss. Subsequently, sense of purposelessness, ongoing rumination and increased vulnerability to intrusive ideation, hallucinatory experiences, sense of losing control, “going crazy”, overgeneralized memories
that contribute to not envisioning a future and that undermines problem-solving, mistrust of others, and identity confusion, enduring search for meaning, engage in contra-factual thinking (Ask “Why Questions” for which there are no satisfactory answers), engage in “Only if” type thinking. Continually replay circumstances of the death, self-blame and critical negative thinking, hold onto unachievable goals. (See Janoff-Bulman, 1989, 1992; Nolen-Hoeksma, 2001; Stroebe & Stroebe, 1999, 2006).

The following are examples of the LOSS MINDSET and the accompanying METAPHORICAL NARRATIVES that characterize individuals who experience PCG. Such thinking processes and the accompanying emotional reactions contribute to the perpetration of complicated grief. The thinking processes include:

1. Inconsolable emotional pain.
2. A lack of a future outlook.
3. Guilt-engendering thoughts, self-blame, “hindsight bias” (judging something in the past on the basis of knowledge that one has now, but did not have then; “Monday Quarterbacking”).
4. Ongoing search for meaning.
5. Ruminations and self-doubt.
6. Contra-factual "If only" and "If then" thinking processes.
7. Thoughts that undermine help-seeking.
8. Low self-efficacy statements

Examples of the Narrative of Individuals with PCG

1. Inconsolable Emotional Pain

“I am (lost, adrift, bereft, a cry baby, entangled in a cascade of grief, a loop of unresolved grief).”
“I am experiencing a (fog of grief, bereavement overload, waves of grief).”
“I feel (alone in my suffering, stuck in the past, frozen in Time, an emptiness with a hole in my heart that cannot be filled).”
“I don’t know who I am any more. The light in my life is no longer living.”

2. A Lack of Future Outlook

“There is no future. My life is over.”
“I will never get better.”
“I am stuck in this forever.”
“This will never end.”
“There is no way to be happy again.”
“I don’t deserve to be happy, laugh, love again.”
“His pain ended, but mine will be forever.”
“Time has stopped for me.”
“It feels like it just happened.”
“I don’t have confidence in the future.”
“There are more yesterdays than tomorrows. I have nothing to look forward to.”
“I feel an impending doom.”
“I am waiting for the other shoe to drop.”


“I killed him/her. His/her death was my fault.”
“I was too busy and too self-absorbed that I overlooked (denied) the warning signs.”
“I didn’t do anything right when he/she was alive.”
“I am a bad person for letting this happen.”
“I must suffer like he suffered. It is not right to enjoy myself.”
“This is God’s punishment.”

“I feel guilty about all of the unfinished business between us. I never got a chance to say ‘I was sorry’.”
“I never got a chance to say a proper goodbye.”
“I was not there to comfort him when he died. He died alone.”

4. Ongoing Search for Meaning

“I haven’t been able to put the pieces of my life together since this event.”
“I have trouble making sense of her death.”
“How unfair that he/she died. It makes no sense?”
“His/her death was useless. What did he/she sacrifice his/her life for?”
“I am devastated. Since his/her death life has no meaning. It is purposeless.”
“I feel cheated.”
“I asked God to protect her, and He did not.”
“I was betrayed.”
“His/her death has robbed my life of meaning.”
“Since _____ died, I feel worthless, directionless.”
“Life has nothing to offer me.”
“I am trapped. I am up against a wall.”
“I keep asking why questions, but there are no satisfactory answers.”

5. Rumination – “Not Let It Go”- “Reenactment Story; Desire for Retribution

“I keep thinking about how he/she died.”
“I replay it over and over.”
“I repeatedly think about how things could have been different.”
“It is too painful. I do not want to think about it, but I can’t stop thinking about his/her death.”
“I keep asking, ‘Why me?’; ‘Why my child?’”
“I continually dream about revenge.”
“I am suffocated by my anger.”
“I can never feel completely safe again.”

6. Contra-factual Thinking Processes: “If only” and “If then…” Thinking

“If only X (I had, or I had not), I could have prevented his/her death.”
“Only if I had X, he/she would be alive today.”
“If I did X before and things turned out badly, how can I ever trust myself to make good decisions?”
“If only he/she were here now.”
“If I get better, then his/her death has no meaning.”
“If I don’t continue mourning, there is no one to hold onto his memory.”
“My grieving keeps his/her memory in the public “eye.”

7. Thoughts That Undermine Using Social Supports and Accessing Help

“No one knows how bad I feel.”
“No one can help me.”
“This is too painful to bear and share.”
“This is the worst thing that could happen. If I talk about his/her death, I will go crazy.”
“I cannot confront the reality of his/her death.”
“Nothing and no one can ease my pain.”
“No one will want to be around me when I am so miserable.”
“I am not whole. I have lost an important piece of me and it is not reparable.”
“I can’t trust anyone.”
“I feel shut out, a stigma over my head, like I had the plague.”
“I avoid and limit contacts with others.”

8. Lacking Ability to Cope: Low Self-efficacy

“I can’t cope.”
“I am emotionally worn out.”
“I can’t cope with anything that reminds me of him/her.”
“I can’t make myself better. I am trapped.”
“I will never have someone this close again, this important.”
“I don’t want to have someone this close to me again, and have them die on me.”
“Others will die and I won’t be able to bear it.”
“I was so dependent on ______. I cannot function without him/her.”
“Here I go again. The same vicious cycle that I cannot stop.”
“I don’t mourn the way I should.”
“I feel as if part of me has died.”
“I can’t trust my own judgment any longer.”
“Drained my vitality. My life has no purpose and meaning.”
“My life is now filled with never again.”
9 o’clock – **Behavior and Resultant Consequences**

Uncontrollable crying spells, sighing, fatigue, decreased appetite, difficulty sleeping, nightmares, neglect of self-care, increased use of substances, increased tobacco use. Difficulty concentrating, irritability, restlessness and difficulty reinvesting in life.

Proximity seeking behaviors- - wear deceased cloths, sleep in his/her bed, lie near the grave, hallucinatory experiences, hard to part with loved one’s possessions.

Avoidance of emotions and reminders, withdrawal, disengaged from usual activities that give pleasure, engage in mindless self-distraction activities, keeping busy, lack of acceptance of death, denial. Attempts to control rumination by suppressing thoughts and engaging in avoidance behaviors.

Difficulty “moving on” with life, failure to engage in memorial, commemorative ceremonies, avoid seeking social supports and help/treatment.

Social withdrawal can contribute to feelings of isolation, estrangement, loneliness. Self-isolation is an important factor associated with health problems, PTSD and complicated grief. Not participating in leisure activities that one enjoyed with the deceased because they trigger bittersweet memories; not participating in religious-based activities because disillusioned with one’s faith, engaging in overprotective behaviors with surviving loved ones can each contribute to PCG. Such reactions by survivors can be exacerbated by the social ineptitude of others who minimize the loss, or who offer “moving on” statements, or who avoid contact or fail to offer comforting supportive emotional and tangible assistance. (Dyregov, 2003-2004; Wolfert, 2006).

The grieving process can also be impacted by the legal system and media coverage in the aftermath of traumatic violent death of the deceased and by the need for victim impact statements.

Challenges of fulfilling new social roles and responsibilities (financial, parenting, role models). Loss of self-identity (e.g. being a “military spouse”) can contribute to Prolonged and Complicated Grief.
ASSESSMENT PROCEDURES
(See Neimeyer 2016 and Neimeyer et al. 2008 for a discussion of measurement of grief)

1. Guided Interview and the “Art of Questioning”

2. Self-report Measures

3. Self-monitoring Procedures

4. Risk assessment” Past and Present (Potential Suicidality)

5. Checklist of Coping Strategies with Grief

A number of event-related and person-related factors have been found to contribute to the mourning process. In terms of event-related factors these include: the characteristics and type of death - natural versus traumatic violent death (suicide, homicide, accident; finding or viewing the loved one’s body after a violent death; death in a hospital versus home and not being present when one’s loves one died); treatment related factors (perceived failure or negligence of treatment, perceived as a preventable death), caregiver burden, medical and related expenses; dissatisfaction with death notification; multiple deaths “bereavement overload”; threat to one’s own life, or witnessed the death.

The person-related factors include: gender - female (especially mothers), close kinship to the dying patient, especially spouse or child, being a widow/widower; high pre-loss marital dependency, vulnerability factors - developmental adversities including trauma history and prior losses; insecure attachment history; current physical health and degree of self-care behaviors; coping strategies such as optimism and use of one’s faith and spiritual/religious beliefs; supportive social network and kinship relationships. (See Pearlman et al. 2011 for a discussion of how event and person-related factors interact. For example, the loss of a spouse versus loss of a child interacting with the gender of the survivor and how Complicated Grief and Traumatic Bereavement overlap).

1. GUIDED INTERVIEW AND “ART OF QUESTIONING”

For a Guided Interview see Rando (1993) Grief and Mourning Status Interview and Inventory (GAMSII) that assesses the client’s mourning process and areas that need to be addressed. Topics include:

- Circumstances surrounding the death
- Nature and meaning of what has been lost
- The mourner’s reactions to the death
- Changes in the mourner’s life since the death
• The history of the mourner’s relationship to the deceased

• The mourner’s self-assessment of how well he/she is coping with the loss. Has his/her symptoms worsened, maintained or reduced since the traumatic event or death of your loved one?

• The mourner’s comprehension of the mourning processes and his/her expectations regarded the mourning process.

The following questions are designed to help identify the complex combination of grief, trauma and psycho-social problems (secondary losses) that clients experience. Clinicians should sample from this list of questions. Note that most of the questions are “How” and “What” questions. As Neimeyer and Thompson (2014) highlight, the interview should cover both the story of the events (“Event Story”) and the “Back Story” about the changed relationship with the deceased, and an account of the lingering impact and accompanying coping abilities. The interview should begin with Permission Gathering Questions.

Permission Gathering Questions.

Would this be a good time to talk about ________ ?
How would it be for you if we talked about (the deceased- use name and relationship. “the death of your dad, husband”)?
Is there at least one person you have (can) talked to about your grief? Who is that person?
Who would be a good person for you to share your grief?
Could we begin that conversation now?
You can stop at any time you want. Just share that which you feel comfortable with.

Questions about the circumstances of the death.

Follow the clients lead, but consider the circumstances - - violent traumatic death due to homicide, suicide, body mutilation, multiple deaths, suddenness, out of time death, death-child, death perceived as avoidable and unnecessary (“useless”).

What do you recall about how you responded at the time of the event?
Put yourself back there now.
How did you hear about the death?
How did you respond at the time of notification? Who was there?
How have your feelings changed over time?
Did you have to bear your grief alone?
What was the most emotionally difficult part of the experience for you?
How did you make sense of the death at the time?

Query about a “proper goodbye” and funeral arrangements. “In your eyes, was this a fitting goodbye?”
Questions concerning how currently experiencing grief.

“I would like you to think about how the death of ______ has impacted (influenced) your life.”
Please describe how your life has been since ______ died.
How are you doing with your grieving?
What impact has the death of ______ had on you?
How much does your grief still interfere with your life?
How much trouble are you having accepting the death of ____?
What has it been like for you to go through your daily routine without _____?
What has been going on in your life since the death of _____?
What changes have come about as a result of the death of _____? (Question pulls for possible secondary losses).
What has been lost since his/her death?
What lingers from this loss?
How have you dealt with your loved one’s belongings?

Besides sadness and missing ______, what else are you feeling?
When you talk about these feelings, what else comes to mind?
Can you tell me more about that?
Is there anything you would like me to know about your past experiences?

Do you think it is possible that some of what you are feeling right now, might be related to earlier experiences you have had? (Question designed to assess earlier losses and developmental adversities)
Might some feelings be tied to your concerns (fears, uncertainty) about the future?
Are you struggling to make sense or find meaning in what happened?
What has helped you cope with this loss?
Are there people to support you in your loss?
What have you found helpful and what was of little or no help?
What areas of your life have not been influenced by your loss?
How are these coping strategies useful?

Questions Concerning Emotional Reactions

Litz et al., (2016, p. 106) offer the following questions:

“What are you most sad about?
What are you most troubled by?
How do you think this event has changed you?
Is there anything that could have been different?
What do you think will happen if you let yourself feel the intensity of your grief?
Have there been other times when you’ve lost someone? If so, how is this similar or different?
How did you mourn/grieve in the past?”
In the aftermath of the death of a loved one, individuals may experience a mixture of different feelings. Some may feel sadness, anxiety about the future, anger, guilt, shame and other feelings. Some may even experience positive emotions of relief, gratitude, forgiveness, pride. Can we take a moment to discuss how you felt at the time of ______ death and what feelings linger now?

Can you tell me about your feelings and how they have changed over time?
When you have such feelings, what do you do with those feelings?
Do you ever feel like you have a need to suffer?
Do you feel that you need to live with your (guilt, shame, anger, sadness)?
What gets in the way of your sharing your grief with others or you getting help?
Do you have any goals at the present time?
What would you like to be doing if you were no longer grieving? How can we work on ways to meet these goals?
Can you describe something you did, or something that happened to you that made you feel good and that was meaningful to you and that helped you get through the day?

Questions Designed to Tap Past History of Coping and Current Sense of Self-efficacy.

Can we take a moment to discuss what challenges, setbacks, losses you have experienced in the past? What were these?
How did you handle (overcome) these challenges (losses)?
What coping skills and support from others did you use to handle these challenges?
What helped you then?
Who was most helpful? What did he/she say or do that was helpful?
Is there anything that helped you then that you can use now?
What contributed to your ability to “bounce back”, be resilient, in spite of______?
Could you answer the following question? “Although I am sad, I am still able to _____”
Can you mobilize your own self-healing?
Is it okay for you to be okay?

Questions Designed to Tap Relational History (Past, Present, Future).

(Assess for the importance of the deceased person(s) in the client’s life and in terms of future adjustment - - see Magariel, 2016).

Is it okay if I ask you some questions about your past relationship with your_____?
Can you tell me about your relationship with the deceased? (Use the deceased husband, son, etc - - use the deceased name).
What did you most appreciate about him/her?
What do you think he/she most appreciated about you and your relationship?
If I was watching you earlier in your life, what moments would I have seen that would help me best understand the connection you two shared?
What were the challenges the two of you faced and how did you handle (overcome) them?
What was unique about your relationship?
When did you feel your closest connection with _____?
When did the two of you spend time together?
In what ways did you two care for each other?
Was your spouse (husband/wife) the person in your life who would encourage (help) you through difficult times?
If your _____ were here now, what advice (guidance), if any, would he/she offer?
Do you ever hear his/her words of encouragement in your mind?
How would he/she want you to remember him/her?
Do you think you could develop an ‘internal’ relationship with your _____?
What do you think ______ would want you to do now?
What would you like others to know about your relationship with _____?
What would you like others to know about the legacy (gifts) he/she has left you?
Is there anything you wish you would have said or done before he/she died? What was that?
Is there any “unfinished business”, or any regrets that you have about your relationship with _____?
Is this the first time you shared this with anyone?
What was this discussion like for you?

Lichtenthal & Breitbart (2016) have proposed a set of questions “Who am I?” to help clients engage in collaborative goal-setting.

Who was I before my loved one died?
Who was I while my loved one was sick?
Who am I now?
Who do I want to be?

Assessment of Meaning-making, Spiritual and Religious Beliefs and Practices

For clients who believe in God, Pearlman et al. (2014), suggest asking, “In dealing with the death of X, do you feel supported, abandoned, or betrayed by God?”

For clients who attended religious services prior to the death, “Has the death of X affected your participation in your religious community?”

Do you think that for you this event holds meaning other than loss?
How have you made sense of the death at the time? How do you view the loss now?
What spiritual or religious beliefs help you cope now?
Are there ways that his/her loss has affected the direction of your life?
How in the long run, do you imagine that you will give this loss meaning in your life?

See Meichenbaum’s Handout on www.melissainstitute.org for ways to assess spiritual/religious coping strategies. On the Home Page, click Resources on the top of the page. Scroll down to Author Index and then to Meichenbaum. See paper “Trauma, spirituality and recovery”.

Assessment of any benefit -finding

Has anything good come of this loss (his/her death)?
Have you found any insight, benefits or gifts that came from your grieving? If so, what?
What qualities in yourself have you drawn on that have contributed to your resilience?
Has your loss affected your sense of priorities? What is most important to you now?
What lessons, if any, about loving and being close to others you care for, has this loss taught you?
Has this loss deepened your love, your gratitude for anyone or anything you have?
How has this loss contributed to a new outlook on your life?

2. SELF-REPORT MEASURES

Inventory of Complicated Grief (ICG) and Briefer Version ICG-13, Revised
Prigerson et al., 1995; Prigerson & Jacobs, 2001

Texas Revised Inventory of Grief (TRIG)
Faschingbauer, 1981

Two-track Bereavement Questionnaire for Complicated Grief (TTBQ-CG31)
Rubin & Bar-Nadav, 2016

Trauma and Attachment Belief Scale (TABS)
Pearlman, 2003

Continuing Bands Scale
Field et al., 2003

Hogan Grief Reaction Checklist (HGRC)
Hogan and Schmidt, 2016

Grief and Meaning Reconstruction Inventory (GMRI)
Neimeyer et al., 2016

Inventory of Complicated Spiritual Grief
Burke et al., 2014; Burke & Neimeyer, 2016

Moral Injury Questionnaire- Military Version (MIQ-M)
Currier, 2016

Post Traumatic Adjustment Scale
O’Donnell et al., 2008

Inner Experience Questionnaire
Brock et al., 2006

Inventory of Self-Capacities
Briere & Runtz, 2002

Inventory of Daily Widowed Life (IDWL)
Caserta & Lund, 2007; Caserta et al., 2016

Inventory of Stressful Life Experiences Scale (ISLES)
Holland et al., 2010, 2014; Holland, 2016

Inventory of Social Support (ISS)
Hogan & Schmidt, 2016

Perceived Life Significance Scale
Hibberd, 2016

World Assumption Scale
Janoff-Bulman, 1989
Affect Balance Sheet  Bradburn, 1969
Professional Quality of Life Scale (PROQOL)  Stamm, 2005
Meaning of Loss Codebook  Milman et al, 2016
Analysis of Narratives: Meaning of Loss  Gilles et al, 2014
Collaborative Goal-setting “SMART” Goals  Meichenbaum, 2013; Sage et al., 2008
Specific, Measurable, Attainable, Relevant, and Time-limited
Use Time-lines of Chronological Losses  Neimeyer, 2012
Asses Genograms and Social Supports  Neimeyer, 2002; Wolfert, 2006

Follow up this assessment of Social Supports with detailed questions that probe for:

Who is in the client’s social network? (Note names and relationships)
Which network members provide effective emotional, informational and tangible supports?
Which members were in the network prior to the loss, but have since backed away?
Which members (activities, settings) do you intentionally try to avoid? Why?
What “insensitive” comments and questions have you experienced?
What impact have these comments or actions had on you?
How have you coped with them?
Have you actively sought out social supports (church, work, school, survivor groups, internet)?
Have you gone online and used the Internet to connect with others who have experienced a similar loss; or visited Internet resources like griefnet.org, Memorial Groups or commemorated and memorialized X (the person you lost)?
What types of social support do you need now?
What are some barriers/obstacles that get in the way of your accessing such support?

3. SELF-MONITORING PROCEDURES

Grief Monitoring Diary - - Turret & Shear (2012)

Ask clients to rate their grief intensity on a 0 to 10 scale, where 0 is “no grief at all” and 10 is “the most grief they ever experienced.” Record the highest and lowest level of grief experienced that day.

As Turret and Shear (2012) highlight, such Grief Monitoring serves several functions:

1. Helps clients map and observe the variability in their grief reactions, pinpoint triggers and “stuck points” and “hot spots.”
2. Help clients figure out what feelings are grief and what other emotions are being experienced. “What is grief and what is not grief?”

3. Provides a basis for collaborative goal-setting and a consideration of alternative coping strategies.

Another form of self-monitoring involves having clients notice when they are engaged in a “vicious cycle”. Use CLOCK analysis.

Activity Logs, Day Planners, Monitor engagement activities. (Check in with self and ask “How am I doing?”) Record positive activities.

4. RISK ASSESSMENT: PAST and PRESENT (Suicidality)

Lobb et al (2010) have identified the following factors as being potential risk factors for the development of Prolonged and Complicated Grief Disorder.

History of prior trauma and loss/History of mood and anxiety disorders/Insecure attachment style/Being a caregiver for the deceased/Violent cause of death (e.g., suicide, homicide/Lack of social supports after the loss.

Current risk factors include the presence of comorbid disorders such as depression, PTSD, Substance Abuse and the presence of suicidal ideation and behaviors. (See Jordan and Litz, 2014 for a discussion of the distinctions between free-floating depression versus the focalized grief on the deceased that accompanies PCG).

PCG has been associated with 6 to 11 times the general rate of suicidality. For a discussion of ways to assess for the threat of suicidal behaviors accompanying Complicated Grief, visit the Melissa Institute Website www.melissainstitute.org. See papers by Meichenbaum on “35 years of working with suicidal patients, Lessons learned” and “Child and adolescent depression and suicide: Promising hope and facilitating change”.

5. COPING WITH GRIEF CHECKLIST

Another way to conduct assessment is to ask clients with PCG to fill out a Coping With Grief Checklist and then reviewing their responses afterward. The following article describes such a Checklist and how it can be used. This Checklist should be given after several months have passed since the loss of a loved one. Implicit in having clients fill out this Checklist of Coping Strategies, and the subsequent clinical discussion of what coping strategies the client has used and found helpful, are suggestions of additional potential coping strategies that could be tried. The therapist can ask clients:

“Of the Items that are on the Coping with Strategies Checklist, how did you come
to choose those? How helpful were they? Can you give me an example? Of the remaining items that you did not check, are there any that you think would be worth trying, adding to your coping repertoire? Which ones? How did you come to choose those? Can you give me an example how you might use them? What would change? What would other people notice changing? Can you foresee anything that might get in the way or undermine your using these coping strategies? I am eager to learn if what you chose will indeed be helpful? Are there any coping strategies in your “tool box” that are not on this checklist that you think we should add and share with others?
STRATEGIES FOR COPING WITH GRIEF

Donald Meichenbaum and Julie Myers

CLIENTS FOR WHOM THE TECHNIQUE IS APPROPRIATE

Presenting clients with a history of trauma and loss with a list of coping strategies can help mobilize resilient and adaptive responses for a broad range of survivors. However, it is not intended as a stand-alone intervention for complex loss or trauma, and is restricted in its written form to adults with at least a 6th grade reading level.

DESCRIPTION

In the aftermath of experiencing traumatic events and personal losses, 5% to 20% of survivors evidence prolonged and complicated grief and traumatic bereavement, often with accompanying adjustment difficulties (Pearlman et al., 2014). Although the remaining proportion of survivors is affected, they evidence more robust resilience and are able to continue functioning (Meichenbaum, 2013).

One factor that distinguishes these two groups is the nature of the coping strategies that they employ. We have identified a list of coping strategies, taken from the treatment literature, clinical experience, and focus groups with survivors and their mental health providers, and incorporated them into a self-report list of strategies (see Neimeyer, 2012; Rando, 1992; Shear & Gorscak, 2013). This list (see Appendix XX.1) can be used with all classes of survivors, including individuals experiencing prolonged and complicated grief reactions due to the loss of loved ones some time ago, as well as with individuals experiencing recent traumatic bereavement, as described in the case below.

First, survivors complete the list, indicating which coping strategies they have employed. This can be done either alone or with their healthcare provider. Then, they discuss with their provider the items they used and examine how, when, and in what ways they have proven helpful. A key aspect is to have survivors identify other list items that they might wish to try, and more importantly, what barriers might get in the way of using them.

This format may also be used when facilitating a group of survivors, by having each member review the list before the group meets, and then discussing which coping strategies they chose and how they used them. In this way, survivors can learn from their peers how coping strategies might be helpful and worth trying.

In this approach, assessment and suggestive interventions are interwoven. Filling out the list per se is not the most helpful feature, but rather it is the subsequent discussion and implementation that are critical to the recovery process. The list acts as a catalyst and a self-selected guide to negotiate the mourning process and to bolster resilience. The list helps the bereaved begin a healing journey whereby they can develop a new identity and narrative including examples of a number of "RE" verbs, such as re-framing, re-claiming, re-connecting, re-solving and re-building their lives (Meichenbaum, 2013).
CASE ILLUSTRATION

Tom, a 44-year-old mechanic, had always thought of himself as a happy person. He enjoyed his work and was dedicated to his wife Susan and their children. Susan had difficulty controlling her diabetes, which required that Tom be a caretaker of both his children and his wife, a role he took on willingly. One day, with no sign to her husband, Susan slit her wrists in the bathtub. When Tom found her several hours later, the blood-filled bathwater was still warm.

Tom’s traumatic bereavement was such that he was unable to care for his children or return to work. After a month, he sought professional help and was diagnosed with PTSD. Tom had a particularly overwhelming sense of helplessness, so key to his recovery was instilling a sense of self-efficacy, which made him an ideal candidate for the “Strategies for Coping with Grief.”

After stabilization, Tom was introduced to the list of strategies. He felt “safer” completing the list with someone, so he and his provider reviewed it together over the course of several sessions. Tom reported that some of the items he had tried were helpful, and he was encouraged to continue those activities. In particular, he found most useful the comfort and help from others such as his siblings.

He identified several new items he would like to try and possible ways to modify items that he thought might be helpful. The provider also suggested modifications that Tom might try, for example, as Tom’s faith was shaken, he suggested new ways that he could reconnect with his spirituality, such as poetry and meditation.

As Tom went through the list, what emerged was evidence of resilience and fortitude, despite his traumatic loss. He had a “toolbox” of things he could use by himself, which empowered him, decreasing his sense of helplessness. He found that he turned to the list around anniversary dates and particularly troubling events, even years later. In essence, the list served as a relapse prevention tool.

Although Tom required professional trauma treatment, the list of strategies allowed him to take charge of his own recovery, bolstering his resilience.

CONCLUDING THOUGHTS

The list of strategies provides individuals who are at different phases of their mourning process an opportunity to "take stock" of their present coping strategies and to consider other potentially useful strategies. A discussion about the list with their provider can encourage individuals to ask themselves, "What can help with my grief now?" It can also help individuals identify coping strategies that can be employed "down the road," when emotional upsurges or sliding into negative self-talk with its accompanying dysfunctional emotions occur, or when preparing for high-risk situations such as anniversary events, thus minimizing being “blindsided” by unexpected thoughts and emotions.

Research can be conducted to determine the potential usefulness of Strategies for Coping with Grief as a supplemental tool to varied interventions. We welcome feedback on the content and use of this list.
REFERENCES


Appendix XX. 1

STRATEGIES FOR COPING WITH GRIEF CHECKLIST

Donald Meichenbaum, PhD and Julie Myers, PsyD

The process of grieving is like going on a “journey.” There are multiple routes and people progress at different rates. There is no right way to grieve, no one path to take, no best coping approach. These grief coping strategies list some of the pathways that others have taken in their journey of grieving. It is not meant to be a measure of how well you have coped or how you should cope, since there is no one way to manage the pain following the aftermath of the loss of a loved one, no matter what the cause of his or her death. Rather, the strategies listed are suggestions of things you might consider doing to help you on your journey.

We suggest that you look through this list and put a mark by the coping strategies that you’ve tried. Hopefully, these strategies have helped you. But if you feel that you could use a little extra help, we suggest that you look through the list and then choose some new items that you would like to try. You may find them helpful, and you can add them to the strategies that you’ve already tried. This list is intended to help you discover new ways that you can move forward on your journey through the process of grief. If there are things you have done that you have found helpful that are not on this list of coping strategies, please add them at the end so we can share these with others.

Sought comfort and help from others

___1. I examined the thoughts that kept me from seeking help from others, such as the beliefs that “I am a burden to others,” “No one can help me, no one understands,” “I have to do this on my own,” “I should be stronger,” “Listening to the grieving stories of others will make me feel worse,” or “People are tired of hearing about my loss.”
___2. I reached-out to family, friends, elders, or colleagues for comfort and companionship, but gave myself permission to back-off when I needed time alone.
___3. I took the initiative to reach-out to folks from whom I might not normally seek help. I looked for new friends in church groups, social groups, work, school, or I went on the internet to find others who experienced a similar loss. I made a list of these supports to turn to when I was struggling or experiencing pain.
___4. I forced myself to be with people and to do things, even when I didn’t feel like it. I put something on my calendar almost every day, with back-up plans.
___5. I allowed myself to tell people how much I loved, admired, and cared for them.
___6. I hugged and held others, but felt free to tell people when I did not want to be touched.
___7. I learned to grieve and mourn in public.
___8. I shared my story with others who I thought would appreciate and benefit from it. I told anyone who would listen to the story of the deceased, even if they had nothing to say back.
___9. I gave and received random acts of kindness.
__10. I connected with animals and nature, for example, the deceased’s pet, a beautiful sunset, hike, or garden.
___11. I cared for or nurtured others. For example I spent time caring for my loved ones or children.
__12. I found my faith or religion comforting. I participated in religious, cultural, or ethnic mourning practices, such as attending church services, sitting Shiva, participating in a Wake, celebrating the Day of the Dead, visiting a memorial shrine, etc.

__13. I sought help from organized supportive bereavement groups, hospices, religious groups, grief retreats, talking circles, or groups specific to the way the deceased died, such as cancer support groups or survivors of violent loss groups, such as suicide or homicide.

__14. I sought help from mental health professionals. For instance, attended counseling sessions or took medications as advised by my providers.

__15. I read books written by others who have coped with the loss of a loved one. I read about the grieving process, loss, and advice books about other issues that arose.

__16. I made a list of all the professional resources that I could use in a crisis, such as suicide hotlines, mental health crisis lines, mentors, clergy or imam, or mental health providers.

__17. I decided not to walk through the grieving process alone, so I visited websites that focus on the grieving process *(Refer to the list of websites at the end of this list.)*

**Took care of myself physically and emotionally**

__18. I examined the thoughts and feelings that kept me from taking care of myself physically and emotionally, such as guilt, shame, sense of lost self, and loss of the will to live.

__19. I established routines of daily living. Although things were different, I made new routines and did not berate myself when I was not “perfect.” I maintained personal hygiene, medical care, healthy nutrition, and regular sleep.

__20. I reconnected with my body through exercise, yoga, Tai Chi, or expressive arts, allowing myself time to get stronger.

__21. I recognized that my brain needed time to heal and for things to improve, so I forgave myself when I made mistakes, became distracted, couldn’t remember or understand.

__22. I avoided the excessive use of alcohol, tobacco, recreational drugs, and caffeine as a coping mechanism.

__23. I relinquished avoidance and learned to face my fears by engaging in life. I participated in activities that had meaning and kept me occupied, such as work, hobbies, crafts, singing or dancing.

__24. I allowed myself to pursue and feel positive emotions, such as compassion toward myself and others, expressions of gratitude, and emotions of love, joy, awe, and hopefulness.

__25. I recognized and labeled my feelings, viewing them as a “message” rather than something to avoid. I accepted and dealt with these emotions, understanding that the less I fought them, the more I was able to handle them.

__26. I regulated my strong negative emotions using slow smooth breathing, coping self-statements, prayer, or other mood-regulating techniques.

__27. I allowed myself time to cry at times and gave words to my emotional pain. I distinguished feelings of grief from other feelings such as fear, uncertainty, guilt, shame, and anger.

__28. I expressed difficult feelings through writing and talking to supportive others. I used journaling, reflective writing, letter or poetry writing, or other expressive arts of scrapbooking, dance or music.

__29. I engaged in gratitude activities, such as telling others how much I appreciate their love and support, reminding myself of the things that I am thankful for, and being grateful that I knew the deceased.
30. I established a safe and comforting space for myself, either physically or through imagery.

Stayed connected to the deceased and created a new relationship, while recognizing the reality of the loss.

31. I examined the feelings and thoughts that kept me from forming an enduring connection with the deceased, such as the fear of what others would think of me, guilt, shame, humiliation, disgust, or thoughts of anger, revenge or being preoccupied with my grief.

32. I participated in practices, such as visiting the grave or memorial site, celebrating special occasions, prayer and candlelight vigils, public memorials, or commemorative services.

33. I commemorated the deceased’s life with words, pictures, things, or created a small place of honor for the deceased, which I could visit any time I chose.

34. I thought about what I received from the deceased and the legacy and mission to be fulfilled. I became involved in a cause or social action that was important to the deceased or myself.

35. I created a legacy such as planted a tree, started a scholarship or charity in the deceased's name, started an internet blog, or launched new family or community practices.

36. I allowed myself to talk to the deceased and allowed myself to listen. I wrote a letter to my loved one and asked for advice.

37. I asked for forgiveness, shared joys and sorrows, and constructed a farewell message.

38. I accepted that sadness was normal and learned how to be with my grief. I learned how to contain my grief to a time and place of my choosing. However, I understood that intense upsurges of grief may arise unexpectedly and without warning, and I developed coping strategies to handle such events.

39. I used imagery techniques, shared stories and photos of my loved one, or purposefully used reminders such as music or special routines to recall positive memories. I cherished and hung onto specific, meaningful possessions (objects, pets, etc.). I actively reminisced, holding onto our relationship in my heart and mind.

40. I reached out to help and support others who are grieving for their loved ones. Helping others is a way to reengage in life and combat loneliness and tendencies to withdraw and avoid social contacts.

Created safety and fostered self-empowerment

41. I examined the thoughts that fuel my fears, avoidance, and the belief that I cannot or should not feel happy and that things would never get better.

42. I took a breather and gave myself permission to rest knowing that grieving takes time and patience, with no quick fixes.

43. I identified memories that trigger or overwhelm me and disengaged and/or established boundaries by limiting people, places, or things that cause me stress or overwhelm me so that I could address them one by one, in my own time. I learned to say “no” to unreasonable requests.

44. I identified important activities, places, or things that I was avoiding due to fear of my grief reactions. I slowly reintroduced them or allowed myself to choose those I never wanted to encounter again.
45. I began to think of myself as a “survivor,” if not a “thriver” of my own story, rather than as a “victim.” I reminded myself of my strengths and of all the hard times that I have gotten through in the past.

46. I wrote out reminders of how to cope and put them on my fridge, cell phone, or computer. I looked at them when I was struggling and reminded myself of ways to be resilient.

47. I created a plan about how to cope with difficult times. I learned to anticipate and recognize potential “hot spots” of when things are most difficult. I rated each day on a 1 to 10 point scale on how well I was doing. I asked myself what I can do to make things better and increase my rating. I worked on increasing the number of good days compared to the number of bad days.

48. I avoided thinking “This is just how it is,” realizing that I have choices no matter how hard life is. I came to recognize that emotional pain can be a way to stay connected with my loved one.

49. When I was overwhelmed by negative memories of the past, I avoided “time-sliding” into the past. a) I “grounded” myself to the present by refocusing my attention on the environment around me, b) I changed my self-talk by telling myself “I am safe and that this will pass,” c) I controlled my bodily reactions by slowing down my breathing, and d) I oriented to people’s faces, voices or touch or called for help from a friend.

50. I examined the thoughts and feelings that kept me from moving forward, such as “I am dishonoring the deceased by getting better,” or “I am leaving him/her behind,” or “Feeling happier means that he/she is no longer important to me,” or that “My love for him/her is fading.”

51. I regained my sense of hope for the future. I worked to reestablish a sense of purpose, with meaningful short-, mid-, and long-term goals. I am creating a life worth living, taking control of my future.

52. I worked on regaining my sense of self-identity, knowing that my life had changed, but that I am still me. I focus on what is most important. I developed new goals and action plans, consistent with what I value.

53. I created purpose by keeping the memory of the deceased alive in others. I kept others aware of the circumstances of the death, so that some good could come from the loss. I transformed my grief and emotional pain into meaning-making activities that created something “good and helpful,” for example Mothers Against Drunk Driving and the Melissa Institute for Violence Prevention.

54. I use my faith-based and religious and spiritual beliefs to comfort me and move on. People hold different beliefs, such as "My loved one can continue to influence the lives of others in the world," or "My loved one is no longer suffering and is in a safe place," or "We will be reunited in the future.”

55. I examined the reasons why some of the activities that have been helpful to others in the grief process were not helpful for me, and what I can do to help myself further in the journey through grief.
Other coping activities or strategies I have used to cope with my loss

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Please feel free to let us know if you have any comments about this list, so we can be of assistance to others like yourself. You can reach the authors by e-mail at dhmeich@aol.com or at Julie.Myers100@gmail.com

Helpful websites:
www.griefnet.org
www.compassionatefriends.org
www.dougy.org
www.taps.org
www.missfoundation.org
www.afsp.org/copating-with-suicide
www.opentohope.com
NEED FOR ECOLOGICAL ASSESSMENT: OTHER LOSSES

Hobfoll and de Jong (2014) highlight the impact of various resource losses (material, psychological, social, spiritual), according to Conservation of Resources (COR) theory. Such loses are a major predictor of PTSD and the negative consequences of trauma. They underscore that the loss of “social and cultural capital” is exacerbated by ecological, contextual, and systemic factors such as:

1. the degree of the material resource loss and the length of time to receive assistance (meet basic needs, housing, insurance);
2. the ability to activate and renew their life course;
3. the ease and support during a reentry and reintegration processes;
4. the degree of safety and access to sustainable supportive attachment relationships;
5. the enactment of cultural and societal recuperative processes.

Any interventions need to assess and address these losses that can lead to prolonged and complicated grief. There is a need to address more that the cognitive and emotional responses at the time of the trauma and its aftermath. See Meichenbaum (2013) for a discussion of ways to bolster individual, familial and community-based ecological resilience.
EVIDENCE-BASED PRINCIPLES AND PRACTICES FOR CLIENTS WITH COMPLICATED GRIEF AND TRAUMATIC BEREAVEMENT

(Guidelines gleaned from Allen, 2013; Dyregov & Dyregov, 2002; Foa et al., 2007; Holland et al., 2014; Klass et al., 1996; Meichenbaum, 2013; Neimeyer et al., 2011; Jordan & Litz, 2014; Pearlman et al., 2014; Rando, 1993; Shear et al., 2006, 2011; Shear & Frank, 2006; Stroebe & Schut, 1999, 2010; Stroebe et al., 2013)

1. Grief work or working through the loss may involve loss-oriented coping efforts that include experiencing the pain associated with the loss, reminiscing about life as it had been, ruminating about the circumstances surrounding the death, pining about the future. Restorative-oriented coping efforts include the survivor’s efforts to replenish psychological resources, mastering new skills and engaging in new activities and pursuits, making new social contacts and relationships, and creating a new identity. Each of these restorative efforts provide a respite from the loss and mourning process. Individuals oscillate between loss-oriented and restorative coping efforts.

2. Positive emotions can facilitate the healing process, adjustment and sustain hope. Such positive emotions as happiness, forgiveness, gratitude, a sense of awe, can nurture coping with loss. Positive emotions can bolster resilience. Such resilience-building behaviors can increase affect management capacities by increasing hippocampal volume, decrease amygdala activity and size, increase serotonin and endorphin production and activate the prefrontal cortex (McEwen & Gianaras, 2011; Southwick et al., 2011).

3. The process of mourning in many instances can be viewed as a search for meaning, or an attempt to make sense out of what happened. For some, their faith can act as a coping resource in the attempt to find meaning. The search for meaning may occur at many levels from the material (“How did my loved one die?”); from the relational (“Who am I now that I am no longer a spouse?”); from the spiritual or existential (“Why did God allow this to happen?”). Holland, Currier and Neimeyer (2014) report that from a bereavement standpoint, more adaptive meaning made of a loss has been shown to be associated with greater physical and mental health, over and above complicated grief symptoms, circumstances of the loss, and demographic factors.

4. The failure to find meaning or some form of consoling explanation of what happened can contribute to prolong and complicated grief, for those who are seeking meaning (Kesse et al., 2008; Pearlman et al., 2014). But for some survivors, the search for meaning is not a priority, need or realistic goal and they may not be preoccupied with issues of meaning, or sense making. Some individuals may not need to engage in a quest for meaning.

5. Grieving individuals do not go through a universal, nor normative pattern of mourning consisting of phases of denial, anger, bargaining, depression and ultimately acceptance, as initially proposed by Kubler-Ross (1969). There is considerable variability in the kinds of emotional experiences after loss. Psychotherapists who convey a so-called stage model of emotional reactions to death and dying may inadvertently undermine the healing process. (Doka & Tucci, 2011; Wortman & Boerner, 2001; Wortman and Silver, 1984).
6. There is a need for therapists to be culturally sensitive when treating clients with prolonged and complicated grief. See the following references for varied cultural mourning practices: Rosenblatt & Wallace (2005) for African American grief practices; Houben (2012) for Hispanic traditions; and Klass and Chow (2011) for other cultural variations.

7. For many individuals using some form of spirituality and religious faith practices may be comforting to address bereavement issues. For instance, Bryant and Anderson (2014) report that in the aftermath of the Asian tsunami local monks were employed to pray with the survivors in order to encourage adaptive responses and help them cope with multiple losses. Consider the following examples of spiritually-based coping strategies. A mother of a child, who was killed in the Newton school shooting, had the remains of her son cremated and placed in an urn that she keeps in her bedroom. She has a discussion each morning with these remains. The parents of a firefighter who died at the September 11 terrorist attack, but whose body was never found, discovered that he had donated blood before the tragedy. They had a formal funeral and buried his vial of blood as a proper farewell to their son. Many other examples could be offered including the Hispanic annual ceremony of the “Day of the Dead”, Jewish mourners sitting Shiva, Irish wakes, New Orleans jazz send off, and the like.

8. Interactions in various forms between survivors and the deceased are normative and not a sign of some form of pathology or mental disorders (Klass et al., 1996; Klugman, 2006; Pearlman et al., 2014; Sanger, 2008-2009). In fact, encouraging bereaved persons to break the bonds with the deceased may actually be harmful. A continuing connection with the deceased can be beneficial. A symbolic bond can serve as a “safe haven” for the bereaved and have a significant presence in the survivor’s life.
TREATMENT GUIDELINES AND OUTCOME STUDIES

1. The scientific basis for counseling for grief is weak (Bonanno & Lilienfeld; Currier et al., 2008; Jordon & Neimeyer, 2003; Neimeyer & Currier, 2009; Pearlman et al., 2014; Zhang et al., 2006). Interventions implemented shortly after death has limited effects (small effect sizes). Intervention between 6 to 18 months after the loss has proven more effective than those provided sooner. Moreover, there is a need to customize interventions to the different phases of mourning, and where indicated address the need to help clients cope with both trauma, as well as grief.

2. There is increasing literature on effective modes of treatment with Complicated Grief and Traumatic Bereavement (Boelen et al., 2007; Currier et al., 2008; Horsley & Horsley, 2011; Pearlman et al., 2014; Rando, 1993; Rosner et al., 2011; Ryner, 2011; Ryner & Salloum, 2011; Shear & Gorseck, 2013; Shear et al., 2005, 2001 Wittouck et al., 2011). Although, in some studies up to 50% of individuals failed to respond to treatment and the dropout rate is 20% to 30%. Self-referred clients respond more favorably to treatment.

3. Some individuals may not be ready for active treatment because of the competing demands of the acute posttraumatic phase, or due to a number of more pressing demands due to dislocation, financial, legal and physical individual needs. Until these immediate, more pressing psychosocial needs are met, then psychotherapeutic interventions may be contra-indicated. (Hobfoll & De Jong, 2014).

4. Specialized forms of interventions have been developed for individuals who are trauma survivors (Barski-Carrow, 2010; De Leo et al., 2014); individuals who are grieving the suicide of a loved one (Jordan & Mcntosh, 2011); homicide (Armour, 2003; Barske et al., 2010); loss due to infertility interventions and pregnancy losses (Kersting et al., 2013; Shapiro, 2010), and for individuals who are trying to bolster their level of resilience (Meichenbaum, 2013).

5. A number of innovative forms of interventions have been employed with clients experiencing traumatic bereavement and prolonged and complicated grief. See Neimeyer (2012, 2016) for a summary. These include:

<table>
<thead>
<tr>
<th>Treatment</th>
<th>References</th>
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<tbody>
<tr>
<td>Adaptive Disclosure</td>
<td>Gray et al., 2012; Litz et al., 2016</td>
</tr>
<tr>
<td>2016</td>
<td>Steenkamp et al., 2011</td>
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<td>Behavioral Activation and Exercise</td>
<td>Acierno et al. 2012; Addis &amp;</td>
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<td>Martell, 2001; Dimidjian et al.,</td>
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<td>Papa et al., 2013</td>
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<tr>
<td>Expressive writing through bereavement</td>
<td>Adams, 1999; Neimeyer et al., 2009; Pennebaker, 1997;</td>
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<tr>
<td>(diary work, journaling, letter writing)</td>
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<tr>
<td>Thompson &amp; Neimeyer, 2014</td>
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Expressive arts such as visual arts, music, dance movement therapies, theatrical enactments and horticultural therapy

Physical therapy, massage

Acceptance therapy

Mindfulness Training
Yoga, Tai Chi, Compassion and Loving Kindness Meditation, Engaging in repetitive tasks (woodwork, knitting), and other self-soothing activities.

Companioning the bereaved

Various Narrative forms of treatment
2015; Neimeyer et al., 2010,2014; Neimeyer & Thompson, 2014; Rubin et al., 2012; Saakvitne et al., 2000; White & Epton, 1990; Young et al., 2000

Spiritually-based and religious activities (Use of prayer and connections with congregants)

Imaginal conversations, or “chair work” (Restorative retelling)
Bryant, 2013; Paivio & Greenberg, 1995; Rynearson & Salloum, 2011

Family Therapy

Group Therapy

Public and private Bereavement Ritual and creation of a legacy, Memorialize, create an online memorial

Self-help Workbooks
1996

Internet Therapies
6. Cognitive-behavior approaches have been used with children and youth who have experienced traumatic bereavement and complicated grief (Cohen et al., 2006; Currier et al., 2007; Murray et al., 2008, 2013). (See www.musc.tfcbt.edu for training).

7. Antidepressant medication has little impact on the symptoms and adjustment associated with complicated grief (Zhang et al., 2006), but in combination with CBT it has been found to have some benefits (Jordan and Litz, 2014; Simon, 2013).

8. Internet-based cognitive behavior therapy has been employed successfully with individuals experiencing prolonged and complicated grief (Dominick et al., 2009-2010; Gilbert & Horsley, 2011; Kersting et al., 2013; Litz et al., 2014; Wagner, 2006, 2007, 2013). Caroll and Landry (2010), Lynn and Roth (2012) and William and Merten (2009) have described the use of online social networking to help individuals grieve and mourn.

9. Finally, there is a need to provide “help to the helpers” in order to reduce secondary or vicarious trauma, compassion fatigue and burnout, and transform these reactions into “vicarious resilience.” A number of authors have provided specific strategies to address Vicarious Traumatization (Bober & Regehr, 2006; Dalenberg, 2000; Elwood et al., 2011; Hernandez et al., 2007; Jordan, 2010; Norcross & Guy, 2007; Pearlman et al., 2014; Pearlman & Saakvitne, 1995; Saakvitne et al., 1996; Stamm, 2005; Wilson & Thomas, 2004) (Also see Meichenbaum, 2007 “Self-care for psychotherapists and caregivers-Individual social and organizational interventions” on www.melissainstitute.org - - under Author Index).
Worden (2009) has described the core tasks of grieving as consisting of:

a) acknowledging and accepting the reality of the loss, (balancing denial and reality);

b) experiencing and processing the pain and grief, (externalizing emotional pain);

c) adjusting to the world without the deceased, (adapting life assumptions and meanings);

d) finding an enduring connection with the deceased in the midst of embarking on a new life, (continuing bonds with their deceased loved ones or other loss object).

These overlapping tasks are flexible, since they can be addressed in different orders depending on the client’s needs and can be revisited and reworked over time.

Rando (1993, 2013, 2014) and Pearlman et al., (2014) have outlined the tasks of psychotherapy as the need for survivors to progress through six “R” processes:

1. Recognize the loss
2. React to the separation
3. Recollect and reexperience the deceased and the relationship
4. Relinquish the old attachments to the deceased and the old assumptive world
5. Readjust to move adaptively into the New World
6. Reinvest in life

Neimeyer (2002) has highlighted that the mourner needs to:

1. formulate a coherent narrative of the loss;
2. retain access to the bittersweet memories and emotions and cope with troubling feelings;
3. revise, rather than relinquish one’s relationship with the deceased;
4. redefine one’s life goals and experiment with new roles and relationships.
IMPLICATIONS FOR PSYCHOTHERAPY

An analysis of the grieving processes underscore the variety of core psychotherapy tasks that need to be incorporated in work with individuals who evidence Prolonged and Complicated Grief and Traumatic Bereavement. The Core Tasks include the need to:

1. Establish, maintain and monitor the psychotherapeutic alliance with the client and significant others;

2. Conduct initial and ongoing assessments and provide the client with feedback, using a Case Conceptualization Model of risk and protective factors. Be sure to assess for the client’s “strengths” and for any evidence of resilience. Be sensitive to cultural, developmental gender issues, and the presence of any co-occurring disorders. Also, assess for the client’s implicit theory or belief about the potential to change, as being a member of his/her ethnic or religious group. How should one cope with loss and negotiate the mourning process in a culturally-sensitive fashion?

3. Ensure the client’s safety (possible suicidal tendencies), and address self-care needs and the presence of any therapy-interfering factors. Do so on an ongoing basis;

4. Employ motivational enhancement procedures and involve significant others, where indicated;

5. Conduct psychoeducation about grief. Validate and help normalize the client’s grief. Use the CLOCK metaphor to help clients learn how feelings, thoughts and behaviors are interconnected, and how the client may inadvertently, unknowingly, and unwittingly contribute to his/her adjustment difficulties. Help the client appreciate the nature and influence of their narratives and “story-telling” style;

6. Engage the client in collaborative goal-setting that nurtures hope. Help the client create concrete plans with SMART goals (Specific, Measurable, Attainable, Relevant, Timely). Help clients identify new aspirations and activities;

7. Encourage the client to reengage in pleasurable and reconfirming activities with others (seek new companionship). For example, use Behavioral Activation (exercise) with others. Promote social reengagement. Use the Strategies for Coping with Grief Checklist;

8. Conduct emotion-regulation and behavioral skills training in order to nurture self-efficacy and as a way to enhance social supports (networking). Build in generalization guidelines and reinforce any resilience-engendering activities. Include self-attribution (“taking credit”) training;

9. Use Cognitive Restructuring procedures in order to help clients identify and correct any inappropriate self-blaming, mental defeating and unhelpful thoughts, and accompanying behaviors;
10. Have clients engage in loss-focused restorative retelling and reconnecting exercises that may take various forms such as:

A. Intentional repeated retelling that facilitates the acceptance and emotional processing of the reality of the loss. Vividly narrate with eyes closed, the loss and listen to the tape of the narrative account;

B. Use the Gestalt empty-chair procedure, art expressive and journaling procedures, writing about positive and negative memories of the deceased;

C. Use graduated exposure exercises in order to help clients confront people, places and events that they have been avoiding. Use imaginal and behavioral exposure activities.

11. Engage in meaning-making activities, including the client’s use of his/her faith and spirituality, where indicated. Incorporate the client’s cultural group’s ceremonial rituals, as part of the grieving process;

12. Address specific bereavement issues such as “Anniversary” events, evocative reminders of the loss, lingering legal and medical issues, and the like. Conduct relapse prevention and provide ongoing follow-up contacts.
EXAMPLES OF THE CORE TASKS OF PSYCHOTHERAPY

1. **Establishing, Maintaining and Monitoring the Psychotherapeutic Alliance**

The psychotherapist should act as a non-judgmental, “compassionate guide” who uses empathetic attunement, encouragement, supportive collaboration, understanding and respect for the client’s symptoms and struggles. For instance, validate the client’s feelings so the client feels heard and understood.

“I am so sorry this happened to your loved one.”
“I think you are brave for seeking help in the midst of your grief.”
“You seem connected to your experience and can still be able to talk about it.”
“I wonder if you have allowed yourself to express and share the full (fear, anger, guilt) you experience?”
“What do you fear will happen if you allow yourself to feel (your emotions, grief, anger, fears)?”
“I can see that you are learning to express your feelings without trying to escape from them.”
“There may be obstacles along your path, but we can address them in a way that frees you up.”

The therapist can also employ the language of possibilities, change and becoming. For example, bathe the social discourse with such evocative verbs as “notice, catch, handle, tolerate, confront, take control, choose” and a variety of “RE” verbs - - “regain, reclaim, redefine, reaffirm, reauthor, restore, reconcile, reengage, remind, reconnect.” See Meichenbaum’s Roadmap to Resilience book (pp. 127-128 and 136-137 for a discussion of how psychotherapists can ask clients for examples for each “RE” activity, and moreover, what does this mean for the client’s journey? In this way, the psychotherapist can use a Constructive Narrative strength-based approach to help clients develop a “coherent healing story.”

As Perlmutter (2016) highlights, the therapist needs to explore collaboratively with the client, empathize, educate and encourage.

2. **Conducting Psychoeducation**

Psychoeducation may take various forms that include the art of questioning; client feedback on assessment; descriptive sharing of information about specific topics such as the nature and rationale of treatment; the role of avoidance, specific bereavement issues; “myths” about the mourning process; self-monitoring procedures, coping skills and self-attributional training and relapse prevention procedures.

Psychoeducation is not a didactic process, but a highly collaborative, discovery-oriented Socratic questioning approach. Psychoeducation is ongoing and occurs throughout the course of treatment. It is not as if one does psychoeducation and then one does treatment. The two processes are highly interweaved, as in the case of the Coping with Grief Checklist.
Examples of Psychoeducation

1. Provide a description of what therapy entails and the rationale for each aspect of treatment. Check for the client’s understanding throughout.

2. Discuss the nature of grief and the mourning process. Highlight the following:
   a) Grief is often accompanied with sadness, anxiety and uncertainty about the future, and feelings of yearning and longing;
   b) There is no one right way to cope with the death of loved ones. There is no timetable. The grief process unfolds naturally over time.
   c) There are no specific stages that individuals go through in the mourning process.
   d) Most individuals are impacted by the death of loved ones, but they go onto evidence resilience or the ability to “bounce back”. Some individuals need the assistance (help) of others. Joy and sorrow can co-exist.
   e) Individuals can learn to contain their grief, like putting it in a “grief drawer” (see Harris, 2016). They can choose when and to whom to share their grief. They can put their emotional pain into words, or into some other forms of expression (painting, dance), and they can embed their loss into a life-time autobiographical history. Some individuals go back and look at photographs and cherish their memories and their legacy. They learn to support themselves in ways that no other person can. They come to live life fully, even in the wake of their losses.
   f) Highlight that relationships are not really lost when a loved one dies, and who is not physically present, but the relationship is “changed.”
   g) Ask if the client can learn to leave a space in his or her life for their loved one’s presence?”

3. Discuss the nature of avoidance and its impact. For instance:

   “It is human nature for individuals to desire to avoid painful events, disturbing thoughts and distressing feelings about the loss and avoid any reminders that may trigger such emotional pain. But such avoidance actually prolongs the pain in the long run. Unfortunately, such avoidance usually does no work, and pain finds its way into our lives, one way or another” (with the therapist’s assistance, have the client give examples).

Convey how treatment can help individuals, in a safe and supportive environment,
develop the courage to express and share their emotional pain, without becoming overwhelmed, and even learn to view such “emotional pain” as a form of connection with the deceased (reframe the pain). Address the client’s attitude toward expressing feelings and discuss and train emotion-regulation skills on how to tolerate and manage negative emotions and “broaden and build” positive emotions (See Meichenbaum, 2013).

4. Use a CLOCK metaphor to help clients better appreciate the interconnections, and links between how they appraise events, experience primary and secondary emotions, have automatic thoughts and beliefs, and behave and the consequent reactions from others.

5. Psychoeducation can also be used to have the client reexamine “realistically”, the nature of his/her relationship with the deceased (both positive and any negative/disappointing aspects) of their relationships. The therapist can ask:

   “What are some things you most appreciated in your relationship with your loved one (spouse, parent, friend, coworker)? What do you miss the most?”

   “Permit me to ask, what do you wish could have been different in your relationship with X? Is there anything you did not appreciate or wish was different in your relationship with X?”

Such questioning reduces the likelihood of the survivor idealizing the past relationship and may help the client be open to developing new relationships. Also, conduct goal-setting that nurtures hopefulness and the language of becoming.

   “What would you like to be doing if you were no longer grieving?” (See the Section on Questioning)

6. Psychoeducation should include a discussion of possible barriers/obstacles that may undermine the client's personal journey of mourning. Reinforce the client’s development of a “New Identity”, a “New Me.” The therapist can convey:

   “Each person is unique. Each person’s situation is different. Each person negotiates the mourning process at his/her own pace and manner. What, if anything, might get in the way of your personal journey? How can you learn to anticipate these potential barriers and address them ahead of time?”

   “How can you learn to reengage the most painful aspects of your account of loss (narrative), while also learning how to contain the emotional pain and come to terms with it?”

   “Is there any way you can mobilize social supports?”

   “Healing, in the case of grief, involves hearing. Is there someone in your life you can count on, or with whom you can share your story?”
3. **Restorative Retelling Procedures**

Restorative retelling procedures may take many different forms (Neimeyer, 2002, 2012). Each of these procedures are designed to help the survivor to process grief and establish a new relationship with the deceased, but maintain the deceased person’s presence in the life of the survivor. One prominent procedure is to use the Gestalt empty-chair technique (“chair work” Paivio & Greenberg, 1995). In Litz et al.’s (2016) Adaptive Disclosure therapeutic approach, they use the “empty chair” procedure as a vehicle to generate a conversation with the deceased person. It facilitates corrective information, especially when loss and guilt are entangled. They divide the imaginal dialogue into three sequential steps:

1. Preparing the client for the processing of the loss;

2. Engaging in this breakout procedure of loss in which the client has a conversation with the deceased person, in real time (right now);

3. Post breakout component discussion about the meaning and implications of the loss and the client’s experience of talking to his or her lossed person.

As described by Litz et al. (2016, pp. 107-117), the following clinical guidelines should be followed. (A similar approach has been used with clients who have experienced “moral injuries” (See Litz et al., 2016 pp. 117-139). When clients experience moral injuries, the empty chair procedure may employ a “moral mentor”, rather than a deceased person (Litz, 2004).

**I. Preparing the client for the Breakout Imaginal Dialogue Procedure**

The therapist should describe the “empty chair” procedure and address the client’s questions, concerns and possible sources of resistance. The therapist should offer a rationale for the need to emotionally process the nature of the loss. Discuss the impact of avoidance behaviors. The therapist can ask the client:

“By focusing on the impact of the death of X, you will have an opportunity to understand and begin to recover and heal and master your grief. This can create a positive ripple effect in your life. Does this make sense? Do you have any questions?”

“What do you imagine may be any concerns you may have in engaging in this empty-chair activity? Can we discuss these?”

**II. Imaginal Dialogue with the Deceased**

1. The client is asked to have a conversation with the deceased person, in real time right now, as if the deceased person was sitting in the empty chair.
2. The conversation with the deceased uses the first person present tense and the client is encouraged to tell the deceased anything he/she wants, highlighting how the loss is affecting him or her. The client should be encouraged to provide a real emotional confession of how the client feels (haunted, guilty, unhappy). The client may wish to close his/her eyes when conducting the empty chair activity. The therapist may use prompts, as suggested by Litz et al. 2016, p. 108).

“Now I want you to go back to the image of [person who died]. This time, I want you to have an actual conversation with X. What would you like to tell him/her, here, now?”

“I know he/she is gone, but take this chance to talk to him/her and make it real.”

If the client gets stuck, the therapist should guide him/her by suggesting:

“Why don’t you start with what you remember from when he or she was alive? Why don’t you talk a bit about how much you miss him/her; how sorry you are and why?”

After a period of time, the therapist can ask the client to tell the deceased person what has changed behaviorally in him/her since the loss. As suggested by Litz et al. (2016, p.108).

“Tell him/her what changed for you after his/her death, and tell him/her how his/her death has affected you. Tell him/her how his/her death has changed your views of yourself, others, and the world.”

“Tell him/her how stuck you are, and be sure to describe any struggles you are now having.”

To this imaginal dialogue, the client can be encouraged to share what efforts he/she has taken to honor the memory of the deceased and what coping activities he/she has taken. To facilitate level of resilience, Litz et al. (2016) propose that the therapist ask the client to share what the dead person would say to him/her right now, after hearing all of this.

“What is she/he telling you now, after hearing all you have said?”

“What advice would he/she have for you?”

If the client has difficulty coming up with positive forgiveness-type statements, the therapist can offer suggestions:

Does he/she want:

“You to carry on?”

“What is best for you?”

“You to live the fullest life possible?”

“You to claim your life and live it fully for both of you?”
The imaginal dialogue may be repeated during multiple sessions in order to help the client shift his/her perspective and contribute to benefit-finding, meaning-making narratives that nurture healing. This form of restorative retelling can contribute to the reconstructing, rather than to severing one’s relationship with the deceased.

III. Post-breakout Component

The therapist starts this phase by asking the client to open his eyes and return to the here and now and then to discuss his/her experience of what just happened.

“What was that like for you?”

“What are you going to take from this session to think about throughout this week?”

“What really stood out for you?”

The therapist can also provide normalizing and reassuring comments, and encourage the use of coping behaviors should the client become emotionally upset. Litz et al. (2016, p.117) offer the following examples of possible therapist’s comments:

“I know this was difficult, and more than likely you will continue to think about it from time to time throughout this week. This is normal.”

“I often find that as clients start to look at difficult experiences, they sometimes have more unwanted thoughts about the experience. This usually goes away with time.”

See work by Pearlman, Rando, Shear for additional examples of ways to conduct Restorative Retelling Procedures.

Restorative retelling and empty-chair interventions provide individuals with opportunities to reconstruct and reframe the “stories” they tell themselves and others. Making meaning through the construction of stories and the use of metaphorical language contributes to the healing process (Meichenbaum, 2013; Neimeyer et al., 2010).

4. Exposure-based and Supplemental Interventions

In order to address the lingering impact of trauma and to confront avoidance behaviors that undermine recovery, various forms of imaginal and in vivo exposure-based interventions have been developed. Foa et al., (2007), Pearlman et al. (2014), and Steenkamp et al., (2011) provide specific treatment guidelines on how to conduct such exposure-based interventions so clients learn to purposefully tolerate and manage their fears and overcome any avoidant activities. In the case of imaginal exposure, clients are asked to tell and retell their “story” in the first person using the present tense and to listen to the tape recordings of these sessions as “homework”. The in vivo exposure activities are arranged along a gradual hierarchy of increasing demanding challenges.
Such exposure exercises should be conducted for at least 45 minutes, three times a week to the point where the client can learn to tolerate his/her fears. The exposure activities may be learning to use coping skills such as breathing retraining and cognitive restructuring.

Jordan and Litz (2014) raise questions about the use of imaginal exposure therapies of having clients repeatedly retell (relive) memories of the moment of death, or related scenes. Such exposure-based interventions follow from trauma-focused treatment approaches that embrace a conditioning model that targets fear-based memories. They note that PCG is not characterized by such fearful memories and

“therapeutic rationale for repeated and sustained reliving of the traumatic moment is unclear. Moreover, there is no evidence that ‘working through’ a loss by sustained focus on it is necessary for healing for all individuals” (Jordan & Litz, 2014, p. 186).

Restorative retelling and exposure-based interventions may be supplemented by cognitive restructuring procedures that address the client’s Automatic Thoughts and beliefs (shattered “Assumptive World”). Another procedure is the use of Activity Scheduling that provides a means to address the client’s depression, inactivity and withdrawal by means of physical exercise and related engaging social activities (exercise with others).

The therapist should encourage the client to reengage in pleasurable activities, reattach with others, and pursue various wellness activities. As suggested by Litz et al. (2016, p.114), the therapist can ask:

“What type of pleasurable or healthy activities are you keeping yourself from doing since the death/loss of X?”

“Of those who care about you in your life, who are you not spending quality time with?”

“Are there new challenges you might attempt or activities you might devote specifically to the memory of X? Are there life experiences that you might plan to honor X?”

“Are there ways to memorialize (remember and honor) X?”

The therapist can use the Coping with Grief Checklist (see pages 21 to 25) as a way to review possible coping activities. In a collaborative manner, the therapist should elicit specific client commitments and discuss possible barriers that may interfere with the client implementing specific “homework” activities between sessions.

“What do you think would be useful for you to do before our next session?”

“What would you be willing to try to work on for next week?”

“What kind of practice assignment seems doable in the next week?”
Neimeyer (2012) has proposed another cognitive restructuring activity that asks clients to share “stories” of their relationships with the deceased as a way to reaffirm and reorganize their attachment with their loved one. He proposes the use of the following set of questions as a way to initiate such accounts:

Could you introduce me to _____?  
What did knowing _____ mean to you?  
Are there particular times, places, or ways in which you recall _____ importance to you?  
What kind of things did _____ teach you about life, and about how you could manage the challenges you now face?  
What might _____ say he/she appreciated most about you?  
What strengths did _____ see in you?  
In what ways might you strive to grow closer to _____ across time, rather than more distant?  
What difference might it make to keep _____ stories and memories alive?  
What has _____ given you that has had enduring value?  
What do you want _____ to know about you and your relationship?  
Can you describe the lasting impact, of _____ on your life?

Litz et al. (2016, pp.115-116) have offered the following exercises as a way to help clients express their grief and develop possible coping strategies. They ask the client to:

“Think or write about the following:

- How has losing _____ affected me?
- How would _____ say I impacted him/her?
- How did _____ impact me? How have I grown as a person because of _____?
- How can I honor _____ now and move forward in my life?
- What are some of the positive memories I have of _____?

The therapist may ask the client to “write a goodbye letter to _____. Include how the loss has changed you; what you will miss most about the person lost; how do you want to remember him/her; and how will you continue to honor him/her?”

The average length of this comprehensive treatment program for clients with Complicated Grief and Traumatic Bereavement is 19 sessions, as described by Pearlman et al., (2014) (See www.guilford.com/pearlman-materials for a collection of client worksheets). Also see Harris (2011) and Jeffreys (2011) for examples of additional supportive activities.

5. **Addressing Bereavement Specific Issues**

Bereavement-specific issues focus on reawakened intense waves of grief when one least expects it. Rando (1993) have termed these acute grief responses to varied triggers that underscore the absence of the deceased, as Subsequent Temporary Upsurge of Grief (STUG) reactions. These triggers, may
occur in social settings, at cyclical times like anniversaries, holidays or in response to particular occasions such as weddings, graduations. The STUG reactions, or powerful unexpected waves of grief that trigger a crisis of memory and undermine adaptive functioning, can lead to feelings of losing control, embarrassment, and result in withdrawal and avoidance that reinforces a loss grief cycle.

Psychotherapists need to “validate and normalize” such STUG reactions as part of the mourning process. Such emotional pain can be viewed as one way of staying connected to the deceased. In a collaborative fashion, the therapist should help clients anticipate and prepare (have coping strategies in place) in order to handle such episodes or “rough patches”. Role plays and exposure activities can be employed to address STUG reactions. There is also a therapeutic need to address any accompanying self-critical automatic thoughts. The therapist can use the CLOCK analysis to help clients cope with STUG reactions, as well as conduct relapse prevention stress inoculation interventions (Meichenbaum, 2013).

6. Self-attribution training or helping clients “take credit” for changes

A key aspect of relapse prevention interventions is to help clients develop coping skills for bereavement-specific upsurges (“rough patches”) and to ensure that clients monitor their progress and attribute any positive changes to their own personal coping efforts. Psychotherapists can facilitate this process by using Client Checklists, engage in discussions of how clients have handled tough situations, and ways they can anticipate and address future potential challenges (anniversary dates, reminders, and the like). The therapist can “go public with the data” of reported or observed changes. For instance, “It sounds like you have learned to:

“Draw upon your resources.”
“Identify warning signs.”
“Tolerate strong feelings.”
“Move back and forth (oscillate) between your loved one and beginning your life again”
“Reach out for help.”
“Do so many of the things your spouse used to do.”
“Trust your judgment.”
“Express difficult feelings.”
“Catch and challenge your negative automatic thoughts.”
“View your emotional pain as a way of remaining in touch with your loved one.”
“That in spite of your fears, you were able to be courageous and not withdraw.”

The therapist should provide specific examples and have the client offer specific examples of each of these changes. This should be followed up with queries of “How” the client was able to accomplish each activity?

There is also value in discussing what the client has gotten out of treatment and what, if any, “unfinished business”, and issues remain to be addressed. Discuss the possibility of seeking future help if the need arises. “What was the client like when he/she entered treatment and what has changed?” “How has the client’s ‘story’ changed and the accompanying new skills and new identity developed?”
Two additional ways to bolster the client’s level of self-efficacy and resilience is for the therapist to:

1) share examples of coping observations that other clients have offered;

2) ask the client for examples of “RE” based activities that he/she may have engaged in.

I. The therapist can say to the client:

“We have asked other clients, like yourself, to share with us some of the things they have learned over the course of treatment. With their permission, they have offered the following examples and given permission to share them with other clients, like yourself:

LIST OF COPING OBSERVATIONS OFFERED BY INDIVIDUALS WHO HAVE LOST LOVED ONES

“I now recognize that pain is inevitable, but suffering is optional.”

“I unburdened myself by disclosing/sharing my loss with people I can trust and respect.”

“I benefitted from the feedback and advice I received.”

“I reached a turning point, when I began to let go of some of my grief.”

“I am having more good days than bad days.”

“I am in a better place now.”

“I found a new normal, a footing in the world.”

“I have become more buoyant in dealing with the waves of grief.”

“I have learned to compromise with life.”

“I can engage in heart-mending activities.”

“I have been able to transform my pain into compassion for myself and for others.”

“I have learned to invite my emotional pain to tea.”

“I have hope for the future.”

“I cherish life more now. I don’t take life for granted.”

“I now value more of what I have, like my remaining children.”
“I give myself permission to close the lid on my loss and grief in order to turn my energy elsewhere, as needed.”

“I can use my spirituality. I have found God again.”

“I believe they are watching over me.”

“They are in a better place.”

“I can create a space for my loved one to fill in the future.”

“I have chosen not to wrench out of my life, my _____ (loved one), but instead to include him/her to be with me and continue to share my challenges, alongside me.”

“I have a sense of peace.”

“I mastered my grief.”

II. A second intervention strategy that psychotherapists can use is to ask the client to provide examples of behavioral changes they have made, using “RE” verbs. The therapist can say:

“It seems to me, and correct me if I am wrong, or if I am misreading the situation, that you are [Insert one of the following “RE” observations]?...
Can you give me an example when, where and how you were able to do that?”

**With regard to the Past**

Retell your story of loss
Reframe what happened (engage in benefit finding)
Reconcile the past
Revisit your positive memories with _____

**With regard to the Present**

Regulate your emotions
Reengage emotionally
Relax and release your tension
Regain a sense of control
Rewire your brain
Relinquish old habits
Reestablish your routine
Revisit the places you have worked hard to avoid
Readjust to the loss
Retell your “story” when and to whom you choose
Reevaluate how you think
**Restory your life**
**Redefine yourself**
**Reclaim your life**
**Reengage life**
**Reconnect with others**
**Rebuild and reestablish connections with others in your life**
**Repair your relationships**
**React to the separation in a positive way**
**Reengage in pleasurable activities**

**With regard to the Future**

**Reset your priorities and goals**
**Rewrite your list of Reasons for Living**
**Rewrite your “story” of the future**
**Recognize both the losses and gains in your life and look to the future with hope**
**Reinvent a “new identity”. Who am I, now? Who do I want to be in the future?**
**Restore your dignity**
**Reconstruct a world of meaning**
**Reaffirm your life**
**Restore your resilience**

Keep in mind that the critical feature of this intervention is to use discovery-oriented processes to help clients generate examples of each “RE” activity that is discussed. There is a need for the client to take “ownership” for behavioral changes that they have brought about.

There is a need for therapeutic aftercare contacts and booster sessions, where indicated.
REFERENCES


**INTERNET WEBSITES**

Violent Death Bereavement Society
www.vdbs.org

Bereaved By Suicide
www.bereavedbysuicide.com

Grief Net
www.griefnet.org

The Australian Palliative Care Network
www.caresearch.com.au

The Kindness Project
www.projectkindness.org
Compassionate Friends
www.compassionatefriends.org

Miss Foundation
www.missfoundation.org/forums

Dougy Center
www.dougy.org

Treating Traumatic Bereavement: Client Worksheets
www.guilford.com/pearlman-materials

Tragedy Assistance Program for Survivors (TAPS)
www.taps.org

Trauma-focused Cognitive-Behavioral Treatment for Children and Youth Who Experience Complicated Grief
www.musctfcbt.edu
Ways to Treat Victims of Human Trafficking: Core Therapeutic Tasks

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ABSTRACT

This paper enumerates the core psychotherapeutic tasks that need to be implemented in the treatment of victims of human trafficking. Those core tasks build upon the survival skills and coping strategies and bolster the resilience of participants of human trafficking. The major focus is on the development, maintenance and monitoring of the therapeutic alliance. Additional psychotherapeutic tasks include motivational interviewing; collaborative goal-setting that nurtures hope; psychoeducation; intra- and interpersonal skills training; and the need for the therapist to become an Advocate. A strengths-based constructive narrative approach is employed to help clients emotionally process the lingering impact of any victimization experiences.

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“It is not unusual for homeless often runaway adolescents, especially those with histories of childhood sexual, physical or emotional abuse to become involved in prostitution (human trafficking). In some cases, they are recruited and controlled by a pimp. In others, the survivor may exchange sex for drugs, food or shelter. Such prostitution is associated with an elevated risk of assault, disease, depression and posttraumatic stress. Entreaties that the adolescent just stop such behavior is often “less than effective.” (Briere and Lanktree, 2014).

If entreaties to change do not work, then what can individuals and society do to be of assistance? What do we know about behavior-change principles and core psychotherapeutic interventions that can be implemented to help individuals who are “victims” of human trafficking? This presentation will describe the Core Tasks of such psychotherapeutic interventions. (Also, see the multimodal, multicomponent treatment manual by John Briere and Cheryl Lanktree “Integrative Treatment of Complex Trauma for Adolescents – ITCT-A www.attc.usc.edu). The National Human Trafficking Resource Center Website (http://www.acf.hhs.gov/trafficking) has a number of informative reports and helpful resources. See the report on "Human trafficking into and within the U.S." (http://aspc.hhs.gov/hsp/07/Humantrafficking/).

CORE PSYCHOTHERAPEUTIC TASKS

1. The overarching critical therapeutic core task is the ability to develop, maintain and monitor a nonjudgmental, caring and trusting therapeutic alliance. The Health Care Provider (HCP) needs to meet the client/survivor where he/she is at, and “take the individual as he/she is.” The HCP needs to convey an authentic, emotionally-attuned caring and supportive relationship. There is a need to be patient, using a gentle form of inquiry of open-ended questions, conveying a keen compassionate curiosity; a type of Socratic questioning. The survivor needs to feel “heard and respected”. The therapeutic alliance is critical to the effectiveness of any intervention.

In order to maintain the therapeutic alliance, there is a need to consider what, if any, therapeutic interfering behaviors may undermine participation and engagement (fear, hopelessness, depression, and
practical concerns about safety).

The HCP needs to engage in “outreach” efforts and go to the individual in need. Persistent efforts to engage the client is necessary. Convey a willingness to help. Moreover, it is important to have the clients provide regular feedback on the degree to which the intervention sessions are perceived as being helpful in achieving the agreed-upon goals. Also, ask about the quality of the therapeutic alliance (“the fit”). Maintain continuity of care.

2. There is a need to ensure that any interventions are culturally-sensitive, gender-specific and sensitive to the sexual orientation and gender identity of the youth. For instance, Meredith Dank, in a study of LGBT youth found that they were often victimized and that this contributed to their engaging in prostitution and human trafficking. They reported engaging in “survival sex.” (See www.urban.org for more details of the study).

3. Where indicated, there is value in incorporating the youth’s spirituality, religious beliefs, practices and rituals. For instance, in her biographical account “Stolen”, Katarina Rosenblatt (Revell Publishers), describes how her religious beliefs that “God wanted me to have a good life that I deserved”, helped her to escape from sex trafficking.

4. Safety issues are key to treatment engagement. There needs to be a “safe place”, away from the clients' “handlers”, to meet. This safety assessment should be ongoing. In addition, a variety of other safety domains need to be addressed.

   a) Assess for the presence of any present or past incidence of suicidal and self-injurious behaviors and accompanying depression, poly-substance drug abuse, and other “high-risk” reckless behaviors. (See King, Foster, Rogalski, 2013. Teen suicide risk Guilford Press). Keep in mind that the failure to report suicidal ideation does not necessarily indicate the absence of risk for suicidal behaviors).
b) Assess for the presence of any criminal, antisocial behaviors, aggressive behaviors that could get them into trouble with the law. Assess for the history of various forms of substance abuse, sexual activities, and other high-risk behaviors.


d) Help the client have in place a pre-planned detailed safety-plan for exiting the environment when imminent danger is present (pre-packed bag, planned escape route, how to find a new safer environment, hotline telephone numbers, friend’s home, local shelter).

These assessments should be conducted using the “art of questioning” consisting of a compassionate curiosity, gentle inquiry and Socratic questioning. Focus on “What” and “How” questions. Stay away from “Why” questions. Such probes should convey a concern for the client’s well-being and Safety.

5. Assess for developmental and current risk and protective factors. The RISK factors for being vulnerable to becoming a victim of sexual trafficking include:

a) coming from a low SES disadvantaged environment (single parent home);

b) having experienced cumulative forms of victimization (physical, sexual abuse neglect, exposure to domestic violence) and family members similarly being victimized;

c) runaway and rejected by your family, as in the case of one's sexual orientation;

d) history of substance abuse and use of drugs when engaging in sexual activities (engaging in sexual activities to survive);
e) feelings of low self worth, lonely, feeling unlovable;

f) parents involvement in prostitution and in the sex trafficking trade;

g) being a school dropout;

h) poor development of attachment relations (belief that no one cares and what has been called a "daddy hole");

i) engagement in other high-risk activities (antisocial behavior, sexual acting out behaviors).

Determine the cumulative impact of such risk factors.

There is also a need to obtain a behavioral picture of **DEVELOPMENTAL PROTECTIVE FACTORS**

6. Engage the youth in a discussion of how he/she got involved in sex trafficking? How were he/she lured, groomed, recruited and may have placed misguided trust in others? How individuals may have taken advantage of the youth's vulnerabilities? ALSO, permit the youth to relate any instances of what he/she considers "positive aspects" of their associations and experiences. Ask how the youth developed "street smarts" and "survival skills"? What social network did he/she develop? Who could the youth depend on if in need? What would the youth like to see changed? (SEE BELOW ON WAYS TO USE TIME LINES TO SOLICIT THIS ACCOUNT).

Finally, the assessment should also solicit information for any evidence of the client’s “strengths”, “survival skills”, “resilience”. There is a need to highlight the “rest of the story” of what the youth has done, and is doing, to protect oneself. It is critical to obtain the survivors’ perspective, walk in their shoes in order to better appreciate how they negotiate their lives in terms of basic needs (shelter, food, safety protection). For example, ask the following questions:

“How are things going right now in your life and how would you like them to be?” [Be present-focused]
"What have you tried to do to accomplish that goal? How has that worked?"

"How do you think we could work together to help you be X (safer, more in control, less depressed, stay out of trouble, be less exploited")?

When asking such questions, solicit the individual’s permission and put him/her in charge of disclosing only that which he/she feels comfortable in sharing. Indicate that he/she is “in charge” and should feel free to stop the interview at any time, and tell you when you overstep the bounds.

"Is it okay if I ask you some questions about X, since I want to make sure you are safe?" (Not being exploited, controlled, abused)?

7. Use motivational interviewing procedures as a way to engage the individual in a therapeutic relationship. Avoid argumentation, express empathy, help develop discrepancies, support self-efficacy. In order to highlight discrepancies, ask the youth the following questions:

"What is it that they liked about their life (experiences) with their 'handler', their life-style of being part of the sex trade, times with your friends?"

"I now better understand what you liked about your life-style". "What don't you like about it?"

Keep in mind that the individuals may not see themselves as a “victim”, and not be motivated to change. Some may hold an implicit theory that change is not possible (”no escape”), or that the so-called benefits (pros) of their current life-style far outweigh the costs (cons). They may hold an “entity” versus an “incremental” theory of change. The social discourse should highlight the “language of possibilities and becoming”, “change talk” and nurture hope for the future. Bathe the discussion with phrases such as “So far”, “As yet”, and personal agency metacognitive RE verbs such as:

"Are you telling me, are you saying to yourself, that you can notice, sense when you are unsafe, catch yourself, plan ahead of time, use your back up plan and make smart choices.? [Choose one verb]"
“Can you give me an example when you can do that?

Are you saying that in spite of... you are able to do that?

How do you pull that off? Where did you learn such survival skills?”

Also use “Re” verbs, as part of the dialogue.

“Are you saying, one of the things you want in your life is to...? Re-connect with X; Re-duce X, Restory your life? Write a new chapter? Rebuild a life.” (See Meichenbaum’s Roadmap to Resilience book, for examples for ways to conduct such resilience-engendering discussions - www.roadmapresilience.com).

8. Engage the individual in collaborative goal-setting that nurtures hope. Help individuals develop “SMART” goals (Specific, Measureable, Attainable, Relevant to their situation and consistent with their values, and Timely). Be very practical, realistic and present-oriented. Work on sub-goals and small steps. Use foot-in-the-door procedures. Facilitate exploration of other possible safer options for survival that are less self-injurious. Identify specific behaviors that require immediate attention. Collaboratively set behavioral priorities on what should be worked on.

9. Conduct ongoing psycho-education. This is not a mini-lecture, nor a didactic discussion. Out of the art-of-questioning, inform the individual about the services that you and your agency can provide, where and how to access safe shelter, medical and legal services, Hotline telephone numbers, and the like.

Have a discussion of what happens in therapy and counseling; who you are and your background; how such discussions can help you help others. (“Make a gift” of their experiences and survival skills with others you see, but always protecting their privacy and anonymity). A key is establishing and maintaining trust. Share any books, films or TED talks, Websites of how individuals have been able to escape from sex trafficking and make a “gift” of their experiences, so others can benefit. Use peer mentors who have successfully escaped sex trafficking as counselors and provide them with ongoing
10. Conduct Time Lines analyses. Have the individual walk you through their developmental Time Lines, from birth to the present day. Draw a physical line and have the individuals note when and where any form of “victimization” occurred (abuse, neglect, etc.). What, if any treatment services were provided.

“When and how did the individual come into the sexual trafficking/prostitution?”

Normalize and validate their experiences. Ask, “How did they make such choices?” Convey empathy. Help the individual better appreciate how he/she has “internalized the voice”, or “repeat the messages” of those who have abused him/her. Have them consider what, if any, “exploitation” is occurring in their present relationships with their “handlers”. Highlight the concepts of their being “in charge”, “in control”, “making personal choices”. Where are all those instances where the individuals have made “choices”? Ask how did they come to make such choices?

Generate a Second Time Line of what the individuals have been able to achieve “in spite of” the Time Line 1 history of victimization. Document any examples of evidence of resilience and survival skills. Follow this up with probes of “How” he/she was able to engage in such behaviors and accomplish such personal goals, “in spite of” experiencing “victimization” experiences?

“What lingers from such a life history?”

“What beliefs and conclusions does the individual hold about self, others and the future, as a result of these experiences?”

“What story does he/she tell himself and tell others, as a result of this life history?”

“What resources (people) can the individual call upon now to help achieve his/her goals?”

supervision.
A Third Time Line can be generated that begins in the present and projects how the individual would like things to be in the future. Help the individual develop practical short-term, intermediate and long-term goals and sub-goals. Goal-setting is a critical way of nurturing hope.

11. Help the individuals better appreciate the interconnectedness between their feelings, thoughts and behaviors. Use a CLOCK metaphor. **12 o’clock** – how appraise external and internal triggers **3 o’clock** – primary and secondary emotions and the implicit theories about the experience and expression of their feelings **6 o’clock** – automatic thoughts and images, beliefs, attributions, schema, scripts, “self-talk” **9 o’clock** – behaviors and actions and resultant consequences Discuss how these four components can become a “vicious cycle” and what are the “impact, toll and price” he/she and others pay as a result?

“Is this the way he/she wants things to be? If not, what could be done? How has he/she been able to break the ‘vicious cycle’ in the past? What alternatives now exist to break the ‘vicious cycle’?”

12. Teach and nurture the individual’s intra and interpersonal coping skills. These skills include ways to:

a) increase trigger awareness, identification and intervention.

i. Identify instances when she is being triggered. (“What triggers me?” “How do I know I have been triggered?”)

ii. Reframe triggered reactions. “These are old movies being replayed”. “Can I check this out?” “What can I do if I get triggered?”

iii. Cope with such triggers. “What do or say to myself can lessen the impact of the trigger?” “What has to happen for the situation to be less emotional?”

. a) I can analyze the trigger; increase my social supports; engage in positive self-talk; use my breathing exercises; use distraction; remember how I handled this in the past; change my
facial expressions that sends messages to my brain; change my posture and activities. I can relabel my flashbacks, intrusive thoughts as “old movies”, and use acceptance and mindfulness activities and watch non-judgmentally as they come and go - - like “a wave.”

b) Become an “emotional detective” and self-regulate negative emotions and engage in opposite actions (e.g., ground myself; disengage; use visualization, relaxation, mindfulness activities; distress tolerance skills; control impulsivity);

c) Increase positive emotions and pursue pro-social safe pleasant activities; increasing my well- being; help the individual identify their values - - what is really important. Build a life worth living. Attend to relationships and end “destructive” relationships and establish safe boundaries.

d) Use social problem-solving skills. Help individuals develop a Goal-Plan-Do-Check approach. Help them break goals into smaller steps, brainstorm ideas, make choices using a Pros and Cons analyses, anticipate barriers, develop back-up plans, and trouble-shoot.

It is not enough to “train and hope” for generalization. There is a need to build into the training program specific guidelines for generalization. For example, put the trainees in a “consultative role”, so they can describe, explain, demonstrate and teach such skills to others and offer self- generated reasons why engaging in such behaviors are necessary. Bolster self-efficacy. Engage the individual in self-attributional training, or ensuring that they “take credit” for any changes they initiate. Reinforce effort, not outcome. Use “How” and “What” questions to encourage them to describe the specific steps they took to achieve their goals. It is not enough to have individuals change, they need to alter the “story” of what such changes mean about them.

13. Help victims of human trafficking develop a coherent narrative and “restory/reauthor” their lives. Individuals who are engaged in human trafficking likely have had a long history of multiple and
complex victimization experiences. The intervention steps include:

. a) Following the individual’s lead, and at his/her own pace, and with permission, obtain a
victimization history and evidence of any formal or informal interventions. Explore what is the
“lingering impact” of such victimization experiences? What conclusions does the individual draw
about him/herself, other people and the future? What are the “stories” that he/she tells
himself/herself and others, as a result of such victimization experiences?

. b) Decide collaboratively with the individual on whether the intervention focus should be on present-
day issues and/or relating, retelling and reliving (sharing) past trauma experiences with “safe”
others.

. c) Conduct prebriefing discussions about the trauma-exposure based intervention, namely the
rationale, procedures of repeatedly describing his/her trauma story in order to develop a more
coherent account.

. d) Have the client engage in prolong exposure and in writing and journaling activities (Cognitive
Processing Therapy procedures). Describe events in as much detail as tolerable, including
thoughts and feelings experienced during and after victimization. Reread the account at home and
then share it with the therapist (and group members).

. e) Conduct cognitive restructuring in order to consider any faulty cognitions and attributions of self-
blame, deservingness, and responsibility. Address emotional issues of guilt, shame, humiliation,
anger, and the tendency to “internalize” the perpetrator’s comments. Provide an opportunity for
exploration and guided reconsideration and reinterpretation in the form of imagery rescripting and
restorative retelling (Gestalt “empty chair”). Use gentle open-ended questioning. Use specific
cognitive-behavioral interventions tailored to each dominant affective state—guilt ala Kubany;
shame ala Smucker and Dancu; anger ala Novaco and Chemtob. As Briere and Lanktree observe:
“The process of remembering painful (but not overwhelming) events in the context of safety, positive relatedness, emotional expression, opportunities for introspection, and minimal avoidance can serve to break the connection between traumatic memories and associated negative emotional and cognitive responses.”

As a result of such repeated retelling, the individual’s narrative is likely to become more organized, chronologically structured and integrated and contextualized into a larger life story. Sharing one’s victimization account will highlight the likelihood of soliciting the “rest of the story” of what one did to survive and pull for signs of resilience. Keeping one’s victimization story a “secret” exacerbates distress and acts as a block to undertake behavior changes.

14. Focus interventions on identity issues in order to help develop a positive sense of oneself, a sense of self-efficacy, self-validating, self-worth and self-exploration. Involve significant others in this journey, as indicated. Help the client avoid re-victimization by learning how to determine, establish and maintain appropriate boundaries in relationships.

15. Conduct relapse prevention procedures in order to help the client handle possible lapses and avoid relapse, anticipate and plan for possible barriers and setbacks. View these as “learning opportunities”, instead of “catastrophizing” and relapsing. Discuss what is needed to avoid going back into the same lifestyle of prostitution and sex trafficking?

16. There is need to act as an Advocate for the youth and refer them to shelters, and convey ways to access medical and legal services, where indicated. Also, provide life-skills, job training and help them access employment opportunities. Help them access services in the community who treat victims of
human trafficking. Be proactive in conducting follow-up. Do not let the youth “fall through the cracks”.

Continuity of interest and care are critical. Conduct active outreach interventions.

17. Help the helpers who have to deal with such challenging cases.

2. SUMMARY OF CORE THERAPEUTIC TASKS TO BOLSTER RESILIENCE

__1. Develop, maintain and monitor a therapeutic alliance.

__2. Implement culturally-sensitive, gender-specific and sexually

orientation/gender-identity interventions and where indicated, incorporate the client’s spirituality,

religious and cultural beliefs, practices and rituals.

__3. Address any therapeutic-interfering behaviors.


__5. Assess for both developmental and current risk and protective factors (evidence of survival skills

and resilience).

__6. Use the “art of questioning” in the form of compassionate curiosity. Use Time Lines to assess for

the history of victimization, substance abuse, involvement in sex trafficking activities, and for the

“rest of the story” of the client’s strengths and evidence of resilience.

__7. Use Motivational Interviewing Procedures to ascertain the pros and cons of being part of sexual

trafficking activities.

__8. Engage the individual in collaborative goal-setting that nurtures hope.
9. Conduct ongoing psycho-education. Use the CLOCK metaphor to educate the individual about the interconnectedness of appraisal processes, emotions, thoughts, behaviors and resultant consequences. (“Vicious cycle” and ways to break this cycle).

10. Teach and nurture intra-and interpersonal coping skills. Build in generalization, self-attribution and maintenance guidelines. Teach how to become an “emotional detective.”

11. Address the “lingering impact” of past and current victimization experiences. Help individuals develop a “coherent narrative”. Obtain a history of victimization experiences and interventions using the Time Lines; Conduct Prebriefing; Cognitive Exploration, Reconsideration and Retelling; Writing activities; Titrated exposure, and Cognitive restructuring interventions.

12. Help individuals avoid revictimization and conduct relapse prevention.

13. Provide ongoing coaching, where indicated, and follow-up contacts. Take on the role of being supportive, engaged and a helpful advocate.

14. Help the helpers.
5. FRIDAY DEC. 15 8:00-9:00  
Discussion Hour with Scott Miller and Jeff Zeig

TRAINING PSYCHOTHERAPISTS

PRESENTATION OUTLINE

a. “How to spot HYPE and pseudo-scientific HOGWASH in the field of psychotherapy: A Consumer’s Checklist”.

LIST OF HANDOUTS

1. How to spot HYPE and pseudo-scientific HOGWASH in the field of psychotherapy: A Consumer’s Checklist (pp. 234)
HOW TO SPOT “HYPE” AND PSEUDO-SCIENTIFIC HOGWASH IN THE FIELD OF PSYCHOTHERAPY: A CONSUMER’S CHECKLIST

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CHARACTERISTICS OF “HYPE” IN THE FIELD OF PSYCHOTHERAPY

One of the consistent research findings in the field of psychotherapy is the marked variability in effectiveness across psychotherapists. The most effective psychotherapists average 50% better outcomes and 50% fewer dropouts than psychotherapists in general (Wampold, 2017). One of the characteristics of more "expert" psychotherapists is their penchant for “SELF-DOUBT.” Research indicates that psychotherapists self-reported self-doubt predicted outcome--more doubt about their skill in helping patients (e.g., "Lacking confidence that you might have about a beneficial effect on a patient." and "Unsure about how best to deal effectively with a patient."), had better outcomes, particularly if they also had a positive sense of self. Consistent with the article by Nissen-Lie et al. (2015) entitled "Love yourself as a person, doubt yourself as a therapist", the present Consumer Checklist is designed to plant the seed of self-doubt and nurture "HUMILITY", and hopefully improve treatment outcomes.

− 1. Advocates for a therapeutic approach state that their treatment is “revolutionary” and offer outlandish unsubstantiated claims for its superiority (over 90% improvement rates). “Simple, but powerful” treatment approach, “a breakthrough treatment”.

− 2. Claim that the treatment approach could be applied successfully with patients who have a wide variety of psychiatric and physical conditions, and across multiple age groups. Advocates often imply that their treatment approach “fits all” (“One size fits all”).

− 3. Make claims that you can learn from a “guru” and they use marketing terms like “powerful”, “transformative”, “unique and ultimate training,” “life-changing benefits”, “deep psychological healing”, and moreover, assure that your “complete satisfaction is guaranteed”.

− 4. Cite that treatment approach is “evidence-based”, scientifically proven, because it has met the criteria of two randomized controlled trials, but they do not report Effect Sizes, nor provide details about the exclusionary criteria of the patients. “Cherry-pick” the patients. Also, not report on the attrition and drop-out rates, follow-up data. Advocates often broadly define “evidence” (“I saw it work my clients, and that is my evidence”).

− 5. Compare proposed treatment to “weak” comparison groups. Not compare treatment to “bona-fide” comparison groups that are intended to be effective (See Wampold et al., 1997).

− 6. Does not conduct an independent “credibility” check of the treatment rationale of the comparison alternative treatments and control groups.

− 7. Do not report on possible “allegiance effects” of who conducted the controlled outcome studies. Moreover, the cited supportive studies that were initially conducted yielded more effective results than later conducted studies. (“Strike while the iron is hot", and when the enthusiasm for the new therapeutic approach is highest.) See the provocative informative article by Lehrer (2010) of the "decline effect" in research attempts to replicate clinical trials. For example, the efficacy of antidepressant medication has gone down as much as threefold in recent decades. Effect Sizes
from studies from treatment studies drop off. He observes that the researcher’s belief can act as a kind of blindness.

- 8. Compares the proposed treatment versus a reduced, or weaker version of the comparative treatment. For example, see Foa et al. (1999) comparison of Prolong Exposure versus Stress inoculation training (SIT), where the third application phase of SIT was omitted.

- 9. Do not highlight the role of non-specific treatment factors, such as therapeutic alliance, expectancy effects, and other placebo considerations. Not include session-by-session treatment-informed feedback (see Prescott et al., 2017).

- 10. Not include a critical account of the scientific validity, or theoretical basis, for the effectiveness of the proposed treatment. Little scientific basis for the proposed change mechanisms for the treatment. See controversy over so-called “energy –based” treatments such as Tapping, Eye Movements, Magnetic fields, Meridian band techniques and the like. The intervention may work, but it has little to do with the proposed treatment model. The proposed treatment may do better than no treatment, or weak control and comparison groups because of non-specific factors, such as placebo effects.

- 11. The advocates will provide a Certificate that you have taken the training and call yourself an X therapist.

- 12. The advocates of their treatment approach rely on the endorsements of a leader in the field. For example, therapists in the trauma field cite Bessel van der Kolk as an advocate and endorser of their treatment approach.

- 13. Advocates promote advance training, sell paraphernalia, tapes that go along with their treatment approaches. They require that trainees sign statements that they will not share treatment protocols with others.

- 14. Advocates fail to discuss criticisms of their treatment approach. Fail to mention the results of dismantling studies that question the basis of their treatment approach.

- 15. Advocates are very defensive and “thin-skinned” about their approach. They often question the motives and background of those who have questioned the efficacy, theoretical basis of their treatment approach. They fail to question, or laugh about, what they are proposing. Consider the following example as the basis of the origin of a psychotherapeutic approach.

“A charismatic psychotherapist takes a walk in the woods and notices that he has very distressing feelings, thoughts and emotionally-charged flashbacks. He observes that he ‘passes wind’ (farts) and that his level of distress is significantly reduced. He then decides to treat victimized clients, how to turn the other cheek.”

Consider the origins of the treatment.
16. Advocates use “neuro-babble” and “neuro-networks” and reductionism (often with coloured versions of the brain) to explain the treatment approach.

17. Advocates tell their patients that “If this treatment does not help you, then nothing else will”, as reported that Callahan told his patients who were receiving TPT treatment.

18. Advocates establish a coterie of trainers and an International organization to promote the treatment. Advocates use public media (television, blogs, print) and they over sell their treatment approach. Advocates are “slick salespersons,” setting up clinics, training settings, and conferences.

19. Advocates use Acronyms (Acronym Therapies) and “psycho-babble” to sell their treatment approach.

20. Finally, advocates state that “Over X number of studies have consistently demonstrated efficacy and superiority”, without citing or critiquing these studies.

HOW MANY OF THESE 20 ITEMS DOES YOUR TREATMENT APPROACH INCORPORATE?

REFERENCES


6. FRIDAY DEC. 15 9:20-10:20

Invited Address

“WHY SOME PSYCHOTHERAPISTS ARE MORE EFFECTIVE”

PRESENTATION OUTLINE
a. The “State of the Art” of Psychotherapy.
c. The Core Tasks of Psychotherapy.
d. How to achieve “lasting changes”.

LIST OF HANDOUTS

1. Observations on Core Psychotherapeutic Competency (pp. 239)
2. Therapeutic Relationship as a Common Factor: Implications For Trauma Therapy (pp. 243)
3. Nurturing Therapeutic Mastery (pp. 254)
4. Generalization Guidelines (pp. 273)
OBSERVATIONS ON CORE PSYCHOTHERAPEUTIC COMPETENCY SKILLS

Donald Meichenbaum, Ph.D

1. Establish, maintain and routinely monitor therapeutic alliance (TA).

The TA is the most robust predictor of therapy outcomes. The amount of change attributable to TA is seven times that of the specific treatment model, or specific treatment techniques. The specific treatment accounts for no more than 15% of variance of treatment outcomes. In comparison, some 36% to 51% of the treatment outcome variance is attributed to the person of the therapist, which is 3 to 4 X that of the specific treatment approach. Moreover, it is not therapist demographic factors (gender, ethnicity, discipline, or experience) that is predictive of treatment outcomes (Horvath et al, 2011; Sperry & Carlson, 2013).

TA consists of three major elements:
1. the therapeutic bond established between the client and the therapist;
2. mutually agreed upon treatment goals;
3. mutual agreement on the method to achieve the client’s treatment goals (“pathways thinking” and being “practically optimistic”).

2. Actively communicate an accepting, supportive, helpful, empathetic, validating message.

The client’s trust and confidence in the therapist that he/she is competent and interested in the client’s well-being is predictive of outcome. The client must feel safe, hopeful and consider the therapist as trustworthy and nurturing in order to set the stage for the client’s self-disclosure of painful emotions and intimate details. Client must feel accepted, valued, understood, supported, hopeful and confident that treatment will be helpful.

An effective TA may develop as early as the first session, but an effective TA must be firmly in place by the third session if treatment is to be successful. High TA leads to better treatment and greater likelihood of maintaining change (Skovholt & Jennings, 2004; Sperry & Carlson 2013).

The client’s evaluation of the quality of the psychotherapeutic relationship is a better predictor of the TA and treatment outcome than is the psychotherapist’s evaluation of TA (Horvath et al., 2011).

“It is the therapist and not the treatment that influences the amount of therapeutic change that occurs. Relationship skills or developing a therapeutic alliance is the cornerstone of therapeutic excellence” (Sperry & Carlson, 2013).
3. **Use feedback-assisted treatment. Obtain feedback on a session by session basis.**

   Use Rating Scales and Socratic probes and adjust treatment accordingly (see Duncan, 2010; 2012; Duncan et al. 2003; and work by Lambert, Miller summarized on www.heartandsoulofchange.com). These are a four item scale that takes two minutes to complete that cover such areas as how well understood and respected the client felt, and whether the therapist worked on what the client wanted, how good is the “fit” and the degree of change in key areas.

   The client’s subjective experience of change early in the treatment process is a good predictor of treatment success (Norcross, 2002; Orlinsky et al. 2004).

4. **Provide the client with Corrective Experiences both within and outside of therapy.**

   As Alexander and French (1946) had proposed, encourage the client to “reexperience old unsettled conflicts with a new ending.” A number of researchers have highlighted that a key feature of behavior change is to help clients increase their awareness (“behavioral pattern recognition”) and then to give themselves permission to take a risk of behaving differently that elicits results (“data”) that disconfirms their prior expectations. A process of “transformation” (See Castonguary & Hill, 2012; Fraser & Solovey, 2007; Good & Beitman, 2006; Goldfried, 2012; Meichenbaum, 2013; Sperry & Carlson, 2013).

5. **Prepare for termination and help the client become his/her “own therapist”**.

   Provide intermittent retrospective “taking stock” throughout treatment. Nurture the client self-attributions or “taking credit” for behavior change. This naturally transitions into preparing for termination. Tasks to accomplish include:
   - Relapse Prevention training - - plan and develop self-control skills to prevent relapse.
   - Analysis of potential high risk situations and how to view setbacks and lapses as “learning opportunities”.
   - Discuss possible future challenges.
   - “How different”, “What learned”, Fill out checklists, Client give examples and reasons.
   - Listen for client use of “meta-cognitive transition verbs” (“notice, catch, plan, choose”) and use of RE verbs.
   - Discuss self-therapy approach, “Become a therapist”.
   - Discuss life-style balance and changes.
   - Consider graduation ceremony, if part of a group. Include certification of accomplishments.
   - Consider possibility of future treatment.
   - Consider “unfinished business” and use a journey metaphor.
   - Transform into meaning-making and give back activities.
   - Bolster self-efficacy by helping the client to embrace negative emotions as xxx to explain behavioral pattern and associated expectations. (Use “Clock” metaphor).
   - Ensure that learning is “fun” - - put in a consultative mode to teach others.
ULTIMATE GOAL IS TO BECOME YOUR OWN THERAPIST

6. Use the Art of Discovery-Oriented Socratic Questioning Throughout

A) Examples of Questioning - - Focus on “What” and “How” Questions

“Let me explain what I do for a living. I work with clients like yourself and try to find out how things are right now in your life. I want to find out how you would like things to change.”

“I would like to find out what you have tried in the past so we can benefit from those experiences. What worked? What did not work, as evident by? What were you satisfied with that you think we can build upon?

“If we worked together, and I hope we can, how would we notice we were making progress? What would we see changed? What would other folks notice?

“Permit me to ask one last question. Can you foresee, envision anything that might get in the way of our working to achieve your treatment goals?”

B) Questions designed to help clients become their “own therapist”.

“Let me ask you a somewhat different question. Do you ever find yourself out there, in your day to day experience, asking yourself the kind of questions that we ask each other right here in therapy?”

The treatment goal is to have the client become his or her own therapist and to take the “psychotherapists voice” with him or her.

C) Embed questions with “So far”, “As yet”, “In spite of” followed by “How” and “What” questions. Use the language of becoming and nurture a sense of possibility.

D) Questions designed to solicit feedback.

“Are our sessions meeting your needs and doing the kinds of things you would have hoped to accomplish?”

“Is there anything else that you think I can do that might be helpful that I am not doing?”

“As you look back on our work together, what stands out? Are you surprised at all with these changes?”

“On a scale of 1 to 10, where 1 is dissatisfied and 10 is highly satisfied, what number would you rate our working together?”
“As a psychotherapist, I am always trying to learn to become more expert and I wonder if you have any suggestions as to how I might improve the way I work?”

“Would you recommend this type of therapy to a relative or close friend if he/she were in need? What would you say you got out of treatment that they could benefit from?”

“Is there anything I said or failed to say or do in today’s session that you found particularly helpful or unhelpful?”

“Are you all surprised at these changes?”

“It sounds like you are a life in progress and have begun an ‘irreversible journey’. You have become your ‘own therapist’. You have learned what to know and do to identify patterns and get unstuck.”
THE THERAPEUTIC REALTIONSHP AS A COMMON FACTOR:  
IMPLICATIONS FOR TRAUMA THERAPY

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In D. Murphy, S. Joseph and B Harris (Eds.), Trauma, recovery and the therapeutic relationship: Putting the therapeutic relationship at the heart of trauma therapy. London, UK: Palgrave MacMillan.
Here is the challenge. I recently retired from my University to assume the position as Research Director of the Melissa Institute for Violence Prevention (see www.melissainstitute.org). In this capacity, I am invited to consult and train clinicians on ways to work with clients who have experienced traumatic events and victimizing experiences. The clients usually have received a diagnosis of PTSD and an array of comorbid disorders such as substance abuse and depressive disorders. For instance, I have been training clinicians who are working with returning service members, torture victims, Native populations who have been sexually abused, as well as clinicians who work in Residential Treatment Centers. If you were in my shoes, what advice would you offer these clinicians? What specific interventions would you recommend?

Consider the treatment options that can most succinctly be summarized in a list of Acronyms. In fact, I have come to the conclusion that you cannot formulate a treatment for patients with PTSD and related disorders unless you have an Acronym. In fact, I think that therapists must come up with the Acronym first, and then develop the therapy. You can choose from the following list:

DTE, VRE, CPT, EMDR, SIT, AMT, MBSR, MAGT, ACT, CR, TF-CBT, IBT, CP, CMT, IPT, IRT, and others.

In addition, you can select from an additional array of treatment approaches that have been developed to address the presence of comorbid disorders like SS, TARGET, and STAIR-MPE. This list of treatment options could be extended if we consider specific interventions that address patient dominant emotional concerns like complicated grief, guilt, shame, anger, moral injuries and spiritually-based interventions.

Remember, as a consultant I am getting paid to help psychotherapists choose the “best” most effective interventions. The catch-words are “evidence-based” and “evidence-informed” interventions.

Now, here is the rub. In my desire to be an “honest broker” and not a specific advocate of any one Acronym therapy, I find myself on the “horns of dilemma”. On the one hand there is the report of the Institute of Medicine (2008) of the efficacy of exposure-based therapies with patients who suffer from PTSD, and the Veteran’s Administration endorsing and training their clinical personnel on Direct Therapy Exposure and Cognitive Processing Therapy.

On the other side of the debate, there are a number of meta-analytic reviews that question the relative differential efficacy of so-called “evidence-based therapies” versus bona fide comparison groups that are “intended to succeed.” Reviews by Benish et al. (2008), Imel et al. (2008), Keijzers et al. (2000), Norcross (2002), and Wampold et al (1997, 2010) have seriously challenged the proposition that any one Acronym form of treatment is the “winner of the race” and should be embraced and advocated by me in my consultative capacity. Moreover, Webb et al. (2010) have reported that the therapist’s adherence to evidence-based treatment manuals is not related to treatment outcome. In fact, “loose compliance” that is tailored to the patient’s individual needs may be the best treatment approach.

Such meta-analytic reviews have not gone without their critics, as highlighted by Ehlers et al. (2010). But, keep in mind that the clinicians that I am called upon to train, still want to know specifically what to do with their challenging patients.
For the moment, let us assume that each of the Acronym therapeutic approaches, do indeed, lead to favorable outcomes with patients diagnosed with PTSD and comorbid disorders. What are the common mechanisms that contribute to such patient improvements?

Another way to frame this question is to share an example of my supervisory role of clinical graduate students at the University of Waterloo in Ontario Canada. In our clinic, we had several interviews rooms side-by-side, each with one way viewing mirrors. I would sit on a high-backed chair which had wheels and I could roll up and down the viewing corridor watching several students at one time. Okay, so imagine in each clinical interview room you could watch Edna Foa conducting Direct Therapy Exposure, Barbara Rothbaum using amplified Virtual Reality Exposure, Pat Resick conducting Cognitive Processing Therapy, Francine Shapiro conducting EMDR, Marsha Linehan teaching skills in Dialectical Behavior Therapy, and so forth. What makes these psychotherapists effective? What do “expert” therapists do, and not do, that leads to positive treatment outcomes?

In answering this question keep in mind that there is little or no evidence of the “specificity” of treatment effects. Interventions that are designed to alter specific behavioural skill areas do not usually evidence changes in that domain. Moreover, when dismantling treatment studies are conducted, with the key treatment ingredients omitted or altered, favorable treatment results are still evident (see Rosen & Frueh, 2010).

Hopefully, you are beginning to appreciate the source of my challenge. What would you do? My solution has been to identify and enumerate the “Core Tasks” of what underline treatment improvement. My list is gleaned from both the research literature and my 40 years of clinical work.

**Core Tasks of Psychotherapy**

What are the core tasks that characterize the performance of psychotherapists who achieve positive treatment outcomes? This question has been addressed from Carl Rogers (1957) initial examination of the necessary and sufficient prerequisite conditions of psychotherapy to Jerome Frank’s (Frank & Frank, 1991) analysis of common persuasive features of behavior change to a search for the “heart and soul” of change by Miller, Duncan and Wampold (2010).

In each instance, a set of common psychotherapeutic tasks have emerged. These tasks are dependent upon the quality and nature of the therapeutic alliance as being central to patient behavioural change. As highlighted by Ackerman and Hilsenroth (2003), Martin et al. (2000), Messer and Wampold (2002), Norcross (2002), Safran and Muran (2002), and Wampold (2001), the quality and nature of the therapeutic alliance accounts for a significant larger proportion of treatment outcome variance than do therapist effects and the specific treatment interventions, or the specific form of Acronym therapy that is being implemented. Approximately one third of treatment outcome is accounted for by the therapeutic alliance relationship is the “cornerstone” of effective therapy (Norcross, 2009). As Irvin Yalam (2002, p. 34), stated, “the paramount task of psychotherapy is to build a relationship together that will become the agent of change.” Walsh, (2011 p. 585) observed that “Ideally, therapeutic relationships then serve as bridges that enable patients to enhance life relationships with family, friends and community.”

The correlation between the quality of the therapeutic alliance and treatment outcome is approximately .26, which corresponds to a moderate effect size. The pattern of patient participation and the degree of patient therapeutic engagement in the first three therapy sessions
is predictive of treatment outcome. Patients with weaker therapeutic alliance are more likely to drop out of psychotherapy (Sharf et al., 2010).

The relationship between the quality and nature of the therapeutic alliance and the treatment outcomes is further strengthened when psychotherapists assess and employ ongoing real-time patient feedback. Lambert and his colleagues (Lambert, 2010; Lambert et al. 2005; Shimokawa, Lambert & Smart, 2010) and Miller et al. (2007) have demonstrated that measuring, monitoring and alerting psychotherapists to potential patient treatment failure on a session-by-session basis by soliciting patient feedback of treatment response maximizes treatment outcomes. Such feedback permits the psychotherapist to individually alter and tailor the intervention to the patient’s needs, and thereby strengthens the therapeutic alliance.

The role of the therapeutic alliance in impacting treatment outcome has now been demonstrated with diverse clinical populations. For example, a meta-analysis of 24 studies of couple and family therapy using a variety of self-report alliance measures (Working Alliance Inventory, Couple Therapy Scale and Family Therapy Alliance Scale) found that the interplay of each family member’s alliance with the therapist was related to treatment retention and outcomes. Patients who reported feeling “safe” within therapy with the avoidance of excessive cross-blaming, hostility and sarcasm in sessions reported stronger therapeutic alliances and better treatment outcomes. In so far as a shared sense of purpose and the establishment of overarching familial systemic goals were achieved, rather than individual goals, therapeutic alliance development and treatment outcome were enhanced. (Escudero et al. 2011; Friedlander et al. 2011). McLeod (2011) conducted a similar meta-analysis of the relationship of therapeutic alliance and treatment outcome in youth psychotherapy, and reported similar relationships.

A different research approach to studying the role of therapeutic alliance in influencing treatment outcome has been to ask patients what they have found helpful and unhelpful on the part of their therapists. Hamilton and Coates (1993) interviewed abused women who offered the following observations of their psychotherapists.

Helpful psychotherapists

“Listened respectfully and took me seriously.”
“Believed my story.”
“Helped me see if I was still in danger and explored with me how I could deal with this situation.”
“Helped me see my strengths.”
“Helped me understand the impact of traumatic events on myself and on others.”
“Helped me plan for change.”

In contrast, unhelpful psychotherapists

“Did not listen and did not have an accepting attitude.”
“Questioned and doubted my story.”
“Dismissed or minimized the seriousness of my situation.”
“Gave advice that I did not wish to receive.”
“Blamed or criticized me.”
A similar profile of patient reactions was reported by Elliot (2008).

Whether one considers the findings of meta-analytic studies or the results of interview studies with patients, the degree to which the patient feels respected, heard, accepted, empathetically understood, validated and hopeful enhances the likelihood of positive treatment outcomes. The felt sense of collaboration between the therapist and patient, including an emotional bond and negotiation of therapy tasks and goals has consistently predicted favorable treatment outcomes (Horvath et al. 2011).

The therapeutic alliance has come to be defined as the extent to which the patient and the psychotherapist jointly agree on the goals of treatment and the means or tasks by which to achieve these goals (“pathways thinking”), and the quality of the affective bond that develops between them (Bordin, 1979; Horvath & Bell, 2002; Norcross, 2002). McFarlane (1994) observes that trust is an essential feature of the therapeutic alliance with traumatized patients. The patient must feel secure and confident that the therapist is genuine, empathetic and warm, and moreover, that the therapist can cope with bearing witness to the patient’s reported trauma and understand its significance. These various authors are highlighting that the therapeutic alliance is the primary “vehicle”, “prerequisite”, “process”, “glue”, that permits patients to develop the courage to avoid avoidance, reexpose themselves to traumatic events, reminders, cues, and reengage life.

Additional Core Tasks of Psychotherapy

If we now revisit the various trauma psychotherapists (Foa, Rothbaum, Shapiro, Linehan and the other Acronym Therapists), what do they have in common? Clearly, one thing is their ability to establish, maintain, monitor the therapist alliance and address any potential “ruptures” accordingly. But they do much more. They each:

1. Assess for the patient’s safety (conduct risk assessment) and ensure that basic patient needs are being met.
2. Educate the patient about the nature and impact of trauma, PTSD and accompanying adjustment difficulties and discuss the nature of treatment. Address issues of confidentiality billing, logistics, and the like. But always conveying a “caring” attitude.
3. Conduct assessments of the patient’s presenting problems, as well as their strengths. What have the patient’s done to “survive” and “cope?” They tap the “rest of the patient’s story.”
4. Solicit the patient’s implicit theory about his/her presenting problems and his/her implicit theory of change. The therapist provides a cogent rational for the treatment approach and assesses the patient’s understanding. Makes the therapy process visible and transparent for the patient.
5. Alter treatment in a patient-sensitive fashion, being responsive to cultural, developmental and gender differences.
6. Nurture “hope” by engaging in collaborative goal-setting, highlighting evidence of patient, family, cultural and community resilience.
7. Teach intra and interpersonal coping skills and build into such training efforts the ingredients needed to increase the likelihood of generalization and maintenance of treatment effects. The effective therapist does not merely “train and hope” for
generalization, but explicitly builds in such features as relapse prevention, attribution re-training, aftercare, putting patients in a consultative mode (or in the “driver’s seat”), so they become their own therapist.

8. Provide interventions that result in symptom relief and address the impact of comorbid disorders.

9. Encourage, challenge, cajole patients who have been avoidant to reexperience, reexpose themselves to trauma reminders, cues, situations and memories. Enlist the support of significant others in these reexposure activities.

10. Teach patients a variety of direct-action problem-solving and emotionally-palliative coping skills (for example, mindfulness activities), to the point of mastery, addressing issues of treatment nonadherence throughout.

11. Help patients reduce the likelihood of revictimization.

12. Finally, engage patients in developing “healing stories.”

In short, whatever the proposed Acronym-based intervention (direct exposure, cognitive reprocessing, self-regulatory emotional controls, and the like), it is critical to remember that such specific interventions are embedded in a contextualized process. How much of the patient change that is achieved in trauma therapy should be attributed to each of these component steps and how much to “manualized” treatment procedures.

Table 1 is the Psychotherapist Checklist I use in my consulting role. This Checklist highlights how to make the so-called “non-specifics” of psychotherapy specific, trainable and measurable. It enumerates ways to enhance therapeutic alliance and treatment outcomes. The importance of these psychotherapeutic skills are highlighted by a better appreciation of the goals of trauma therapy from a Constructive Narrative Perspective.

**Constructive Narrative Perspective of the Impact of a Therapeutic Alliance**

Most individuals (70%-80%) who have experienced traumatic and victimizing experiences evidence resilience and in some instances, post-traumatic growth (Bonanno, 2004; Meichenbaum 2006, 2007, 2009, 2011, 2012). The 20%-30% of the traumatized population who evidence adjustment difficulties and who are candidates for some form of trauma therapy evidence a cognitive emotional, behavioural and spiritual style that contributes to persistent PTSD. Patients who receive the diagnosis of PTSD are likely to engage in:

1. Self-focused, mental defeating ruminative style of thinking;
2. Avoidant thinking processes of deliberate suppressing thoughts, using distracting behaviors that inadvertently reinforce avoidant behaviors and PTSD symptoms;
3. Overgeneralized memories and a recall style that intensifies hopelessness and impairs problem-solving;
4. Contra-factual thinking, repeatedly asking “Why” and “Only if” questions for which there are no readily acceptable answers;
5. Engage in “thinking traps” that reinforce hypervigilance, safety and emotionally distancing behaviors and that contribute to the avoidance of self-disclosing and help seeking;
6. Negative spiritual coping responses (Having a “spiritual struggle”, anger responses, moral injuries, complicated grief, guilt, shame and the like).
The trauma patients tell others and themselves “stories” that lead them to become stuck. One central goal of trauma therapy, no matter what form it may take is to help patients develop and live a “healing story.” There is a need for patients to integrate the trauma events into a coherent autobiographical account, so the traumatic events are landmarks, but not the defining elements of their accounts. Trauma patients need to develop “redemptive” stories that bolster hope, strengthen self-confidence and indicate that their efforts will bear fruit. Changes in storytelling provide access to new solutions. The patient’s ability to generate a coherent narrative helps to reduce distress and hypervigilance, increases a sense of control, reduces feelings of chaos and unpredictability, and helps the patient develop meaning. Narrative coherence conveys a sense of personal self-efficacy and helps the patient makes sense of what happened and points a direction to the future. Trauma is only one part of an individual’s life, rather than the determinant aspect. Effective trauma therapy helps the patient learn to let the “past be the past”. Patients can learn to disentangle themselves from the influences and lingering impact of traumatic events. In trauma therapy, patients engage in a narrative healing process.

Trauma therapists, no matter which form of Acronym therapy they employ, are in the business of helping traumatized patients become “story-tellers” who can evidence resilience, moving from the 20%-30% group to the 70-80% resilient group. The therapeutic alliance is the framework whereby trauma patients can share their trauma accounts, as well as what they did to survive and cope in the past; bolster their courage to confront, rather than avoid trauma-related situations and remembrances; develop and strengthen coping strategies that foster hope; undertake meaning-making missions and reengage life. Move from being a “victim”, to a “survivor”, to a “thriver.”

In my consultative capacity, I train trauma therapists to become “exquisitive” listeners and help them become collaborators in their patient’s journey to develop “healing stories.” As Stephen Joseph, (2012 p. 43) has observed: “Human beings are story-tellers. We are immersed in stories.” The role of the trauma therapist is to help traumatized patient’s move along this journey of collecting data (results of personal experiments) that will “unfreeze” their beliefs about themselves, others, the world and the future. The therapeutic alliance is the ground in which such growth develops and blossoms (Meichenbaum, 1996, 2007). Its importance to the change process needs to be highlighted, repeatedly.
CHECKLIST OF THERAPY BEHAVIORS DESIGNED TO FACILITATE THE THERAPEUTIC ALLIANCE

1. Convey respect, warmth, compassion, support, empathy, a caring attitude and interest in helping. Be non-judgmental. Listen actively and attentively, and let your patient know you are listening so he or she feels understood.

2. Convey a relaxed confidence that help can be provided and a sense of realistic optimism, but not false hope. Communicate a positive expectancy of the possibility of change. Use phrases like, “As yet”; “So far” and “RE” verbs such as RE-frame, RE-author, RE-engage). Emphasize that your patient can be helped, but it will require effort on both of your parts.

3. Validate and normalize the patient’s feelings. (“Given what you have been through, I would be deeply concerned, if at times you were not feeling overwhelmed and depressed”).

4. Use guided discovery and Socratic Questioning. Use “How” and “What” questions. Stimulate the patient’s curiosity, so he/she can become his/her own “therapist”, “emotional detective”.

5. Enter the narrative text of the patient, using his/her metaphors. Assess the “rest of the patient’s story” and collaboratively discover what the patient did and was able to achieve in spite of traumatic/victimizing experiences.

6. Explore the patient’s lay explanations of his or her problems and his or her expectations concerning treatment. Collaboratively establish “SMART” therapy goals (Specific/Measurable. Achievable, Realistic, and Time-limited). Use motivational Interviewing Procedures.

7. Model a style of thinking. Ask the patient, “Do you ever find yourself in your day to day experiences, asking yourself the same kind of questions that we ask each other here in therapy?”

8. Encourage the patient to self-monitor (collect data) so that he/she can better appreciate the interconnectedness between feelings, thoughts, behaviors and resultant consequences, and perhaps, inadvertently, unwittingly, and unknowingly behave in ways that may maintain and exacerbate presenting problems (e.g., avoidance behaviors reinforce PTSD symptoms).

9. Conduct a pros and cons analysis and help the patient to break the behavioral “vicious cycle.”

10. Address any Therapy Interfering Behaviors and potential barriers. Solicit patient commitment statements. Play “devil’s advocate.”
11. Provide intermediate summaries and a summary at the end of each session. Over the course of treatment have the patient generate this treatment summary. Highlight how the present session follows from previous sessions and is related to achieving treatment goals. Be specific. Have the patient generate the reasons why he/she should undertake behavioral changes.

12. Help patients generate alternative “healing” narratives that empower them to examine their dominant “trauma” story and develop and live personal accounts that contribute to post-traumatic growth.

13. Solicit feedback from the patient each session on how therapy is progressing and ways to improve treatment. Convey that you, the therapist, is always trying to improve and tailor treatment to the needs and strengths of each specific patient. Monitor the relationship for any alliance strains. Accept part of the responsibility for any difficulties in the relationship.
SUMMARY

1. Much effort has been expended to develop evidence-based interventions with patients diagnosed with PTSD and comorbid disorders - what are called “Acronym Therapies.
2. Exposure-based interventions such as Direct Therapy Exposure and Cognitive Processing Therapy have been endorsed as being most effective.
3. Meta-analytic studies of various so-called “evidence-based” therapies for PTSD patients versus bona-fide comparison groups that were intended to succeed have raised questions about the differential effectiveness of various treatments.
4. Both dismantling and specificity-based studies have questioned the mechanisms of change on those interventions.
5. Common to all these “Acronym” therapies are a set of Core Psychotherapeutic tasks with the most central being the nature and quality of the therapeutic alliance which accounts for the largest proportion of treatment outcome variance.
6. The impact of the therapeutic alliance on treatment outcome is strengthened when ongoing, real-time session-by-session feedback is solicited from patients and used by the psychotherapist to identify potential failures and dropout risk and to alter treatment accordingly.
7. Other core psychotherapeutic tasks beside establishing, maintaining and monitoring therapeutic alliance include psychoeducation, nurturing hope by means of collaborative goal-setting and bolstering resilience, teaching coping skills and building in generalization procedures.
8. Key ingredients in the development of a therapeutic alliance include empathy, trust, respect and a caring attitude. Table 1 provides a list of psychotherapeutic methods to enhance the therapeutic alliance and treatment outcomes.
9. A constructive narrative perspective of the therapeutic alliance highlights how to help traumatized/victimized patients develop “healing stories” with redemptive endings that engender hope, self-efficacy and help move trauma patients (some 20-30% of victimized individuals) to the 70-80% of resilient individuals.
10. The therapeutic alliance provides patients with an opportunity to share, reframe, and develop the courage to reexpose, reexperience, reengage and review their lives so traumatic events are incorporated into a coherent narrative and a personal account.

1 DTE-Direct Therapy Exposure; VRE- Virtual Reality Exposure; CPT- Cognitive Processing Therapy; EMDR-Eye Movement Desensitization and Reprocessing; SIT- Stress Inoculation Training; AMT- Anxiety Management Training; MBSR- Mindfulness Based Stress Reduction; MAGT- Mindfulness and Acceptance Group Therapy; ACT- Acceptance and Commitment Therapy; CR- Cognitive Restructuring; TF-CBT- Trauma Focused Cognitive Behavior Therapy; DBT- Dialectical Behavior Therapy; CP- Counting Procedures; CMT- Compassion Mindfulness Training; IPT- Interpersonal Therapy; IRT- Imagery Rehearsal Therapy.
1 SS- Seeking Safety Treatment; TARGET- Trauma Adaptive Recovery Education and Therapy; STAIR-MPE- Skills Training in Affective and Interpersonal Regulation Followed by Modified Prolonged Exposure.
Nurturing Therapeutic Mastery in CBT and Beyond:
An Interview with Don Meichenbaum, Ph.D.

The cycle of excellence: training, supervision and deliberate practice.
London: Wiley Publications.
Cognitive-behavioral therapy is the most widely researched and disseminated psychotherapy approach in existence. Studies have found the approach effective for a variety of presenting complaints and treatment populations compared to no treatment controls (Hofmann et al. 2012). Around the world, the approach dominates official lists of scientifically-sanctioned mental health treatments, including the National Institute for Health and Clinical Excellence in the U.K., and the National Registry of Evidence Based Practices and Programs in the U.S. (Wampold & Imel, 2015).

The CBT model posits that mental health problems result from dysfunctional beliefs and information processing errors and accompanying emotional dysregulation (Beck, 1979). Over the years, a number of CBT techniques and treatment protocols have been developed and standardized. Each aims at helping people identify, evaluate, and modify the distorted thinking believed to be at the core of various disorders. Behavioral strategies designed to enhance cognitive and emotional skills, as well as to increase engagement in activities associated with improved mood and functioning are also included.

Popularity and overall efficacy notwithstanding, research has failed to provide evidence that CBT is more effective than most other treatments, or that it works through the purported mechanisms of change (Wampold & Imel, 2015). When CBT is directly compared with other therapies designed to be therapeutic, no differences in effectiveness are found (Wampold & Imel, 2015). Moreover, dismantling studies to date have not found any specific ingredient is critical to the benefits of CBT (Ahn & Wampold, 2001; Bell, Marcus, & Goodlad, 2013). This evidence
suggests that an emphasis on adherence to any one method or treatment protocol as a means of improving the quality of mental health services is misguided (Evans, 2013). As presented in previous chapters of this volume, there are a number of critical therapeutic skills unrelated to particular protocols, which if practiced and mastered, would improve outcomes.

In the United Kingdom large amounts of money have been spent over the last five years training clinicians to use cognitive behavioral therapy (CBT). The expenditure is part of a well-intentioned government program aimed at improving access to effective mental health services (Griffiths & Steen, 2013, IPAT, 2011). And yet, the benefit of these expenditures is questionable (Mukuria et al., 2013). Consider a recent study by Branson, Shafran, and Myles (2015) that investigated 43 clinicians who participated in a year-long “high-intensity” CBT training that included more than 300 hours of training, supervision, and practice in CBT. The outcomes of 1247 service users were tracked using standardized measures administered at regular intervals. Not surprisingly, adherence to and competence in delivering CBT improved significantly throughout the training. However, contrary to expectations, results showed that greater adherence and competence, acquired through this CBT specific training, did not result in better outcomes. The therapists were, in other words, no more effective following the training than they were before.

While one might hope such findings would lead to questions regarding the relationship between the treatment method and outcome, the researchers chose instead to question whether “patient outcome should … be used as a metric of competence…” (p. 27). Said another way, despite the results, adhering to protocol was still viewed as more important than whether adherence improved outcomes!
Given our (the editors’) understanding of the evidence about CBT, we were eager to have a chapter about developing expertise in CBT with improving outcomes as the goal. After attempts to find CBT authors who would take improving outcomes as opposed to adherence as critical to expertise failed, we approached Don Meichenbaum to gain some insight into this process. Meichenbaum is one the most prominent founders of CBT. Early on, he began studying transtheoretical patterns associated with expert performance in psychotherapy. In time, he developed a model of therapeutic expertise, identifying a core set of tasks that effective therapists use.

The editors were pleased that Meichenbaum agreed to be interviewed about his model of expertise and how his thinking about psychotherapy evolved from CBT to an emphasis on improving outcomes through deliberate practice.

The Interview

**Editors (Eds.)** We are pleased to have you contribute to our discussion of how to nurture expertise in psychotherapists.

**DM** I am honored to be invited to contribute. This is a challenging issue that I have been struggling with for some time. I have been involved in training psychotherapists for over 40 years, as a clinical supervisor, as a consultant to various psychiatric treatment centers where the clientele range from children to the elderly. In addition, I have been offering Continuing Education for over 30 years. I have been concerned about what trainees and what participants take away from my instruction and supervision.

**Eds.** You are considered one of the founders of cognitive behavior therapy, and you initially conducted a number of innovative treatment outcome studies designed to
determine the relative efficacy of such therapeutic procedures as self-instructional training, stress inoculation training, cognitive restructuring procedures, and problem-solving approaches. How did your clinical research lead you to a more generic concern with the concept of “expertise” of psychotherapists?

DM

You are correct in noting my professional trajectory. In fact, recently I was invited by Routledge Publishers to conduct a retrospective of my publications over 40 years (Meichenbaum, 2017). This was an opportunity to reflect on my ongoing preoccupation with what constitutes the core tasks that “expert” psychotherapists engage in.

Eds.

How did you come to this position?

DM

The answer comes in three parts. First, I was impressed by the marked variability in the treatment outcomes of the therapists we were working with. Some therapists consistently achieved better outcomes than others. This finding is in accord with the findings of a number of researchers (Dawes, 1994; Baldwin & Imel, 2013; Wampold 2001, 2006; Wampold & Imel, 2015). Second, as a consultant to various treatment programs and as a provider of continuing education, I had a strong desire to be an “honest broker” and advocate for evidence-based interventions. My presentations were tempered, however, by the finding that all treatments that are intended to be therapeutic seem to be approximately equally effective. Thus, my interest turned to what are the behavior change principles and core psychotherapeutic tasks that are common to these varied treatment approaches.

The third and most critical contribution to my evolving views of expertise and psychotherapy was that I also wear a “professional hat” of being a
developmental psychologist. With a colleague, Andy Biemiller, we wanted to better understand “why smart children in school keep getting smarter, and other students fall further and further behind”? For example, by the time students reach high school, the spread between high and low achieving students could be as much as six grade levels. In some sense, the high-achieving students are “experts” in negotiating the demands of the school system (Meichenbaum & Biemiller, 1998).

**Eds.** How did your work on students’ academic performance link with your training of psychotherapists?

**DM** In our work with students, I reviewed the research on the acquisition and structure of expertise (Ericsson & Charness, 1994; Ericsson et al., 2006; Shanteau, 1992). In fact, Neil Charness was a colleague at the University of Waterloo, in Ontario, Canada, where I worked for 40 years.

As a result of a number of observational studies of independent student learners (so-called “budding experts”), we developed a theoretical model that could be applied to the acquisition of expertise, including psychotherapy (Biemiller & Meichenbaum, 1992).

**Eds.** That is interesting. Can you describe the model and discuss its implications for the training of psychotherapists?

**DM** Figure 1 provides a pictorial presentation of the Model of Mastery. It is a three dimensional framework that includes an X Axis (horizontal), a Y Axis (vertical), and a Z Axis (diagonal). The X Axis represents a tutee’s movement from easy to more difficult tasks that require more knowledge and skills. For school students, this may reflect moving from simple math problems to more difficult problems. For
novice psychotherapists, this may entail taking on patients with less complex straight-forward Adjustment Disorders to more complex high-demand, traumatized patients with chronic co-occurring disorders who have few social supports. The critical feature in moving along the X Axis is the nature of the “fit” between the tutee’s competence and the task demands. An effective teacher or clinical supervisor attempts to match, and slightly challenge, the tutee and “scaffold” instruction, providing necessary supports and then reducing guidance and fading them as the tutee acquires skills.

The Y vertical Axis reflects further steps in the development of mastery. A tutee (either student or psychotherapist) moves from an initial point of being a complete novice (lack of knowledge, skills, experience) by means of deliberate practice to the point of task efficiency, where he or she can consolidate skills and performance. Such deliberate practice is goal-directed in achieving well defined specific tasks that the tutee seeks to master. It includes multiple repetitive opportunities to engage in the tasks and affords immediate feedback, highlighted errors and represents “teachable moments”. As automaticity develops the tutee can learn to perform more than one skill set at a time.

In school, students may have opportunities to do and redo a particular academic task. For a psychotherapist, it may be working on ways to establish, maintain and monitor a therapeutic alliance, or deal with “ruptures” to such an alliance. Therapists can use session-by-session patient input to monitor the perceived fit and effectiveness of the therapeutic alliance, and alter the
One of the goals of this deliberate practice is to help automatize performance (put the tutee on “auto-pilot”), so it frees up mental capacity. This consolidation process should be revisited on a regular basis when feedback indicates that performance errors have occurred.

But engaging in deliberate practice in moving from initial steps of acquisition to consolidation is not sufficient to evidence mastery and develop expertise. The tutee needs to continue up the Y Axis to the point of becoming a mindful, reflective, deliberate consultant, to themselves and to others. It is in this consultative role where situational awareness develops, as the tutee can self-monitor, observe and “own” his/her skills. In order to develop mastery, the student or psychotherapist needs to develop conditional strategic knowledge knowing when and how to implement the skill set, but can also describe the process, and even teach it to others. The learner must come to spontaneously use language or some other form of mental representation (diagrams, semantic webs) in a way to direct others and him or herself.

As the tutee moves up the Y Axis with more and more difficult demanding tasks (moving concurrently along the X Axis), he or she calls upon meta-cognitive, executive skills, and can even shift goals.

But the journey to expertise is not yet complete. The tutee needs to learn how to apply the acquired skills to new tasks, in new situations, and in innovative ways. In short, the tutee (student or psychotherapist) needs to move along the Z...
Axis. There are two ways to negotiate the Z Axis (OUT and BACK). The training sessions can take the form of what is called, Near Transfer. The training opportunities can closely approximate the initial training tasks that were used in the acquisition of the skill set. One can “criterion cheat”, making the training tasks similar to the transfer tasks. In this way, the tutee can apply his or her knowledge and skills in a methodical, and perhaps, innovative manner to new tasks, settings and patients.

A second way to negotiate the Z Axis is to confront the student or psychotherapist with an “authentic” challenging task, and have the tutee deduce, infer and problem- solve ways to figure out and apply his or her knowledge and skills, which is called Far Transfer.

The Z (OUT) dimension denotes the planning and application complexity of a task, as tutees apply their knowledge and skills to new tasks in novel situations. The learners acquire or generate strategies for planning new tasks - - transferring or generalizing their knowledge and skills. As noted, the tasks may vary from near transfer (tasks and contents similar to training) to far transfer (“authentic” applied tasks that require high levels of skill integration and complex decision making). Tutees move from merely consuming knowledge to constructing knowledge, tasks and procedures.

Tutees may move OUT from the initial simplified learning settings to complex “authentic” tasks. They may also move BACK from “authentic” complex tasks to focusing on the acquisition of further needed skills and strategies. This bidirectional movement is a dynamic interactive process.
In summary, the proposed Model of Mastery means that in order to develop “expertise”, individuals need to:

1. move from simple to more complex difficult tasks (patients) (X Axis);
2. move from being a novice to becoming proficient by means of deliberate practice, to the point whereby they consolidate their skills that frees up mental capacity all the way to the point of becoming a consultant to themselves, as well as to others. In this way, they now come to “own” their skill set and can teach them to others (Y Axis).
3. apply and extend their knowledge and skill sets to new tasks (patients), settings, and to do so in innovative, creative ways. They can do so by applying their skills to an increasingly challenging set of transfer tasks, or they can do so by engaging in “authentic” real-life tasks, even inventing new applications. In order to become an “expert” in any area, an individual needs to move OVER, UP and OUT, along the three dimensions proposed by Model of Mastery. If you want to become an “expert” at something, the individual has to learn to perform more challenging tasks, on their own, as a result of deliberate practice, and apply these skills in new ways on novel tasks in different settings. According to this analysis, deliberate practice is embedded in the journey toward expertise.

The development of such expertise by means of deliberate practice in implementing the Core Tasks of Psychotherapy will contribute to the ultimate objective of helping patients achieve their treatment goals that they have collaboratively established with their therapists.

Eds. How did the three dimensional Model of Mastery contribute to your training of
In order to answer your question, let us take one Axis at a time. Keep in mind that when the contributors to this volume call for deliberate practice, the critical question is what specific skill sets should psychotherapists deliberately practice?

Exactly!

Research indicates that the most robust predictor of therapy outcomes is the quality of the therapeutic alliance (TA). The amount of change attributable to TA is seven times that of the specific treatment model, or specific treatment techniques. In fact, the specific treatment accounts for no more than 15% of variance of treatment outcomes. In comparison, some 36% of the treatment outcome is attributed to the person of the therapist, which is 3 to 4 times that of the specific treatment approach (Sperry & Carlson, 2013). But as Miller et al., (2008) highlighted, it is the availability of timely quality feedback from patients on a session-by-session basis that is critical to the development of expertise in any area.

In terms of the Model of Mastery, this translates into the need for psychotherapists to engage in deliberate practice with more and more challenging patients (namely, across the X Axis of level of difficulty), and to actively solicit patient feedback on an ongoing basis.

But a big feature of developing a good therapeutic alliance is for the patient and therapist to mutually agree upon the treatment goals and methods by which to achieve the patient’s goals (“pathways thinking” and being “practically optimistic” in order to nurture the patient’s level of hopefulness) (Bordin, 1979; Horvath et al. 2011).

Thus, a second core set of tasks that psychotherapists need to deliberately practice are motivational interviewing and collaborative goal-setting procedures.
As Goldfried observed (2012), the patient should hold the belief, “My therapist really understands and cares about me,” and the therapist should hold the belief, “I really enjoy working with this patient.” The patient’s trust and confidence in the therapist that he/she is competent and interested in the patient’s well-being is predictive of outcome (Norcross, 2002; Skovholt & Jennings, 2004).

An effective TA may develop as early as the first session, but an effective TA must be firmly in place by the third session, if treatment is to be successful (Sperry & Carlson, 2013).

“It is the therapist and not the treatment that influences the amount of therapeutic alliance that occurs. Relationship skills at developing a therapeutic alliance is the cornerstone of therapeutic alliance (Sperry & Carlson, 2013, p. 86).

The use of patient rating scales and Socratic probes, and the therapist’s adjustment of treatment accordingly, are predictive of treatment outcomes.

It is the adjustment of treatment interventions that are in response to patient feedback that is a critical aspect of being a successful psychotherapist. Expert therapists tend to be more reflective and work harder between sessions, seeking mentoring opportunities (Miller et al., 2008). In terms of the proposed Model of Mastery, in order to develop expertise individuals have to move up the Y Axis to the point of being a “consultant” to themselves, as well as to others (including their patients). Both the therapist, and the patient, have to “own” their newly developed skills, and moreover, “take credit” for the changes they have brought about. A core task for psychotherapists is to deliberately practice ways to have their patients engage in self-attributional training that
nurtures personal agency and self-efficacy. Patients need to see the connections between their efforts and resultant changes, and become more situationally aware of the consequences of their efforts and interventions (Duncan et al., 2010; Messer & Wampold, 2002).

In short, therapists who achieve better outcomes have developed a way of teaching their patients how to become their own therapists. Expert therapists teach their patients how to take the therapist’s voice with them. For instance, the therapist teaches patients how to become “experts” in achieving their treatment goals, and ways to improve the quality of their lives. Consider the potential value of psychotherapists asking their patients the following question: “Let me ask you a somewhat different question. Do you (the patient) ever find yourself, in your everyday experiences, asking yourself the kind of questions that we ask each other right here?”

The Model of Mastery highlights that there is also a need to have psychotherapists, not only move across the X Axis, and up the Y Axis, but to also move out and back along the Z Axis. In order to truly become an “expert” at any skill, there is a need to apply, extend, generalize, and invent new and creative applications of their skill sets. Psychotherapists need to apply their knowledge and skills to “authentic” challenging new and complex cases. Psychotherapists require knowledge and skills on how to increase the likelihood of transfer and generalization in order to help their patients achieve “lasting changes”. Expert therapists do not merely “train and hope” for such transfer, but they build in specific ways their patients can move out along the Z Axis (Meichenbaum & Biemiller, 1998).

Eds. Let us see if we have captured what you are proposing. You have highlighted three main
features that characterize psychotherapists who achieve better treatment outcomes:

(1) the development, maintenance and monitoring of the quality of the therapeutic alliance with more and more challenging patients;

(2) the self-reflective activity to use such patient feedback on an ongoing basis to adjust their treatment approach accordingly, in order to become more meta-cognitively active, or what you call being in a consultative role with themselves, as well as with others, including their patients. Interestingly, you are proposing that therapists who achieve better results, teach their patients how to become “experts” themselves, in using the principles of deliberate practice;

(3) finally, you have proposed that effective therapists challenge, cajole, nurture and support their patients to undertake these activities on new and challenging tasks, in new situations and settings with significant others.

Indeed, three basic features characterize “expert” psychotherapists who obtain better treatment outcomes, namely, (a) the ability to establish, maintain and monitor on an ongoing basis the quality of the therapeutic alliance that has been implemented in a culturally-sensitive manner; (b) the ability to become more strategically knowledgeable, self-aware and reflective as they operate in a consultative role to their patients and to themselves in order to alter treatment accordingly; (c), the ability to increase the likelihood of their patients achieving “lasting changes” by their incorporating into their treatment protocols behavioral generalization guidelines. Insofar as psychotherapists deliberately practice implementing these Core Tasks of Psychotherapy, they will improve their patient’s treatment outcomes.

“Expert” psychotherapists do not view themselves as experts, but continually seek
feedback from their patients, colleagues and supervisors on their personal journey to becoming more effective catalysts of change.
Figure 1. The Model of Mastery
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REPORT CARD ON HOW WELL YOUR TRAINING PROGRAMS FOSTER GENERALIZATION

How many of these features are included in your training program?

What grade would you give to your Intervention Program in its ability to foster generalization?

In order to foster transfer at the OUTSET OF TRAINING, my training program:

1. Establishes a good working alliance with trainees, so the trainer is viewed as a supportive constructive “coach.”

2. Uses explicit collaborative goal-setting to nurture hope. Discusses the reasons and value of transfer and relates training tasks to treatment goals.

3. Explicitly instructs, challenges and conveys an “expectant attitude” about transfer.

4. Uses discovery learning, labelling transfer skills and strategies. Use a Clock metaphor. (12 o’clock refers to internal and external triggers; 3 o’clock refers to primary and secondary emotions and accompanying beliefs/theories about emotional expression; 6 o’clock refers to automatic thoughts, thinking patterns such as rumination and beliefs and developmental schemas; 9 o’clock refers to behavioural acts and resultant consequences). These contribute to a “vicious cycle”.

5. Solicits trainees’ public commitment and uses behavioral contracts.

6. Anticipates and discusses possible barriers to transfer.

7. Chooses training and transfer tasks carefully (builds in similarities and uses ecologically-valued training tasks).

8. Develops a “community of learners” (e.g., advanced trainees, an Alumni Club).

In order to foster transfer DURING TRAINING, my training program:

9. Keeps training simple- uses acronyms and reminders (wallet-size cards and a “Hope Chest”).

10. Uses performance-based training to the point of mastery. Provides regular feedback and has trainees self-evaluate and record performance.

11. Accesses prior knowledge and skills, uses advance organizers and scaffolded instruction.

13. Conducts training across settings, using multiple trainers and environmental supports.


15. Promotes generalization through between session assignments and between session coaching. Have trainees engage in deliberate practice.

16. Includes relapse prevention activities throughout training that decreases the chances of setbacks after training is completed. “Inoculates” against failure.

In order to foster transfer at the CONCLUSION, my training program:

17. Puts trainees in a consultative role (uses reflection, provides trainees with an opportunity to teach others, puts trainees in a position of responsibility).

18. Ensures trainees directly benefit and receives reinforcement for using and describing their transfer skills.

19. Provides active aftercare supervision-fades supports and “scaffolds” assistance, and where indicated, provide continuation treatment.

20. Ensures trainees take credit and ownership for change (self-attributions). Nurtures personal agency.

21. Ensures participants design personal transfer activities and become self-advocates.

22. Involves training significant others and ensures that they support, model and reinforce the trainees’ new adaptive skills.

23. Provides booster sessions.

24. Conducts a graduation ceremony and offers a Certificate of Accomplishment.
CHECKLIST OF WHAT TRAINERS SHOULD DO AT THE OUTSET, DURING AND FOLLOWING TRAINING IN ORDER TO INCREASE THE LIKELIHOOD OF GENERALIZATION

PROCEDURAL CHECKLIST ON WAYS TO IMPROVE GENERALIZATION

AT THE OUTSET OF TRAINING ACTIVITIES:

1. Establish a good working alliance with the trainee because the quality of this relationship is the single most important factor in producing positive outcomes and it exceeds the proportion of outcome attributed to any other feature of the training. The quality of the relationship predicts drop out rate and level of compliance. The trainee needs to feel respected, accepted, engaged, and be treated as a collaborator. Hostile, confrontational, fear-engendering interactions are counter-productive and ineffective. If training is being conducted on a group basis, then the level of group cohesion and identity with the group is predictive of outcome. The trainer should be viewed as a “constructive supportive coach.”

2. Engage the participants in explicit goal-setting. Highlight that the treatment is not only about changing, but transferring (extending) the newly acquired skills (changes) learned in the training program to new situations/settings.

3. Discuss the challenge to generalize or transfer skills. Lead participants to view generalization as an attitude, rather than just as a set of transferable skills. Participants need to find (search out) opportunities to practice what was learned in a supportive environment.

4. Raise concerns about transfer from the outset of training. Have participants examine how learning such skills will help them achieve their short-term and long-term goals. Discuss why learning these skills is of value. Relate skills and homework tasks to treatment goals. Use Motivational Interviewing strategies to engage trainees.

5. Provide participants with opportunities to come up with suggestions of what should be done to transfer skills. Use collaborative Socratic questioning and discovery-oriented learning procedures. The concepts to be learned should emerge as part of an activity requiring little verbal expression so trainees can figure out what is being taught and why. The trainer can use shaping and scaffolding procedures with prompts of Socratic questioning. When required, directed teaching methods can be added.

6. The skills should be taught in a manner that allows the training to build one skill upon another in a sequenced fashion. Name and describe each skill that is being taught. Encourage the trainees to view these skills as “tools” that they can carry with them and draw upon as needed. Label and refer to transfer strategies and convey that generalization is the goal of treatment. Help them understand how
similar skills can be applied across multiple settings (e.g., self-talk, problem-solving). Trainers should discuss, model, and label metacognitive self-regulatory strategies.

7. **Tell** participants explicitly that transfer is expected. **Encourage** and challenge patients to **apply and adapt** skills and strategies to varied and novel situations, rather than learn to apply specific skills to discrete behaviors and settings. Use “like a” statements throughout training. “This skill is like...” Use teachable stories and anecdotes.

8. **Solicit public commitment statements** of what they are going to do and why. Write out on a decisional balance sheet, the pros and cons of making changes. Use **behavioral contracts** that include transfer activities.

9. **Tailor instructions** to the developmental needs of the participants and be sensitive to **gender and cultural differences** and train skills that are **ecologically valid**. Training should **build upon** the trainees' strengths and abilities.

10. Throughout the course of training **anticipate** and **discuss possible barriers** and obstacles to implementing homework (both external and internal barriers). Include in the training program skills designed to handle potential barriers.

11. Help participants select training and transfer tasks carefully—where there is a high likelihood of similarity. The more similar the features of the training and the real life setting, the greater the likelihood of generalization (e.g., use exposure-based training and provocation challenge procedures in training that are ecologically valid and are as similar to real life as possible).

**DURING THE TRAINING ACTIVITIES**

12. Nurture a **“community of learners”** -- where participants can help each other (e.g., an Alumni Club of graduates, other trainees, pro-social peers).

13. Ensure that the **training tasks** are tailored to the trainees' levels of competence, namely, **slightly above the trainees' current ability levels** (“teachable window” or work within the “zone of proximal development” or “zone of rehabilitation potential”). Skills to be taught should be broken down into identifiable parts. Trainers should use minimal prompts and fade supports (scaffold instruction), as trainees gain competence.

14. Keep training simple by using **acronyms** to summarize teaching skills (e.g., SNAP—Stop Now And Pause; RETHINK—Recognize, Empathize, Think, Hear, Integrate, Notice, Keep present problem at hand, or Linehan's Dialetical Behavior therapy uses such acronyms as RAID, SCIDDELE, RSVL, DEAR MAN), so they come to be readily retrievable **mnemonics**. Use **reminders** such as wallet-size index cards. Have trainees keep a **Training Folder** and refer back to it often.
15. Provide prolonged, in-depth training with repeated practice to the point of mastery, in order to ensure conceptual understanding. Facilitate skill practice and provide constructive feedback. The length of training should be performance-based, rather than time-based. Provide extended individual and group training where indicated, so participants can develop mastery of skills and strategies. Provide help and coaching to complete “homework” assignments. Have trainees engage in deliberate practice that is goal-directed.

16. Promote awareness of skills and teach problem-solving metacognitive executive skills and strategies (self-monitoring, planning and freeze-frame procedures) that can be applied across settings. Use overt and covert rehearsal and self-monitoring. Use Clock Metaphor (12 o’clock - - external and internal triggers; 3 o’clock - - primary and secondary emotions; 6 o’clock - - automatic thoughts and images, thinking style such as rumination, schemas, beliefs and values, 9 o’clock - - behaviors and resultant consequences). Help trainees appreciate how these elements contribute to a “vicious cycle” and learn ways to break the “vicious cycle”.

17. Begin by accessing participants' knowledge. Provide advance organizers (“big picture” reminders of goals) and informed instruction (how the content of this session relates to previous sessions; “Where have we been? and “Where are we headed?”).

18. Explicitly instruct on how to transfer. Use direct instruction, discovery-oriented instruction and scaffolded assistance (fade supports and reduce prompts as trainees' performances improve). Employ videotape coping modeling films as training material. Have the trainees make a self-modeling video of successfully performing the skills that they can watch. The training can include such skills as the ability to label emotions and use feeling language; use a calm down plan and how to take a time out; how to solve interpersonal conflicts using social problem-solving, negotiation and assertive communicative skills (e.g., “I” statements, instead of “you” statements).

19. Conduct training across response domains and settings. Training should be conducted “loosely.” This involves varying stimulus contexts for training. Use diverse examples to illustrate the application of skills to different behaviors and to different situations. Use multiple trainers. Work on skills development and maintenance in real world settings using environmental modifications and supports. The trainer should maintain close contact with significant others who should be viewed as “change agents” (e.g., parents who are trained as therapists, or residential staff, classroom teachers, probation officers who are taught how to support, model and reinforce the desired behavioral changes).

20. Use cognitive modeling, think aloud-diaries, journals, behavioral and imaginal rehearsal and role playing. Have an Alumni Club of recent graduates who act as teaching models, like a 12-Step AA sponsor.
21. Nurture a “cognitive shift” and attitudinal change. Can use modeling films, bibliotherapy, story-telling that nurtures a new “possible self.” Help trainees alter the stories they tell themselves and that they tell others. Have the trainees make a “self-advocacy” videotape of where they have been, where they are now psychologically, and what they hope to achieve in the future, and moreover, how they plan to get there. Trainees might develop a “Hope Chest” that includes items that reflect a different pro-social life-style.

22. Have participants repeat reasons why they should engage in transfer activities; reconfirm public commitment statements; review goal statements with “If...then” and “Whenever...” rules.

23. Review with the trainee, his or her relapse prevention training procedures throughout training. Have trainees analyze and learn from transfer failures and successes and keep a Relapse Prevention (RP) workbook. The trainer should design "Relapse Prevention Sheets" with the trainee. These sheets should contain reminders of key responses for any problematic situations that the trainees can refer to when necessary. Encourage trainees to use RP concepts and language.

AT THE CONCLUSION OF TRAINING ACTIVITIES

24. Put trainees in consulting reflective roles. Following an experiential exercise have participants reflect on the activity (i.e., think about what they just did and what it meant, how can they use these skills in future situations). Have participants teach (demonstrate, coach) and explain verbally or diagrammatically (alone or with others) their acquired skills and transfer strategies. Have participants be in a position of responsibility, giving presentations to and consult with other beginning participants or younger individuals. Have them make teaching videotapes. Be sure to have trainees describe the reasons for engaging in such transfer tasks and how doing so will help them achieve their treatment goals.

25. Ensure that participants directly experience the benefits (“pay offs”) of choosing new (non-aggressive) options. Ensure that trainees receive naturally occurring rewards.

26. Label and reinforce participants' transfer activities. Talk about maintaining and building upon change.

27. Provide between session coaching. Access to ongoing counselling (computer chat lines, telephone counselling and telephone hotlines).

28. Have the trainee develop an explicit written relapse prevention plan and “trouble shoot” possible solutions to potential obstacles, barriers and responses to possible lapses. Encourage trainees to view “failures” as a reflection of a lack of skills, not enough practice, the training program not being sensitive to trainees' needs and skill levels, rather than a sign of being a “sick,” “bad,” or an “incompetent” person.
29. Provide active aftercare case management supervision. (e.g., Assertive Community Treatment, Supported Employment). Use Websites, Interactive Diaries Technology - see [www.warfighterdiaries.com](http://www.warfighterdiaries.com) and ongoing computer chat-lines. Fade supports and “scaffold” assistance throughout training.

30. Review progress and ensure that trainees take credit (make self-attributions) and declare ownership for performance gains and transfer efforts. Have participants talk about what they learned and take “personal ownership” of coping skills. Trainers should use “how” and “what” questions. (“How did they change? How can they maintain improvements?” “What did they do differently this time, as compared to what you did in the past?”) Nurture trainees’ sense of personal agency and personal efficacy. “Are you saying that in spite of x, you were able to do what? How did you do that?

31. Encourage trainees to design personal transfer activities. Enlist trainees in a mutual search for situations in which the coping skills can be employed, discussed and practiced. Ask the trainees to discuss and identify the variety of situations where they could apply new skills and strategies. Prompt the trainees to set goals for implementing these skills over the next week. Provide monitoring forms to map progress. Have the trainees adopt a “personal scientist’s” approach.

32. Involve significant others in training. Keep in touch with significant others (peers, parents, teachers, administrators, family members) from the outset of training and through follow-up. Use a primary prevention institutional-wide intervention program that involves peers and all staff. Use a bystander intervention program to supplement training for the targeted group.

33. Space out training sessions to every other week, then monthly, so trainees can assume more responsibility for implementing changes.

34. Provide booster sessions and ongoing follow-up group meetings. Have trainees enter group training if they fail to handle lapses successfully. (Use the analogy of a General medical practitioner where patients go for annual checkups. “Fine-tuning” is a smart thing to do). There is research to indicate that merely sending participants a post card after intervention expressing interest and concern enhanced efficacy. (See [www.melissainstitute.org](http://www.melissainstitute.org) - Meichenbaum Lessons learned working with suicidal patients).

35. Use a graduation ceremony, involving significant others and include certificates of completion and appreciation. Provide trainees with “transitional objects” (e.g., pictures, logos, tee shirts, trainer's business card and ways to remain in touch). Consider how to use Internet resources, IPOD technology and Intreactive Diaries Technology.
7. FRIDAY DEC. 15  10:40-11:40

Discussion Hour

“EVOLUTION OF COGNITIVE BEHAVIOR THERAPY: ORIGINS, WHERE HAVE WE BEEN, WHERE ARE WE NOW, AND WHAT IS IN THE FUTURE?”

PRESENTATION OUTLINE

b. How CBT changed its Theoretical basis?
c. The current “state of the art” of CBT: A critical appraisal.
d. The future of psychotherapy, including CBT, using computer technology.

LIST OF HANDOUTS

1. Reviews of “The Evolution of Cognitive Behavior Therapy: A Personal and Professional Journey with Don Meichenbaum (pp. 281)
2. The Nature of The Challenge for Psychotherapists (pp. 282)
ORDER INFORMATION FOR DON MEICHENBAUM'S BOOK

"THE EVOLUTION OF COGNITIVE BEHAVIOR THERAPY: A PERSONAL AND PROFESSIONAL JOURNEY WITH DON MEICHENBAUM"

ROUTLEDGE PUBLISHERS  www.routledge.com

"This is a must read for every psychotherapist and others working in health and behavioral healthcare. Don Meichenbaum, a founder of Cognitive Behavior Therapy, is a critical force in the field of psychotherapy and the clinical science of behavior change. With his unique wisdom and wit, Don Meichenbaum shares his thinking style and the creative and scientific process he brings to the science and practice of Cognitive Behavior Therapy. In this era of evidence-based treatment, this volume offers a much needed perspective on how to develop, evaluate, and apply our science to improve lives and reduce suffering."

Joan Asarnow, Ph.D., ABPP, Professor of Psychology and Biobehavioral Sciences, UCLA

"Dr. Meichenbaum is one of the giants of CBT. His work on self-directed learners, stress inoculation training and promoting resilience, the development of a constructive narrative perspective for anger, pain management, PTSD, and suicidality, and his conceptualization of the core tasks for psychotherapists are essential. A veritable research encyclopedia as well as a committed clinician, he is brilliant, innovative and passionate. Reading these papers is a treat, Highly recommended!"

Michael Hoyt, Ph.D.  Author and Editor of books on Brief Therapy

"Just when I think I have learned everything there is to be learned from Don Meichenbaum's treasure house of clinical wisdom, I find more. This collection of articles offers all of us, from graduate student to senior clinician, gem after gem from one of the masters. His ' Evolution' is not to be missed."

David Wexler, Ph.D., Executive of the Relationship Training Institute, CA.

"Imagine having the fortune of being mentored by a leading thinker, practitioner, and researcher in the field of psychology. The Evolution of Cognitive Behavior Therapy provides just that experience, taking you on a personal and professional journey with Don Meichenbaum, one of the pioneers of Cognitive Behavior Therapy and a clinician rated one of the ten most influential of the century."

Scott D. Miller Ph.D.  Director of the International Center for Clinical Excellence
1. There has been no improvement in treatment outcomes in the field of psychotherapy over the last 30 years, as reflected by changes in Effect Sizes (ES) and by meta-analytic studies (Budd & Hughes, 2009; Hunsley & D. Guilio, 2002).

2. The dropout rate from psychotherapy averages between 20% and 47% for adult patients. The dropout rate for children and adolescents ranges from 28% to 85%.

3. Some 30% to 50% of adult patients do not benefit from psychotherapy. In the treatment of patients with Substance Abuse Disorders, the relapse rate is 75%, no matter what substance is being used.

4. The deterioration rate among adult patients in psychotherapy is 5% to 10%. Those patients who deteriorate in psychotherapy account for 60% to 70% of the total expenditure of mental health care costs.

5. Psychotherapists routinely fail to successfully identify patients who are not progressing. Such patients who are deteriorating are at most risk of dropping out and having negative treatment outcomes (Lambert, 2007; Lambert & Shimokawa, 2011).

6. Psychotherapists lack knowledge and usually do not seek treatment outcome data and as a result have a tendency to overestimate their effectiveness. There is a need to check-in with patients on a regular basis regarding the quality of the therapeutic relationship and their progress (Sperry & Carlson, 2013).

7. The Partners for change Management System which is a SAMHSA National Registry evidence-based program provides a session-by-session tool kit for obtaining real-time patient feedback. Also see Lambert’s OQ-45 measure (Duncan, 2010; Lambert 2007).

8. Psychotherapists need to focus on early changes and monitor and bolster patient progress. There is a dose-response relationship between early improvement and treatment outcome of patients who are engaged in treatment:

   a) 30% of them improve by the second session;
   b) 50%-60% evidence improvement by session 7;
   c) 70%-75% by 6 months;
   d) 85% by the end of the year.
Sudden gains in symptom reduction contributes to improved therapeutic alliance, and in turn, to a “positive spiral” of change. Early improvement and patient progress predicts positive treatment outcomes (Tang & DeRebeis, 2005).

9. With experience psychotherapists treatment effectiveness does not improve. What does change with experience is the psychotherapists’ confidence in their competence and effectiveness (Wampold, 2001).

10. For example, a study by Branson et al. (2015) provided 43 psychotherapists with 300 hours of training in CBT. They tracked outcomes in 1247 patients and found that the 300 hours of training significantly improved adherence to CBT protocols, but the extensive training did not result in better treatment outcomes, relative to untrained psychotherapists. The CBT therapists were no more effective following training than before. There was little support of a general association between CBT competence and patient outcome. Moreover, Webb et al. (2010) have reported that the psychotherapists’ strict adherence to evidence-based treatment manuals is not related to treatment outcomes. In fact, “loose compliance” that is tailored to the patients’ individual needs and preferences may be the best treatment approach (See doi.10.1016/jbrat.2015.03.002 for the Branson et al. study).

11. There is substantial variation in outcomes between providers with similar training and experience. Some psychotherapists are more “expert” in achieving better treatment outcomes and “lasting changes” in their patients.

Patients of effective psychotherapists improve at a rate of at least 50% higher and their drop-out rate is at least 50% lower than the less effective psychotherapists (Norcross, 2002; Skovholt & Jennings, 2004).

12. A variety of studies have shown that the difference in effectiveness of individual psychotherapists, within a given treatment, accounts for a larger proportion of variance than the variance accounted for between various treatments. The person and his/her clinical skills are more important than the specific treatment being implemented in contributing to treatment outcomes (Sperry & Carlson, 2013).

13. The person of the psychotherapist is more important than the psychotherapists’ theoretical orientation, years of experience, and discipline or professional affiliation (Horvath et al. 2011).

14. Over 90% of the differences in treatment outcome between more and less effective psychotherapists is attributable to differences in their ability to establish, maintain and monitor on a regular basis, the quality of the therapeutic alliance and patient progress
toward achieving the collaboratively-generated treatment goals. For example, in DBT with Borderline Personality Disorder patients, those patients who perceived their therapist as both affirming and protective had longer lasting changes and were less self-injurious (Thoma et al., 2015).

15. Caution and humility is warranted even when considering the most widely endorsed evidence-based intervention of Cognitive behavior therapy (CBT). For example, consider the following findings:

a) CBT has not been found to be more effective than most other treatment approaches such as interpersonal and supportive psychotherapy. Tolin (2010) did report that CBT was more effective than psychodynamic approaches, especially for the treatment of patients with anxiety and depressive disorders.

b) However, Thoma et al. (2015) reported that the more methodically rigorous that the randomized control study of CBT with depressed patients, the poorer the treatment outcomes. Moreover, there were “allegiance” effects, with those who most advocate CBT approach, the better the outcome results. Earlier studies of CBT were more effective than more recent CBT treatment outcome studies (Thoma et al., 2015).

c) CBT has not been found to work through the proposed mechanism of change in several studies (Muse & McManus, 2013).

d) Dismantling studies do not find specific ingredients as being critical to the benefits of CBT.

e) Critical psychotherapeutic skills related to the therapeutic alliance and that are not directly related to the specific protocols contribute the largest proportion of variance in accounting for treatment outcomes (Baardseth et al., 2013).

16. A common finding in psychotherapy research has been the inability to detect differences when active, bona-fide psychotherapists as compared with specific treatment approaches (Wampold, 2011). Wampold argues that psychotherapy works in large part through general mechanisms of “remoralization” (ala the work of Jerome Frank), as patients develop a sense that they have value and can be effective in their lives as a result of the healing relationship with their psychotherapists (Wampold et al., 1997).

17. When comparing various Acronym-based psychotherapeutic approaches for treating patients with PTSD and Complex PTSD, there are no significant differences between the
varied treatments. Whether the acronym-therapy approach is DTE, CPT, EMDR, DBT, ACT, SIT and the like, there are “no winners of the race” (Meichenbaum, 2013).

18. The psychotherapists’ effectiveness is in terms of the patient treatment outcomes tends to plateau over the course of their careers in the absence of a concerted effort to improve as a result of “deliberate practice”. (See Meichenbaum’s recent papers on “Nurturing therapeutic mastery” and “The psychotherapeutic relationships as a common factor: Implications for trauma therapy.” Please visit www.melissainstitute.org and on the top of the Homepage click Resources and then scroll down to Author Index. You can then scroll down to Meichenbaum to open these and related articles. Contact Don Meichenbaum at dhmeich@aol.com with your comments.)
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8. FRIDAY DEC. 15 2:30-3:30

Panel Discussion

“THE ROLE OF THE THERAPIST”

PRESENTATION OUTLINE

a. “How to bolster resilience in psychotherapists: How to help the helpers”.
b. Individual, social and organizational interventions.

LIST OF HANDOUTS
1. Self-care for Trauma Psychotherapists and Caregivers: Individual, Social and Organizational Interventions (pp. 289)
SELF-CARE FOR TRAUMA PSYCHOTHERAPISTS AND CAREGIVERS: INDIVIDUAL, SOCIAL AND ORGANIZATIONAL INTERVENTIONS

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# TABLE OF CONTENTS

- Introduction

- Conceptualization of Vicarious Traumatization (VT): Relationship to Related Constructs (Burnout, Secondary Traumatic Stress, Countertransference and Vicarious Resilience)

- Caveat: Status of Concept of Vicarious Trauma (VT)

- Most Common Signs of VT: Increasing Self-awareness of Feelings, Cognitions, Behaviors, Organizational Indicators

- Risk Factors For Developing VT
  - Characteristics of the Client, Job, Helper

- Assessment Tools of VT and Related Reactions
  - Measures and Self-assessment of VT

- Interventions: Ways to Cope with VT
  - General Guidelines
    - Ways To Cope With VT: An Overview
    - Individual Level: Practice Self-care
    - Peer and Collegial Level
    - Organizational and Agency Level

- Special Case of Dealing with Violent Clients: Risk Assessment, Risk Management and Suicidal Clients

- Further Resources

- Summary

- My Personal Self-care Action Plan

- Self-care Checklist

- References

- Internet Resources (Websites)
By way of introduction, I have spent the last 40 years of my clinical and research career working with a wide variety of clients who have experienced multiple victimizing and traumatic experiences. I have listened to clients share their stories of being victims of natural disasters, victims of intimate partner violence, sexual and physical abuse, combat exposure, victims of torture, school shootings and personal loss such as suicide by family members.

I have been involved in the training and supervision of trauma psychotherapists who have lost their clients to suicide, or whose clients experienced revictimization. This CE course is my effort to help psychotherapists bolster their resilience.

As a supplement to this course, I would encourage you the interested participant, to supplement this course by looking at my recent book Roadmap to resilience that enumerates practical ways to bolster resilience in six domains (physical, interpersonal, emotional, cognitive, behavioral and spiritual). (Please see www.roadmaptoresilience.com).

The need for such a CE course on Self-care for psychotherapists is underscored by the research findings that trauma-focused treatments can be emotionally difficult and taxing for therapists and care-givers leading to vicarious traumatization, burnout, secondary stress disorder and compassion fatigue. Research indicates that:

- 50% of professionals who work with trauma patients report feeling distressed
- 30% of trauma psychotherapists report experiencing "extreme distress"

Such distress is exacerbated by the fact that some 30% of psychotherapists have experienced trauma during their own childhood (see Brady et al., 1999; Figley, 1995; Kohlenberg et al., 2006; Pearlman & Mac Ian, 1995; Pope & Feldman-Summers, 1992).

As a result of taking this course you will be able to:

1. Increase your self-awareness and conduct a self-assessment of growth level of self-care and self-satisfaction;
2. Improve your self-care skills at the individual, collegial and organizational levels;
3. Bolster your vicarious resilience when working with victimized and traumatized clients;
4. Address the special cases of dealing with violent clients and the suicide of one’s clients;
5. And where indicated, access personal therapy.

This CE course is dedicated to the memory of an esteemed colleague and friend who wrote insightfully about vicarious traumatization. We miss you Michael Mahoney.
CONCEPTUALIZATION OF VICARIOUS TRAUMA

Milton Erickson used to say to his patients, “My voice will go with you.” His voice did. What he did not say was that our clients' voices can also go with us. Their stories become part of us – part of our daily lives and our nightly dreams. Not all stories are negative - indeed, a good many are inspiring. The point is that they change us. (Mahoney, 2003, p. 195). For those stories involving trauma or human suffering, sometimes they are more difficult than other stories to relinquish from memory and can contribute to burnout and in some cases vicarious trauma.

A number of diverse constructs have been offered to describe the health care providers’ reactions to working with traumatized and victimized clients (Baird & Kracen, 2006; Newell & MacNeal, 2010; Newell et al. 2015). Let’s consider the differences in these varied concepts.

**Vicarious Traumatization (VT)** is defined by Pearlman and Saakvitne (1995, p. 31), as the "negative effects of caring about and caring for others". VT is the “cumulative transformation in the inner experience of the therapist that comes about as a result of empathic engagement with the client’s traumatic material”. Empathy is the helper’s greatest asset and also possibly his/her greatest liability as the emotional engagement can sometimes entangle us to such as degree that it impact us, emotionally.

VT is not the same as burnout, although burnout may be exacerbated by VT. VT places emphasis on changes in meanings, beliefs, schemas and adaptation. VT is more likely to lead to imagery intrusions and sensory reactions. Hatfield, Cacioppo and Rapson (1994) describe the type of emotional contagion that may lead psychotherapists to the “catching of emotions" of their clients. VT permanently transforms helpers’ sense of self and their world and can influence Countertransference responses such as avoidance and/or over identification with the client.

**Burnout** is often defined as a prolonged response to chronic emotional and interpersonal stressors on the job which consists of three components: Exhaustion, depersonalization (defined as: disengagement or detachment from the world around you) and diminished feelings of self-efficacy in the workplace. It reflects a form of "energy depletion".

**Secondary Traumatic Stress** or what Figley (1995) calls Compassion Fatigue, refers to the adverse reactions of helpers who seek to aid trauma survivors. STS is often used interchangeably with VT, although VT implies more permanent, than temporary stress responses (See Stamm, 1999).

**Countertransference** implies that the helper’s response is influenced by the helper’s own unresolved issues (e.g., lingering impact of the helper’s victimization experiences). This may lead to avoidance and over identification with the client. The helper may take on a protective role for the client, becoming the “champion” of the client and adopt a role of “rescuer”. The helper may inadvertently become a “surrogate frontal lobe” for the client.
Vicarious Resilience. In contrast to the concepts of vicarious Traumatization, Burnout, Secondary Traumatic Stress, and Countertransference, it is important to keep in mind that trauma-focused psychotherapists can also become strengthened and more resilient as a result of working with traumatized clients who evidence PTSD and co-occurring psychiatric disorders. Consider the following findings:

- PTSD is essentially a disorder of non-recovery
- No matter what form of victimization or trauma exposure, some 70% of individuals will be impacted, but they go onto evidence resilience, or the ability to “bounce back”, and in some instances evidence post-traumatic growth. (Bonnano, 2004; Calhoun & Tedeschi, 2006; Meichenbaum, 2014).

The trauma psychotherapists willingness and ability to listen to and bear witness to their clients’ stories of healing, recovery and resilience can prove inspirational and contribute to “vicarious resilience” in psychotherapists. Like our clients, most trauma psychotherapists evidence resilience (Farrell & Turpin, 2003; Hernandez et al. 2007). Keep in mind that resilience and post-trauma stress can coexist. It is not an either-or situation. In the same ways that clients may experience the aftermath of traumatic events and victimizing experiences, they can also evidence grit, perseverance as they call upon a variety of intra and interpersonal supports and their faith. In a similar fashion, trauma psychotherapists also evidence resilience.

This CE course will highlight ways to bolster resilience in psychotherapists.

Caveat: Status Of The Concept of Vicarious Trauma (VT)

While the concept of VT has received widespread attention (Avery, 2001; Blair & Ramones, 1996; Danielli, 1988; Norcross, 2000; Pearlman & Maclan, 1995; Neumann & Gamble, 1995; Schauben & Frazier, 1995; Sexton, 1999; Stamm, 1997) leading to various self-help books for mental health workers (Baker, 2003; Gamble, 2002; Herbert & Wetmore, 1999; Rothschild, 2006; Saakvitne et al., 2000; Saakvitne & Pearlman, 1996; Williams & Sommer, 1995), Sabin-Farrell and Turpin (2003) provide a number of cautionary observations that are critical to keep in mind:

- “There is yet no one questionnaire that has been designed to measure the concept of VT as a whole.” (p. 469)
- “Symptoms of PTSD, burnout and general psychological distress have been found by some studies, although most correlates are weak.” (p. 472)
- “The evidence for VT in trauma workers is inconsistent and ambiguous.” (p. 472)

With these caveats in mind, there does appear to be some mental health workers for whom the work with victimized clients is traumatizing and can cause PTSD symptoms, particularly intrusive symptoms, and more general symptomatic distress and disruptions in beliefs concerning
safety, trust and world view. Helpers who have a personal trauma history, who are newer to such work, who have had little or no past or ongoing supervision, and who experience high-related job stress may be most vulnerable to developing VT. What are the signs of VT and what can be done to reduce and prevent VT?

**MOST COMMON SIGNS OF VT: INCREASING SELF-AWARENESS**

Vicarious Trauma can manifest in emotional, behavioral, and cognitive symptoms that impact both the individual and the organization. The negative impact of VT can involve personal costs of altered beliefs and frames of reference, negative impact on feelings and relationships, poor decision-making social and professional withdrawal, substance abuse and clinical problems (Pearlman & Saakvitne, 1995a, b, c; Rothschild, 2006). More specifically, here are some examples of symptoms of how VT can impact the individual:

1. **Individual:**

   **A. Feelings:**
   
   - Feel overwhelmed, drained, exhausted, overloaded, burnt out
   - Feel angry, enraged, and sad about client’s victimization; such feelings may linger
   - Feel loss of pleasure, apathetic, depressed, despairing that anything can improve
   - Overly involved emotionally with the client
   - Feel isolated, alienated, distant, detached, rejected by colleagues
   - Experience bystander guilt, shame, feelings of self-doubt

   **B. Cognitions**
   
   - Preoccupied with thoughts of clients outside of your work. Overidentification with the client. (Have horror and rescue fantasies.)
   - Loss of hope, pessimism, cynicism, nihilism
   - Question competence, self-worth, low job satisfaction
   - Challenge basic beliefs of safety, trust, esteem, intimacy and control. Feel heightened sense of vulnerability and personal threats
C. Behavior

- Distancing, numbing, detachment, cutting clients off, staying busy. Avoid listening to client's story of traumatic experiences
- May experience symptoms similar to those seen in clients (intrusive imagery, somatic symptoms)
- Impact personal relationships and ability to experience intimacy
- High overall general distress level
- Overextend self and assimilate client’s traumatic material
- Difficulty maintaining professional boundaries with the client

2. Organizational Indicators of VT

The organization is not immune to the impacts of VT. When individuals are struggling with VT, it impacts the organization in the following ways:

- High job turnover
- Low morale
- Absenteeism
- Job Dissatisfaction
- Organizational contagion

With VT impacting both individuals and organizations, it is important to be able to identify those who may be struggling and who may be at risk for developing VT. There are a variety of measures and instruments that can help individuals and organizations identify those that may be prone to develop VT. I will discuss these instruments in a moment. First, let’s discuss some of the risk factors for developing VT.

**RISK FACTORS FOR DEVELOPING VT**

We begin with a consideration of three classes of risk factors that increase the likelihood of psychotherapists developing VT, namely, the characteristics of the clients, the features of the work setting, and the attributes of the helpers/psychotherapists.
1. Characteristics of the CLIENT that can contribute to VT include:

- Work with demanding patients who evidence therapy-interfering behaviors (e.g., no shows, non-payment, noncompliance with treatment regimen, calling too frequently, repeatedly demanding extra session time)

- Working with patients who are hostile and threatening the therapist, others, or the treatment program (e.g., verbally and physically threatening, stalking the therapist, bringing weapons to sessions)

- Work with suicidal patients and patients who have a history of violence towards others

- Work with survivors who are also perpetrators.

- Work with clients who may relate trauma stories of human cruelty and intense suffering such as
  - Graphic details of trauma, especially sexual abuse, work with rape and torture victims, Holocaust survivors
  - Descriptions of acts of intentional cruelty and hatred (e.g., child physical and sexual abuse). Client reenactments in therapy of aspects of the trauma
  - Ongoing risk of further revictimization to client and possible threats to health care providers (e.g., work in domestic shelters)

2. Characteristics of the Job/Work Setting that can contribute to VT

- Large caseloads – overextension due to work demands, excessive overtime or on call

- Large percentage of clientele who have trauma experiences and suffer PTSD and co-occurring disorders

- Back-to-back clients who are trauma survivors

- Cumulative exposure to traumatized clients over time

- Lack of clinical/personal peer support in the workplace

- Absence of clinical supervision

- Few resources to which to refer clients for ancillary services

- Professional isolation – poor collegiality and peer support
• Cultural clash between clients and the treatment agency
• Workplace structural and personal strains—lack of resources, personnel, and time to complete a job
• Role conflict or ambiguity
• Reimbursement issues, managed care, poor compensation
• Legal consequences for helper
• Barriers to achieve interventions and treatment goals
• Barriers to the helper seeking help—concerns about confidentiality, fear of stigmatization

3. Characteristics of the Helper/Psychotherapist that can contribute to VT

• Personal victimization history that is unresolved—issues of shame, guilt, anxiety, anger, grief
• Lack of experience—novice workers are at greater risk
• Additive effects of trauma and other stressors (personal, job-related)
• Lack of coping skills—impose excessive demands on oneself, others or work situation
• Low level of subjective personal accomplishments—low fulfillment of goals. (There is a need for psychotherapists to establish doable goals in each session)
• Unrealistic expectations around recovery of patients
• Excessive time in the same job
• Helpers who are more aware of VT and countertransference are less susceptible to Secondary Traumatic Stress
• Presence of protective factors that promote resiliency including high self-esteem, resourcefulness, desire and ability to help others, faith, and opportunities for meaningful action and activities.
• Failed to share one’s “story” of victimization with supportive others (keeping one’s story of trauma and victimization a secret).
**ASSESSMENT TOOLS OF VT AND RELATED REACTIONS**

There are a variety of standardized assessment protocols that are available for assessing VT as well as self-assessment measures and techniques. *(See Website Addresses at end of this Handout)*

1. **Measures**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Reference</th>
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<tbody>
<tr>
<td>Professional Quality of Life Scale (ProQOL)</td>
<td>Stamm, 2004</td>
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<tr>
<td>Traumatic Stress Inventory (TSI-BSL)</td>
<td>Pearlman, 1996a</td>
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<tr>
<td>Traumatic Stress Inventory Life Event Questionnaire (LEQ)</td>
<td>Pearlman, 1996b</td>
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<tr>
<td>Compassion Fatigue Self-Test</td>
<td>Figley, 1995a</td>
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<tr>
<td>Maslach Burnout Inventory</td>
<td>Maslach, 1996</td>
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<tr>
<td>Secondary Trauma Questionnaire</td>
<td>Motta et al., 1999</td>
</tr>
<tr>
<td>Self-report Posttraumatic Stress Disorder Scale (PSS-SR)</td>
<td>Foa et al., 1993</td>
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<tr>
<td>Impact of Event Scale – IES</td>
<td>Horowitz et al., 1979</td>
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<tr>
<td>Trauma Symptom Checklist-40</td>
<td>Elliott &amp; Briere, 1992</td>
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<tr>
<td>Symptom Checklist-90 (Revised SCL-90-R)</td>
<td>Derogatis, 1983</td>
</tr>
<tr>
<td>Brief Symptom Inventory</td>
<td>Derogatis, 1993</td>
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You can conduct a self-assessment of your level of Compassion Satisfaction and Fatigue by downloading the PROQol measure developed by Hamm. Go to the following Website [www.PROQol.org](http://www.PROQol.org).

This Self-assessment Questionnaire can be supplemented by answering the following questions.

2. **Self-assessment of VT**

The following self-assessment questions are designed to assist psychotherapists in becoming more aware of where they are emotionally, behaviorally, and cognitively. These are general questions that you can ask yourself. However, it is suggested that you review these questions with a trusted and supportive colleague.
• “How am I doing?”
• “What do I need?” "What would I like to change?"
• "What is hardest about this work?"
• "What worries me most about my work?"
• “How have I changed since I began this work? Positively, and perhaps, negatively?"
• “What changes, if any, do I see in myself that I do not like?”
• “Am I experiencing any signs of VT?” (See the previous list of common reactions.)
• “What am I doing and what have I done to address my VT?”
• “As I think of my work with my clients, what are my specific goals? How successful am I in achieving these goals?”
• “What is my sense of personal accomplishment in my work?”
• “What work barriers get in the way of my having more satisfaction and how can these barriers be addressed?”
• "What am I going to do to take care of myself?" "How can I keep going as a person while working with traumatized clients?"
• “How can I use social supports more effectively?” Draw a picture (web diagram) of your social supports on the job (colleagues) and in non-job-related areas (family, friends).
• “For instance, have I talked to other people about my concerns, feelings and rewards of my job?”
• “Who did I talk to (both in the past and now)? What were their reactions” What did he or she say or do that I found helpful (unhelpful)?
• “What were my reactions to their reactions?”
• “Is there anything about my work experience or other stressful events in my life that I have not told anyone, that is ‘unspeakable’, that I have kept to myself (a secret)?” (Try putting it into words, such as, “I haven’t shared it because ...” or “I am very hesitant to share it because ...” What is the possible ongoing impact, toll, emotional price of not sharing and working through these feelings?)
• “Is there anything about my stress experience that I keep from myself? An area or an event that I have pushed away or kept at arm’s length from myself? Or about which I say to myself, ‘I can’t handle that.’? What aspect of my life have I not put into words yet, that is still lurking in that corner of my mind that I have not looked into yet?”

• “How will sharing these feelings help?” Remember, what cannot be talked about can also not be put to rest!

In addition, Kohlenberg et al. (2006, p. 189) challenges psychotherapists to ask themselves the following questions:

• “What are the most difficult and the most rewarding aspects of my job?”

• "What are my own issues and how do they play out in my therapeutic work?"

• "How do I find the balance between caring too much and caring too little?"

• "How do I handle the situation when what is in the best interest of the client clashes with what is in my own best interest?"

• "How can I keep growing as a therapist and as a person while working with my clients?"

The self-assessment and standardized assessments are designed as a means for clinicians to help identify the symptoms of VT. Let’s discuss intervention strategies and ways to cope with VT.

**INTERVENTIONS: WAYS TO COPE WITH VT**

1. **GENERAL GUIDELINES**

There are many strategies addressing ways to cope with the VT, both at the individual, social and the organization levels. For the individual, the psychotherapist has many innate tools at his/her disposal. Using self-care strategies, using one’s cognitive abilities, engaging in behavioral activities, and even reaching out to colleagues can be effective methods for addressing VT. For the organization, strategies can involve team meetings, ongoing supervision, and even more in-depth interventions such as Stress Inoculation Training and General Resilience training. As general guidelines in preventing and treating VT, it is important that psychotherapists keep in mind these following items:
• Remember treating trauma patients is not for everyone. As responsible psychotherapists, we each need to know our limitations and what type of clients we can and cannot work with effectively.

• In treating trauma victims, we will hear some emotionally difficult stories. The longer we treat clients, the more stories we will hear. It is important to know that being proactive in managing VT, rather than ignoring the possibility of VT is a good first step towards prevention.

• Emphasis should be on early identification and treatment, reducing the long-term negative impact of VT.

• Interventions need to be multi-leveled and should not be left up to the individual. It should be a policy identified and implemented at the organizational level rather than having the individual psychotherapist to “fend for him/herself.”

• Psychotherapist or helper should not feel ashamed or guilty about experiencing VT. Attitude should be on validating and normalizing such reactions. Reframe VT as being a sign of being a committed and a sensitive therapist.

• Nurture Awareness, Balance and Connections

Now that we covered some of the general guidelines, let’s spend consider specific to cope with VT at the individual level.

WAYS TO COPE WITH VT: AN OVERVIEW

1. Individual Level:

To cope with VT at the individual level, increasing your self-awareness, engaging in self-care behaviors, using your cognitive abilities, and engaging in behavioral activities can all help mitigate the impact of VT.

A. Practice Self Care

As psychotherapists, many of us will go out of our way to ensure the well-being of our clients. However, when it comes to taking care of ourselves, we can put our own needs on the backburner. Self-care is a necessary element for psychotherapists who treat trauma victims in order to address and prevent VT. It involves, ensuring physical and mental well-being, having an outlet for emotional discharge, and engaging in healing activities to renew life both in and out of therapy. As Mahoney (2003, p. 26) suggests, “Even though you are likely to carry your clients' struggles with you after work, learn to formalize a transition from your profession to your
**personal life (a walk, a prayer, a brief period of meditation, etc.).** As Norcross and Guy (2007) observes, learn how to leave your distress at the office.

**B. Increase Your Self-observations**

Recognize and chart signs of stress, vicarious traumatization, and burnout. The assessments and measures discussed above can be effective ways for the psychotherapist to monitor his/her own VT. When dealing with difficult or challenging clients and their stories, it is good for the psychotherapist to be aware of the possible impact simply by maintaining self-awareness. Conducting a quick self-analysis by asking yourself the self-assessment questions cited above or by filling out one of the Self-report Scales will increase self-awareness.

**C. Engage in Emotional Self-care Behaviors**

Taking care of oneself is easy to overlook, but self-care is vital to VT prevention and maintenance. Self-care behaviors don’t have to be elaborate rituals or procedures. They can be simple, daily activities such as:

- Engage in relaxing and self-soothing activities like yoga, relaxation exercises, mindfulness, and/or meditation between clients or after work. Develop a ritual for leaving work in order to help you leave work stress and work identity at the office.

- Engage in physical and mental well-being through exercise or outdoor activities. Replenish by having a getaway weekend or vacation. Give yourself permission to escape when necessary. Cherish your friendships and intimacy with family.

- Maintain a healthy balance in your life; don’t let work consume you. Have outside outlets and interests such as hobbies, social activities, etc. that allow you to reinforce your identity outside your professional one and that allow for you to recharge. Engage in activities that are positive and that have concrete outcomes or products that foster a sense of accomplishment. Have a vocational avenue of creative and relaxing self-expression in order to regenerate energies.

- Engage in expressive or healing activities both in and outside of therapy. Engage in healing activities that renew meaning of life both in therapy and out of therapy settings. For example, some therapists report bringing into their offices “signs of life and beauty” such as plants that remind them of beauty and rebirth. Engage in life-generating activities that help you express feelings through writing, gardening, painting, art, dance, or other mediums that allow you to express your emotions or thoughts freely.
D. Use Your Cognitive Abilities

Most psychotherapists will be aware of or familiar with Cognitive Behavioral Techniques used to help clients. Psychotherapists can use these same coping strategies on themselves.

- Recognize that you are not alone: Normalize and monitor your “story-telling narratives.” Validate and normalize your reactions. It is not that you experience VT and job stress, but rather what you tell yourself and others about your reactions. Listen for the “stories” you tell yourself and others and ensure that your story is one of empowerment and healing, “redemptive”.

- Set realistic expectations to enhance feelings of accomplishment. Recognize your limitations and the fact that therapists will make mistakes. The percentage of goals and sub goals achieved is critical to foster feelings of accomplishment. Avoid wishful thinking. Set specific achievable goals for each session. Use SMART goals (specific, measurable, attainable, relevant and time-limited).

- Adopt a more philosophical accepting stance. Appreciate the rewards. Use your spirituality. Accept those aspects that cannot be changed, and work on those aspects that are potentially changeable, and as the adage goes, “know the difference”. Take pride in the work you do in helping serve human development. Honor the privilege of the helping profession. Remind yourself that you cannot take responsibility for the client’s healing, but rather you should act as a “midwife” on the client’s journey toward healing. Remind yourself that there are some things (like traumatic grief) you can’t fix. “People in deep grief want to feel that you have heard their pain. If you try to ‘fix it’, you may rob them of that passage. They often want someone they can trust, cry with, confess to, someone who is nonjudgmental. Remember it is a privilege to be part of the healing process,” as noted in Gail Sheehy's (2003, p. 366) moving account of the aftermath of September, 11.

- Do not take on responsibility to “heal” your clients”: Remind yourself of the treatment rationale. As Taylor (2006, p. 132) observes, the intense emotions that the client experiences is a necessary component of effective treatment. "Remember cognitive-behavior therapy for PTSD is similar to dentistry for treating patients with root canal problems, but represents a treatment intervention that is empirically supported and generally effective. But like dentistry, cognitive-behavior therapy enlists some degree of pain"

- Challenge negativity: Don’t play the blame game! Find meaning and hope. Solicit “the rest of the client’s story”. Focus on resilience in therapy. Minimize self-blame and blame in others. Address feelings of shame, guilt, incompetence, frustrations. See stressors as problems-to-solved or use acceptance strategies and not as occasions to “catastrophize”.
Focus on finding meaning and hope by attending to the client’s “rest of the story”, (i.e., "signs of resilience"). Use humor.

- Be sure to ask your clients “What they have been able to achieve in spite of the lifetime history of victimization?” Ask them “how” and “what” questions (not “why” questions) on how they were able to achieve these personal life accomplishments and goods.

E. Engage in Behavioral Activities

Behavioral activities refer to the changes you can do in your work and personal life to modify the routine or procedures that is more conducive to well-being and preventative measure for VT. These can include:

- Balance the composition of caseloads (victims and non-victims). Diversify your caseloads. Do not spend all clinical hours with trauma clients-- "dose" yourself to a manageable limit. There is a suggestion that clinicians should not spend more than 60% of their time, or at most three days, working with trauma survivors (Taylor, 2006).

- Limit overall caseloads. Monitor work balance and work/life balance. Don’t take on more than you can handle. Know when to refer out if you are at your limit.

- Share reactions with clients: Nurture therapeutic alliance and monitor and impose personal limits. For example, the helper can comment to the client:

  “Sometimes there is a part of me (that is, the helper) that does not want to hear that such horrific things happened to you (the client). But there is another part of me that says that we must continue because it is important, and moreover, doing so is part of the healing process. But, I would not be honest with you (the client) if I did not comment that no one should have suffered, nor endured, what you have experienced.

  I am heartened by your willingness and by your ability, your courage to share your story, as part of the healing process.

  I am also impressed to learn about the “rest of your story” of what you did to survive. As I have come to know you in spite of X (specific victimization experiences) you have been able to (highlight specific examples of resilience).

Such helper statements to the client can foster a stronger respectful collaborative therapeutic alliance as the helper conveys empathy and humanity. Such statements also convey to the client that his or her reactions are not unique and that the client is being “heard” and that the helper’s reactions are also not unique.
The helper can also go on and ask the client’s permission to share (make a gift of his or her experiences and suffering with others) – find meaning in -- The helper can ask the client:

*I would like to ask you a question. Could I obtain your permission to share what you did to survive, to keep going in spite of X, with my other clients or with my colleagues? I would not mention your name and I would describe your situation in very general terms so no one could identify you. But, I would like them to benefit from your example. Would it be okay to “make a gift” of what you have done with others I see? Would that be okay?*

At the same time it is important for the therapist to also set personal limits with challenging clients. As Miller et al. (2007) observe:

"Therapists must take responsibility for monitoring their own personal limits, and clearly communicate to their clients which behaviors are tolerable and which are not. Therapists who do not do this will eventually burn out, terminate therapy, or otherwise harm clients" (p. 65)

For example, Miller et al. (2007) suggest that a therapist might tell a challenging client:

"When you mimic me, insult me, and frequently compare me (unfavorably) to your last therapist, it makes it hard for me to want to keep working with you. A different therapist might not have a problem with this, but it just crosses my personal limits" (p. 80).

- When necessary, take time off. Take a break (daily, weekly, monthly). If you notice the symptoms of burnout, don’t ignore them. Take time off to recharge when you need to. Give yourself permission to be cared for and counseled. Enjoy yourself. Finally, when and if necessary, take a break from PTSD practice and seeing new PTSD clients. Engage in other activities like teaching, research, clinical, administrative activities to allow yourself to recharge and come back to work gradually.

Mindfulness-based Stress Reduction (MBSR), as developed by Kabat-Zinn (1990) has been used to reduce work-related stress, anxiety, depression, by increasing empathy, positive emotions, self-compassion and serenity in psychotherapists, social workers and counselors (Brown et al, 2016; Gerber, 2009; Hick, 2009). Learning to focus attention on the present in a non-judgmental mindful manner can be combined with a number of cognitive behavioral interventions including relaxation, guided imagery, perspective taking, self-talk, and supplemented by meditation and yoga.

2. Peer and Collegial level

Engaging with other professionals at the collegial level can help to mitigate the effects of VT. The psychotherapist or “helper” should be able to reach out to professional social networks, supervisors, and even be available to other professions, if and when appropriate.
A. Helper Initiated Activities

Activities that help you take stock and reach out to colleagues when necessary can be important. They don’t have to be overly formal or complicated. They can include the following:

- Assess social support network. Draw a map of supportive people. Who is there to provide emotional, informational, material supports? Note, it may not be the same folks for each type of support. What is your “game plan” to access and use supports? Who are the people in your life who can provide a “supportive, holding environment”?

- Seek social support from supervisors, colleagues, and family members. Talk with colleagues and friends. Maintain connections with others. For example, Kohlenberg et al. (2006, p. 189) suggest that the distressed psychotherapist might say to a supportive colleague:

"I am feeling very upset, hopeless and helpless right now. I don't seem to be enough for my client. I feel inadequate, angry and upset. Will you help me understand my feelings better and develop a perspective that will be helpful to my client"?

Caregivers are often quite good in nurturing self-care in their clients. Taylor (2006) remind psychotherapists that they need to remind themselves that emotional self-care is also important. With regard to family members, psychotherapists often set limits about what they disclose and share about their trauma work in order not to burden family members. Loved ones can provide nurturance and sustenance for the challenging work of dealing on a daily basis with human cruelties and adversities.

- Provide support: Don’t overdo it! Don’t be embarrassed or ashamed to ask for support, as well as reciprocate and offer support to others. But don’t overdo it or you can increase your level of "caregiver stress".

- Use buddy system, especially for novices. Novices should be buddied up with more experienced helpers. Identify a colleague with whom you can discuss your work, its challenges and rewards. Have weekly consultation meetings with a colleague to discuss their difficulties in providing treatment.

- Obtain peer supervision- use Consultation Teams. Review cases on a regular basis. Audiotape or videotape cases to be reviewed. Use a therapy consultation group to review difficult cases.

One way to enhance capabilities and motivation of therapists is to use regular (weekly) team consultation. For example, those who advocate the use of Dialectical Behavior Therapy (DBT) with clients who are suicidal and who evidence Borderline Personality Disorder characteristics
highlight the value of requiring all DBT therapists to attend such team consultation meetings. (Linehan, 1993; Miller et al. 2007). They propose that such team consultation meetings are integral to therapy and that team notes be taken and kept in the therapy records. Miller et al. (2007) propose that the team leader can use at the team meetings what they call a small "mindfulness bell" and ring it whenever team members make judgmental comments (in content or tone) about themselves, each other, or the client, or if they fail to adequately assess a problem before jumping to conclusions. The instant feedback provides members with ongoing reminders not to be "too harsh on themselves and on others".

- Engage in “debriefing”. Develop informal opportunities to connect. Beyond case reviews, engage in “debriefing” (either informally or formally) around difficult and challenging cases (e.g., where threat of violence is an issue). In such debriefings the following questions can be addressed:

  “What is it like to work with “traumatized” clients or with client families who have experienced multiple problems, or with patients who have a diagnosis of Borderline Personality Disorder?”

  “What is most difficult or challenging in such cases?” “What is most rewarding in working with these clients?” “What do you (the helper) need right now?” “How can we (other helpers, friends) be of most help?”

- Participate in training opportunities and training group forums about vicarious traumatization and job stress, focusing on possible solutions. (Do not just attend group sessions that can lead to more “emotional” contagion.)

- Participate in agency building or community building activities. Join others around a common purpose or value.

- Continue to learn more professionally. Join a study group, consultation group, attend continuing education conferences, join divisions or organizations that specialize in trauma or take workshops and study evidence-based interventions. (See Website List).

One way to reduce staff burnout is to enhance therapists' capabilities and motivation by means of implementing effective evidence-based interventions such as Dialectical Behavior Therapy with suicidal patients (see Katz et al. 2004). Another important area for professional development is that of Risk Assessment of patients who are potentially violent towards others or toward themselves. Therapists can reduce their stress levels by being informed about how to conduct ongoing risk assessments and having in place backup teams or colleagues.

- If indicated, participate in time-limited group therapy or individual psychotherapy. For helpers who have a history of trauma and for those who are being most impacted as a result of working with traumatized clients and high job stress, the use of time-limited
group therapy can be helpful. The group can address self-doubts and countertransference issues and nurture varied levels of coping. Engage in self-analysis and use personal coping skills. Ask for and accept comfort, help and counsel. Find others whom you trust to talk to. If you can’t find a therapist, create an imaginary one (who doesn’t charge too much!). Embrace your spiritual searching. (See Pearlman & Saakvitne, 1995a; Saakvitne et al. 2000).

3. ORGANIZATIONAL AND AGENCY LEVEL

Organizations and agencies should be proactive in helping psychotherapists reduce burnout and VT. There are a variety of strategies organizations can implement to help the psychotherapist individually and collectively. These include:

- Scheduling team meetings as a means of “emotional check-ups.”
- Agency should balance the psychotherapist's (helper's) caseload. Agencies should work collaboratively and proactively towards distributing and decreasing the number of demanding victimized clients.
- Provide ongoing supervision, especially for novice psychotherapists.
- Promote education and training about vicarious traumatization, burnout, and wellness programs to foster awareness and interventions.
- Ensure staff takes care of themselves in terms of nutrition, exercise, sleep and that they take frequent breaks. Help foster spiritual renewal.
- Maintain professional connections and identity. Collaborate with other helping agencies to foster a sense of team working toward common objectives.
- Address boundary issues, "Manage boundaries". Support “altruistic” activities. Agencies should conduct meetings and run workshops on boundary issues between clients and helpers to reduce this source of stress. Help helpers limit their trauma exposure outside of work.
- Agency can support a “mission” and accompanying activities to actively change the circumstances that lead to victimization. This may be done at the local, organizational and national levels such as advocating for legislative reform and social action. Help workers transform stress into ways of finding “meaning” and “purpose”.
- Provide Stress Inoculation Training, General Resilience Training Acceptance/Mindfulness Skills Training that have each been found to reduce job-related stress in helpers. Reivich and Shatte (2002) highlight that resilience is a “mind set” and
they describe how a variety of cognitive and affective factors can block or erode resilience. They propose seven skills designed to nurture resilience including:

1. Self-monitoring your thinking processes;
2. Avoid “thinking traps” such as blaming yourself or others, jumping to conclusions, making unfounded assumptions, and ruminating;
3. Detect “icebergs” or deeply held beliefs that lead to emotional overreactions;
4. Challenge these assumptive beliefs and examine the “if ..then” rules that are implicitly accepted; rather engage in problem-solving that is “realistically optimistic”;
5. Put events into perspective;
6. Learn ways to stay calm and focused;
7. Practice skills in real life as you change counter-productive thoughts and behaviors into more resilient thoughts and behaviors.

To be added to this list of practical skills, is the need to learn to use acceptance and meditative – mindfulness skills which emphasize the ability to accept things as one finds them, perceptual clarity and freedom from the judgmental aspects of language. These coping procedures call upon individuals to treat thoughts as “just thoughts” and they highlight the value of diminishing self-absorption, being less defensive and more open to experience, more accepting and the cultivation of moment-to-moment attention. (See Hayes et al., 1999; Kabat-Zinn, 1990; Salmon et al., 2004). In mindfulness training thoughts are viewed as "normal" and compared to clouds passing by through the sky. Individuals are encouraged to notice them and let them go and return them to the sky.

- Provide a psychologically healthy workplace programs. Some programs can include:
  - Employee orientation, training, development and recognition, celebrate accomplishments;
  - Employee involvement in decision-making; flexible work schedules; enhance communication; onsite health and fitness centers and child care centers; build a sense of communication;
  - Translate these objectives into actionable steps;
The Stress Inoculation Training procedure (Meichenbaum, 2003, 2007) that has been used to reduce job stress incorporates varied cognitive-behavioral skills into a three phase intervention:

- **Phase I – Initial Conceptualization** that collaboratively educates individuals about the nature and impact of stress and coping;

- **Phase II – Skills acquisition and consolidation** where individuals can acquire and practice both intrapersonal and interpersonal coping skills that follow from the initial conceptualization phase;

- **Phase III – Application Training** where individuals in groups can practice the intra and interpersonal coping skills, both in the training sessions and in vivo. These application trials should be as similar as possible to the real life demands, activities and settings (scenario training).

SPECIAL CASE OF DEALING WITH VIOLENT CLIENTS: RISK ASSESSMENT, RISK MANAGEMENT AND SUICIDAL CLIENTS

There is a high co-occurrence of PTSD resulting from trauma exposure and violent behavior toward others, as well as toward oneself (see Bongar, 2002; Meichenbaum, 1994, 2001). Increased incidents of violence against mental health staff and dealing with suicidal clients can all add additional emotional and physical stressors on psychotherapists. Consider the following illustrative data and the potential impact on the stress level of psychotherapists.

INCIDENCE OF VIOLENCE AGAINST MENTAL HEALTH STAFF

- Nearly one-half of psychotherapists will be threatened, harassed or physically attacked at some point in their careers by their clients. This may take the form of unwanted calls, verbal and physical attacks, stalking behavior on self and loved ones, or even murder.

- Between 4% to 8% of individuals brought to psychiatric emergency rooms in the U.S., bring weapons.

- 50% of all staff compensation cases of psychiatric facilities result from patient assaults. The mental health personnel who are at the lowest ladder of the organization are the most likely to be assaulted.

CLINICAL PRACTICE AND CLIENT SUICIDE

- Full time psychotherapists will average 5 suicidal patients per month, especially among those clients who have a history of victimization.
• 1 in 2 psychiatrists and 1 in 7 psychologists report losing a patient to suicide.

• 1 in 3 clinical graduate students will have a patient who attempts suicide at some point during their clinical training and 1 in 6 will experience a patient's suicide.

• 1 in 6 psychiatric patients who die by suicide die while in active treatment with a health care provider.

• Work with suicidal patients is considered the most stressful of all clinical endeavors. Therapists who lose a patient to suicide, experience that loss as much as they would the death of a family member. It can become a career-ending event.

• Such distress in psychotherapists can be further exacerbated by possible legal actions. 25 % of family members of suicidal patients take legal action against the suicidal patient's mental health treatment team (see Bongar, 2002).

1. What Can Psychotherapists and Other Mental Health Professionals Do To Address Their Patient’s Violence Potential Towards Others and Towards Themselves?

I have discussed this topic at some length elsewhere (See Meichenbaum1994, 2001, 2005). However, there is a need to be informed about possible warning or danger signs and for psychotherapists to conduct ongoing risk assessment. There is a need to implement best practice guidelines on ways to manage violent patients and remove weapons and reduce suicidal risk (See Meichenbaum, 2001, pages 192-195 on the "Do's" and "Don'ts" in handling violent patients and see Meichenbaum, 2005 for a Risk Assessment Checklist for suicidal patients). Moreover, there is a need for psychotherapists to Document, Document, Document in their progress notes their ongoing assessment of risk and protective factors and interventions.

To be informed and prepared for probable high-risk assessment and risk management are valuable ways to reduce stress in psychotherapists. There are effective psychotherapeutic interventions for violent and suicidal patients and there are resources to help clinicians who have lost patients to suicide. The American Association of Suicidology has put together a Clinical Survivor Task Force for "Therapists as Survivors of Suicide". Visit http://myspace.iusb.edu/~jmcintos/basicinfo.htm See their extensive bibliography on the impact of patient suicide on clinicians and ways to cope. Also see the Oxford Handbook of Behavioral Emergencies and Crises edited by Philip Kleespies.

Tom Ellis, who is in charge of the listserv for the American Association of Suicidology has offered the following advice on What To Do If You Lose a Patient To Suicide.
1. Procedural (Immediate)

a. Notify supervisor  
b. Notify director of service  
c. Contact hospital attorney  
d. Strongly consider contacting family  
e. Consider attending funeral

2. Emotional (soon)

a. Attend to your need to mourn  
b. Seek support from your supervisor, colleagues, significant others  
c. Use cognitive strategies to dispute dysfunctional self-statements and beliefs

3. Educational (later with supervisor or review group)

a. Write a case summary, including course of treatment  
b. Review case formulation, identifying risk and protective factors  
c. Review intervention strategies

See suicidology@LISTO.APA.ORG for additional resources

You can also visit my article on the Melissa Institute “35 years working with suicidal patients: Lessons learned” (www.melissainstitute.org).

A number of authors have discussed ways to improve self-care in psychotherapists and other health care providers. The interested reader can find useful suggestions in the writings of Baker, 2003; Corey & Corey, 2015; Cox & Sterner, 2013; Figley, 1995; Kabat-Zinn, 1990; Maslach & Lecter, 2005; Meichenbaum, 2014; Norcross & Guy, 2007; Pearlman & Saakvithe, 1995; Pope & Vasquez, 2005; Pryce et al. 2007; Rothschild, 2006; Saakvitne & Pearlman, 1996; Skovholt & Trotter-Matheson, 2016; Stamm, 1999; Wicks, 2008 and Wicks & Maynard, 2014.

SUMMARY:

Work with traumatized patients can alter psychotherapists' views of the world and of themselves and can affect many aspects of their psychotherapeutic efforts. Vicarious Traumatization (VT) comes with the territory of working with victimized individuals. The present Handout enumerates many different ways to cope with VT at the individual, social and organizational levels. There is a need to translate these coping strategies into active ongoing coping activities to be conducted at the individual, group and organizational levels. How many of these coping procedures and strategies do you, your colleagues, and your agency employ? How can you bolster your level of resilience?
MY PERSONAL SELF-CARE ACTION PLAN

Now that I have worked through the Self-care CE material, I need to identify at least three specific activities that I can undertake to improve my level of self-care and bolster my resilience. I need to develop and implement a specific Action Plan.

To begin with, I can start by taking a moment and answer the following questions.

Self-reflection Exercise

Take a moment and reflect on what are the most rewarding parts of your job as a therapist?

What are the proudest moments of your professional career?

Have you shared these proudest moments with a colleague, a family member, a novice helper entering your profession?

What challenges do you face on your job?

How can you anticipate and address these challenges? (See Self-care Checklist)

1. At the personal level, I can and will take the following actions.

________________________________________________________________________
________________________________________________________________________

2. At the collegial level, I can and will take the following actions.

________________________________________________________________________
________________________________________________________________________

3. At the organizational level, I can and will take the following actions.

________________________________________________________________________

After accomplishing my personal goals, I can retake the self-assessment of my level of Self-care and Compassion Satisfaction and Fatigue.

www.PRoQol.org

REMEMBER THAT SELF-CARE IS BOTH A DAILY AND LONG-TERM ACTIVITY
SELF-CARE CHECKLIST

Individual Level

1. Increase self-awareness and personal commitment.
2. Take Self-assessment Scales.
3. Answer Self-questions of Vicarious Traumatization (VT).
4. Secure feedback from coworkers and family members.
5. Be on the lookout for warning signs of VT, Burnout, Compassion Fatigue.
6. Make self-care a priority (sleep, nutrition, exercise, bodily rest). Self-renewal is an ongoing process. (“Being too distressed decreases the quality of care.”)
7. Pay attention to the “rest of the story” for evidence of your Vicarious Resilience (VR) and ways you have become strengthened as a result of working with traumatized and victimized clients. Admire and be fascinated by your clients’ resilience and their ability to “bounce back”. Consider your proudest moments in helping others.
8. Cultivate self-pity. Be gentle with yourself and reduce perfectionistic standards and corrosive expectations. Recognize that all psychotherapists will make mistakes.
9. Take an environmental audit of your work situation and office. Take proactive actions to reduce stress. Ensure your safety, at all times.
10. Reduce your caseload, when feasible. Diversify your clientele (not all trauma clients).
   Say “No” to clients for whom you do not feel comfortable and competent to treat. Know your limitations and preferences. Have a list of referral resources and have back up professional colleagues to whom you can call upon.
11. Establish and implement boundaries with your clients. Say “No” to clients who continually impose high levels of stress (no shows, comes late, threatens and harasses, makes unreasonable requests, fails to reimburse for sessions).
12. Develop and implement transition ritual designed to leave your stress at the office. Establish a boundary between work and home.
13. Engage in self-regulation routines to reduce negative stressful emotions and accompanying behaviors. For example, during the day schedule breaks (at least 10 minutes) between clients to unwind, do stretches, and reflect on what happened. Schedule time during the day to return telephone calls, write progress notes and the like.
14. Engage in self-soothing activities (relaxation, mindfulness exercises.)
15. Replenish yourself with breaks that increase the experience of positive emotions away from the office (go for a massage, take days off, vacations, mini-sabbaticals). Add to your “Bucket List.”
16. Arrange for assistance for filling out Insurance and Reimbursement forms. Where feasible, enlist the help of a good secretary or office manager. “Delegate to more competent folks.”
17. Solicit feedback from your clients on a regular session-by-session basis about the quality of the therapeutic alliance. Be open to feedback and adjust treatment accordingly. Be collaborative with your clients and check-in regularly. Be patient and be a catalyst (“a midwife”) for a client’s behavior change.

18. Take satisfaction and pride in your willingness and ability to help others; making a difference in the life of others. Savor your career satisfaction and keep a Gratitude List.

**Peer and Colleague Level**

19. Assess your social support network at work and in other settings. Make a list of whom you can turn to for informational consultation, practical back-up assistance, and emotional support. You may choose to go to different people for fulfilling your varied needs.

20. Adopt a team approach. Cultivate a support network at the office. Participate in peer supervision, care reviews, study groups.

21. Take advantage of training opportunities (Website training sites, CEU courses, workshops, conferences) and supervision activities.

22. Engage in agency professional and community-based activities that foster self-care.

23. When indicated, seek professional help (enter group or individual psychotherapy). (“Practice what you preach.”)

**Organizational Level**

24. With colleagues, encourage your agency, or employer to schedule team meetings (“emotional checkups”). If in private practice, arrange for such meetings with a colleague. (Keeping stress a secret makes things worse and compromises both your therapeutic effectiveness and self-care).

25. Engage in diverse professional activities (consultation, teaching, research, supervision.) Balance your work load.
REFERENCES BOLSTERING RESILIENCE IN HELPERS


INTERNET RESOURCES

Melissa Institute for Violence Prevention
(For additional papers by Dr. Meichenbaum visit this Website. On the top of the Home Page click on Resources then scroll down to Author Index. Then scroll down to Meichenbaum in order to open other related papers).

www.melissainstitute.org

Professional Quality of Life Scale

www.ProQol.org

Maslach Burnout Inventory

http://maslach.socialpsychology.org

Vicarious Traumatic Toolkit: Northeastern University

www.VTToolKit@Northeasternprojects/current/vicarious-trauma-toolkit-vtt

Self-care Starter Kit

https://socialwork.buffalo.edu/resources/self-care-starter-kit.html

Compassion Fatigue Awareness Project

www.compassionfatigue.com

Self-compassion: Scale and research

www.selfcompassion.org

Reach Out to Professionals

http://au.professionals.reachout.com

American Institute of Stress

www.stress.org

National Child Traumatic Stress Network

http://www.nctsn.org
The Cost of Caring: Child Trauma Academy

http://www.childtrauma.org

National Center for PTSD

www ptsd.va.gov

International Society for Traumatic Stress Studies

www.istss.org

American Psychological Association Help Center

http://www.apahelpcenter.org

Examples of Evidence-based Training Websites Designed To Improve Psychotherapists’ “Expertise”

www.melissainstitute.org

www.musc.edu.tfcbt

www.attc.usc.edu
References


Duncan, B. (2012). The partners for change outcome management system (PCOMS): The heart and soul of change project. Canadian Psychology, 53, 93-104.


How to Spot Hype and Pseudoscience in the Field of Psychotherapy:

A 25-Item Consumer Checklist

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Abstract

How can consumers of psychotherapies, including practitioners, students, and clients, appraise the merit of largely or entirely untested therapies? We propose that consumers should be especially skeptical of interventions that have been substantially overhyped and overpromoted. To that end, we offer a provisional “Psychotherapy Hype Checklist,” which consists of 25 warning signs suggesting that an intervention’s efficacy and effectiveness have been greatly exaggerated. We hope that this checklist will help to foster a sense of healthy self-doubt in practitioners and assist them with becoming more discerning consumers of the bewildering marketplace of psychotherapies. This checklist should also be useful in identifying the overhyping of well-established treatments.
How to Spot Hype and Pseudoscience in the Field of Psychotherapy:

A 25-Item Consumer Checklist

The world of psychotherapy is bewildering. There are at least 600 “brands” of psychotherapy, and this figure is almost certainly growing on a virtually monthly basis (Eisner, 2000; Lilienfeld, Lynn, & Lohr, 2014). The substantial majority of these interventions have never been subjected to controlled trials. Many of these largely or entirely untested treatments may very well be effective; but some may be largely or entirely ineffective, and a few may even be directly harmful (Lilienfeld, 2007). The lack of research evidence notwithstanding, scores of untested interventions are extensively and enthusiastically promoted, often with great fanfare and accompanied by expansive claims of efficacy and effectiveness. Nevertheless, practitioners and graduate students in training receive scant guidance for how to appraise such interventions in the absence of adequate research: Should they be particularly dubious of some of them, and, if so, which ones?

The Dodo Bird Verdict

Some scholars might contend that we need not be concerned by the challenges posed by untested interventions. To support this view, they frequently invoke the Dodo Bird verdict (Rosensweig, 1936), which implies that all psychological treatments work equally well (the name of this verdict derives from the Dodo Bird in Lewis Carroll’s “Alice in Wonderland,” who declared after a race that “Everybody has won, and all must have prizes”). Hence, this reasoning continues, we should not be alarmed by the promotion and marketing of pseudoscientific and otherwise questionable treatments, because these treatments are likely to be as effective as well-established interventions. Nor should we be especially worried about the overhyping of
unsubstantiated treatments given that these treatments will probably turn out to work just about as well as others.

Comparative studies of psychotherapy impart a valuable lesson, namely, that nonspecific factors (e.g., the therapeutic alliance) account for sizeable proportions of variance in treatment outcomes (Wampold & Imel, 2015). In this respect, research on the Dodo Bird verdict reminds us not to advance expansive claims concerning treatment specificity. Nevertheless, there are at least three reasons that findings concerning therapeutic equivalence should not be cause for complacency with respect to untested interventions. First, the Dodo Bird verdict as originally conceptualized referred only to a broad equivalence in efficacy across different schools of psychotherapy (e.g., behavioral, cognitive-behavioral, humanistic, psychodynamic); it never implied that every intervention was equally efficacious overall, let alone equally efficacious for every psychological condition. Second, data clearly refute the strict claim of exact equivalence of therapeutic effectiveness across all disorders (Hunsley & DiGuilio, 2002; Lilienfeld, 2014; Tolin, 2014). To take merely one example, meta-analytic evidence demonstrates that critical incident stress (crisis) debriefing, a widely used prophylactic treatment for trauma-exposed victims, is associated with negligible and perhaps even negative effect sizes (Litz, Gray, Bryant, & Adler, 2002). The same holds for several popular “get-tough” interventions for antisocial adolescents, such as Scared Straight and boot camp treatments (Lilienfeld, 2007). Third, the conclusion of approximate equivalence of psychotherapies across all major conditions applies only to “bona-fide” interventions, that is, well-specified treatments grounded in an adequate theoretical rationale and that have already been found to work reasonably well (Wampold et al., 1997). There are no compelling grounds for extending this verdict to psychological interventions that
fall far outside of the therapeutic mainstream. Furthermore, the onus of evidence falls on the proponents of novel interventions to demonstrate that they work well.

**Healthy Self-Doubt**

Making the evaluation of the psychotherapy outcome literature more complicated, findings point to marked variability in effectiveness among psychotherapists themselves. The most effective psychotherapists average 50% better outcomes and 50% fewer dropouts than do psychotherapists in general (Wampold, 2017). Still, the sources of this variability remain largely unknown.

We hypothesize that one largely unappreciated characteristic of effective psychotherapists is their penchant for maintaining a skeptical attitude, both toward their own practice and toward psychological treatments in general. Although skepticism has acquired a bad name in many quarters, it means only a propensity to withhold judgment on assertions until adequate evidence is available (Shermer, 2002). In this respect, skepticism is merely a broader term to describe what many scholars have referred to as the *scientific attitude* (Sagan, 1995). In clinical psychology, such skepticism is well illustrated by Meehl’s (1973) classic chapter, "Why I Do Not Attend Case Conferences," which in our view should be required reading for all mental health professionals-in-training. We can also conceptualize skepticism in terms of several closely allied concepts, such as epistemic humility (Leary et al., 2017; Lilienfeld, Lynn, O’Donohue, & Latzman, 2017) and the term we elect to emphasize here, *healthy self-doubt*.

By healthy self-doubt, we mean a propensity to engage in thoughtful self-reflection regarding one’s biases and limitations. Self-doubting therapists are not diffident. To the contrary, they are confident, but not overconfident: Their confidence is properly calibrated to their level of knowledge and skills. Moreover, their confidence derives from an adequate appreciation of their
shortcomings and of the best means of compensating for them: “Forewarned is forearmed.” In the lingo of social cognition, therapists with a sense of healthy self-doubt are characterized by a small bias blind spot (see Pronin, Lee, & Ross, 2002). Admittedly, virtually all of us are probably blind to our biases to some degree, but we posit that therapists with a sense of healthy self-doubt are more cognizant of their propensity toward systematic error than are other therapists. In addition, we hypothesize that therapists with a sense of healthy self-doubt are inclined to rightly turn a doubtful eye to interventions that have been substantially overhyped and overpromoted. As a consequence, they may be less likely to fall prey to the seductive charm of therapeutic fads and fallacies, as well as psychological pseudoscience more broadly.

Much of what we have written in the preceding paragraph is conjectural. Nevertheless, correlational research raises the possibility that psychotherapists’ self-doubt predicts better treatment outcomes, at least among experienced therapists (Nissen-Lie, Monsen, Ulleberg, & Rønnestad, 2013; Nissen-Lie et al., 2017; but see Odyniec, Probst, Margraf, & Willutzki, 2017, for a replication failure). In this research, endorsement of such items as "lacking confidence that you might have about a beneficial effect on a patient." and "unsure about how best to deal effectively with a patient” was tied to superior treatment outcomes, especially among therapists with a positive self-concept. Aptly, the title of Nissen-Lie et al. (2017, p. 48) article was "Love yourself as a person, doubt yourself as a therapist?” It is unknown, however, whether such self-doubt is trainable, and if so, whether it is causally related to better client outcomes.

More broadly, overconfidence is linked to suboptimal decision-making in medicine and allied health fields (Berner & Graber, 2008; Croskerry & Norman, 2008), raising the possibility that instilling a well-calibrated sense of self-confidence – one that balances appropriate self-assurance with healthy self-doubt - will enhance therapeutic outcomes. This goal is important for
several reasons, not the least of which being that many therapists, like most people in general, appear to substantially overestimate their abilities. For example, among 129 private practice psychotherapists, the average clinician rated him- or herself at the 80th percentile of all therapists in effectiveness and skills; 25% rated themselves at the 90th percentile. *None* rated themselves below average (Walfish, McAlister, O’Donnell, & Lambert, 2012). Further, data demonstrate that most therapists markedly overestimate the percentage of their clients who are improving and underestimate the percentage of their clients are becoming worse (Hannan et al., 2005). We would hope that therapists would steer clear of the hazards of overconfidence, both with respect to their own therapeutic skills and with respect to their enthusiasm for embracing unsubstantiated or overhyped interventions.

*A Consumer’s Checklist of Psychotherapy Warning Signs*

In the following section, we present an admittedly provisional checklist of 25 “Psychotherapy Hype Warning Signs” (see Table 1, for a capsule summary). In the spirit of our own humility, we provide this list as merely a first approximation, and we welcome further suggestions and constructive criticisms from readers. We have drawn the items on this list from academic publications and presentations, trade books, claims made at continuing education workshops, inspection of printed and online advertisements of treatments, informal consultations with colleagues inside and outside of academia, and other sources. Some of these warning signs (especially 1-20) bear largely on the promotion and marketing of treatments, others (especially 21-25) on the quality of research ostensibly supporting them. Although we do not provide references for each warning sign, we encourage interested readers to consult the following sources for examples of the overhyping of interventions (Dawes, 1994; Eisner, 2000; Herbert et al., 2000; Jacobsen, Fox, & Mulick, 2005; Lilienfeld, Lynn, & Lohr, 2014; Lilienfeld, Marshall,
We offer this checklist primarily for mental health practitioners and practitioners-in-training who are attempting to navigate the confusing maze of mental health treatments. We hope that this checklist will plant the seeds of healthy self-doubt in practitioners and trainees, and help to nurture in them a sense of humility in treatment selection and delivery. In the long term, we also hope that this checklist may enhance treatment outcomes by dissuading practitioners away from embracing overhyped and pseudoscientific interventions, although this conjecture awaits formal research corroboration. We also hope that non-clinician readers, especially (a) mental health consumers, their friends, and loved ones, (b) psychology instructors, and (c) science journalists will find this checklist useful as a field guide to spotting overhyped and dubious interventions.

We discourage readers from implementing this checklist in a cookbook, DSM-style fashion. There is almost certainly no categorical cut-off that demarcates largely pseudoscientific from largely scientific therapies, so we are reluctant to suggest a specific “number” of warning signs for a treatment to acquire “overhyped status.” Furthermore, even many well-established psychotherapies, such as some cognitive-behavioral and acceptance-based interventions, have at times been substantially overhyped (see Rosen & Lilienfeld, 2016).

Nevertheless, it seems safe to conclude that the more warning signs a given psychological treatment displays, the more alarm bells should ring in therapists’ and other consumers’ minds. Phrasing it a bit differently, consumers should become especially suspicious of interventions that have been hyped relative to the strength of the extant scientific evidence. Such overpromotion can be misleading to both practitioners and clients, both of whom may come to expect miracle
cures. Clients in particular may become demoralized and disillusioned after receiving overhyped interventions that are either largely ineffective or substantially less effective than promised.

As Marcello Truzzi (1978) and later Carl Sagan (1980) reminded us, “extraordinary claims require extraordinary evidence.” Hence, proponents of interventions who advance extraordinary claims of efficacy and effectiveness in the absence of equally convincing data are opening themselves to justifiable criticism.

**Psychotherapy Hype Warning Signs: A 25-Item Checklist**

(1) Advocates of a therapeutic approach routinely advance greatly exaggerated claims. For example, they may assert that their treatment is “revolutionary,” “ground-breaking,” or that it is a “gold standard.” They are likely to offer excessive and unsubstantiated claims for its Superiority. For example, the developer of Thought Field Therapy (TFT), a prominent energy therapy, claimed to be able to cure specific phobias in 5 minutes or less (Callahan, 1985), and several websites assert that hypnosis is 30 times more effective for weight loss compared with no treatment (e.g., see [http://johnmongiovi.com/pages/weightloss](http://johnmongiovi.com/pages/weightloss)).

Proponents may further assure clients and practitioners that their “complete satisfaction” will be guaranteed. It is perhaps worth noting that there have been few or no changes in the overall effect sizes in psychotherapy outcome over the past three decades (Budd & Hughes, 2009), suggesting that humility with respect to the prospect of treatment breakthroughs is in order.

Other commonly used terms and phrases to beware of are:

- “Simple, but powerful” treatment approach
- “A breakthrough” or “remarkable advance”
- “Paradigm shift”
• “Miracle cure”
• “Powerful”, “transformative”, “life-changing” or “uniquely effective” treatment approach
• “Dramatic” or “remarkable” improvements
• “Unique and ultimate training”
• “Life-changing benefits”
• “Deep psychological healing”
• Use of such terms as “proof” or “cure”

(2) Advocates tell their clients that “If this treatment does not help you, then nothing else will.” They strike to convey a powerful expectancy that reinforces treatment outcomes.

(3) Advocates advance claims that one can – or needs to - learn the technique from a “master,” a “leading expert,” “a renowned specialist,” and so on. In this regard, Meehl (1992) warned of the guru omniscience fantasy, the temptation to believe that a single glorified expert can provide most or all of the answers to exceedingly complex psychological questions. As one example, the late Arthur Janov, founder of primal therapy (colloquially called primal scream therapy) was widely viewed as a guru and virtual messiah by many of his therapeutic acolytes, as well as by celebrities, such as ex-Beatle John Lennon and his wife Yoko Ono (Fox, 2017). In some cases, the treatment developer may have discovered the approach in a sudden personal epiphany, which may add to the mystique of the approach.

(4) Advocates rely heavily on the endorsements of presumed leaders in the field. For example, many therapists in the trauma field cite Bessel van der Kolk as an advocate and endorser of their approach. Although the endorsements of well-established experts can sometimes be
informative for consumers, this practice should never substitute for systematic research evidence.

(5) Advocates establish a coterie of trainers and perhaps an international organization to promote the treatment. Advocates use public media (television, blogs, print) to oversell their treatment approach. Advocates are “slick salespersons,” setting up clinics, training settings, workshops, and in-house conferences.

(6) Advocates provide a certificate or diploma indicating that one has taken the training and can now call oneself an X therapist. They may offer to place clinicians on a referral list of Certified X practitioners.

(7) Followers of the treatment are insular. They create specialized listservs for advocates of the intervention to share their positive experiences and to criticize skeptics of their perspectives, newsletters for treatment acolytes, and special interest groups at conventions.

(8) Advocates promote advanced, multi-level training, and sell paraphernalia and tapes that go along with their treatment approaches. For example, some advocates of eye movement desensitization and reprocessing sell wands and “Megapulsars” to assist them with providing bilateral stimulation (see https://www.colleenwest.com/for-therapists/what-equipment-do-i-use/). Proponents may require that trainees sign confidentiality statements that they will not share treatment protocols with others. These practices exemplify the maxim “commercialism is rampant.”

(9) Advocates make frequent use of “psychobabble,” psychological verbiage that sounds scientific but in fact contains little or no content, to market their treatment approach (Rosen, 1977). Consumers should be especially dubious of advertisements or courses that make extensive and uncritical use of such terms as “inner child,” “closure,” “codependency,”
“issues,” “attachment wounds,” “sex addiction,” “healing,” and so on, or that invoke concepts from quantum mechanics to explain psychological change principles (see Hummler, 2017, for a critique of the use of quantum mechanisms to explain everyday phenomena).

Advocates liberally use “neuro-babble” as well as naïve biological reductionism (often accompanied by brightly colored functional imaging figures or diagrams of the brain) to explain the treatment approach. Such neurobabble may involve the use of such terms as “neuro-networks,” “synaptic networks,” “hemispheric synchronization,” right brain attachment,” “sensorimotor integration,” “memory integration,” “body memories,” or “neuroplasticity,” especially when they are detached from their original meanings. A key and largely unappreciated problem is that many and arguably most “brain-based therapies” are not ready for application to clients given our present lack of understanding of how to bridge the vast gulf between the neural and psychological levels of analysis (Francken & Slors, in press).

Exacerbating this problem, proponents of such treatments often resort to dubious neurological bases to explain their approach, frequently dressed up in language couched in neuroscientific terminology (see Schwartz, Lilienfeld, Meca, & Sauvigne, 2016). For example, consider the following passage from a scholar’s effort to offer a neurobiological basis for the effectiveness of eye movement desensitization and reprocessing (EMDR):

…the constant reorienting of attention demanded by the alternating, bilateral visual, auditory, or tactile stimuli of EMDR automatically activates brain mechanisms which facilitate this reorienting. Activation of these systems simultaneously shifts the brain into a memory processing mode similar to that of REM sleep. This REM-like state permits the
integration of traumatic memories into associative cortical networks without interference from hippocampally mediated episodic recall...Once successfully integrated, corticohippocampal circuits induce the weakening of the traumatic episodic memory and its associated affect (Stickgold, 2002, pp. 71-72).

(11) Advocates are defensive and thin-skinned about their approach. They often question the motives, background, and training of those who have raised concerns regarding the efficacy or theoretical basis of their treatment approach. They may argue that “outsiders” are not qualified to evaluate their treatment, because they have not administered the approach themselves.

(12) Advocates rely extensively on anecdotal evidence at the expense of controlled outcome data (e.g., “Read these testimonials from three people who claim that treatment X helped them”). Anecdotal evidence from multiple satisfied clients sometimes provides sufficient grounds for investigating a novel treatment in greater depth, but it rarely if ever provides sufficient grounds for concluding that the treatment is effective (Lilienfeld et al., 2014).

(13) Advocates neglect to discuss or even acknowledge legitimate criticisms of their treatment approach. When they do mention criticisms, they frequently present them in straw-person form that can be easily rebutted. Advocates fail to mention the results of dismantling studies that question the ostensible theoretical basis of their treatment approach, or the absence of such studies.

(14) The treatment claims are marked by an absence of clear boundary conditions (Hines, 2003). Advocates may claim that the treatment approach can be applied successfully with patients who have a wide variety of psychiatric and physical conditions, and across multiple age
groups without any clinical trial evidence. Some may even claim that their approach works for pets. Advocates may imply that their treatment “fits all” or “cures all” (“One size fits all”). For example, the developer of TFT insisted that this treatment is efficacious not only for adults but for “horses, dogs, cats, infants, and very young children” (Callahan, 2001b, p. 1255).

(15) Advocates maintain that their intervention is “evidence-based,” “empirically supported,” or “empirically validated,” but they define “evidence” broadly and subjectively, referring largely or exclusively to their informal clinical observations (e.g. “I saw it work with my clients, and that is my evidence”) or to informal reports from clients rather than systematic sources of evidence obtained from well-controlled studies.

(16) Advocates maintain that their treatment approach is “evidence-based” because it has met a low criterion for evidence, such as two randomized controlled trials demonstrating significant differences from no treatment. Nevertheless, advocates do not discuss effect sizes, nor provide details about the exclusionary criteria of the patients. They also do not report on drop-out rates or follow-up data.

(17) Advocates advance vague claims without referencing them, such as “More than X number of studies have consistently demonstrated efficacy and superiority,” without citing or critically evaluating them.

(18) Advocates do not present a critical account of the scientific validity, or theoretical basis, for the effectiveness of the proposed treatment. They frequently offer little or no scientific basis for the proposed change mechanisms for the treatment. Many energy interventions, such as Emotional Freedom Techniques (EFT) and TFT, exemplify this problem. The intervention may “work” (in the weak sense of outperforming a no-treatment control group), but this
success probably has little or nothing to do with the proposed treatment model. The intervention may perform better than no treatment or than weak control groups because of non-specific factors, such as placebo effects or the beneficial influence of therapeutic support.

(19) Advocates do supply a theoretical rationale, but it conflicts overwhelmingly with known scientific evidence. That is, the treatment rationale lacks “connectivity” with well-established science (Stanovich, 2012). For example, proponents of energy therapies claim that psychopathology is produced by blockages in invisible, unmeasurable energy fields that violate the known laws of physics. Proponents of hypnotic regression therapy claim that hypnosis can recover memories that date prior to the onset of infantile amnesia. Some maintain that they can bring back memories from before birth, or even from past lives (Singer & Lalich, 1996).

(20) Advocates routinely resort to multiple implausible “ad hoc hypotheses” (after-the-fact excuses or loopholes) to explain away negative findings. This indiscriminate use of ad hoc explanations for unsupportive findings renders the key treatment claims difficult or impossible to falsify. For example, when advocates of EMDR were confronted with controlled research evidence that their intervention did not outperform a fixed eye movement condition, some responded that it did not disconfirm the intervention’s theoretical rationale because the eyes “wanted” to move (see Lilienfeld et al., 2014) In response to a published study of EFT that demonstrated comparable effects on phobic fear from tapping on a doll as from tapping on oneself (Waite & Holder, 2003), the developer of the method insisted that because the fingertips themselves contain energy meridians, this control condition was invalid (Craig, 2003). In still other cases, advocates of
a therapy may claim, without adequate justification, that unsuccessful replications of their positive treatment results are attributable to failures to implement the treatment protocol with adequate fidelity.

(21) Advocates compare their favored approach with “weak” comparison groups, that is, “intent-to-fail” conditions, which are virtually guaranteed to yield null or weak effects (Westen & Bradley, 2005). They do not compare their treatment with “bona-fide” conditions that are intended to be efficacious or effective (see Wampold et al., 1997).

(22) Advocates compare their proposed treatment with a diluted or weaker version of the comparative treatment. For an example, see Foa et al.’s (1999) comparison of Prolonged Exposure versus Stress Inoculation Training (SIT), in which the third application phase of SIT was omitted.

(23) Advocates do not report on potential allegiance effects (see Luborsky et al., 1999), that is, positive outcomes that depend on whether the primary investigator was favorably disposed to the intervention, or on who conducted the outcome studies. Allegiance effects may help to account in part for another phenomenon, namely, the decline effect (“the law of initial results”) in which effect sizes from treatment studies in early clinical trials tend to drop off over time (Lehrer, 2010; Schooler, 2010). Initial positive effects for a given psychotherapy may sometimes be inflated because early studies were conducted by enthusiastic adherents of the intervention (‘strike while the iron is hot’); these effect sizes may shrink when the intervention is later examined by impartial investigators (see Johnsen & Friborg, 2015, for potential evidence of decline effects for cognitive-behavioral therapy; but see Ljótsson, Hedman, Mattsson & Andersson, 2017 and Waltman, Creed, & Beck, 2016; for alternative views). The same principle holds in some
domains of psychiatry, where an old saw holds that one “use the new drugs while they still work.” For example, the efficacy of antipsychotic medication appears to have decreased in recent decades (Leucht, Corves, Arbter, Engel, Li, & Davis, 2009), although some of this decline may also reflect more rigorous methodology in more recent studies.

(24) Advocates do not independently determine whether the treatment rationale offered to the alternative treatment and control groups was as credible as for the advocated treatment. This potential confound can lead to differences in expectancy effects across groups.

(25) Advocates do not acknowledge the role of non-specific treatment factors, such as the therapeutic alliance, expectancy effects, and other placebo-related effects. For example, their studies do not include measures of the ongoing quality of the therapeutic alliance, such as the Therapeutic Alliance Scales, or the Quality of Relationship Measures, or the session-by-session treatment-informed feedback (Prescott et al., 2017).

Conclusions

David Shakow (1969), arguably the founder of modern clinical psychology, wrote that “psychology is immodest” (p. 146). We hope that this provisional 25-item checklist, which we hope will evolve over time in response to constructive feedback, is itself a modest step toward safeguarding practitioners and other consumers of psychotherapy against exaggerated claims and ideally, toward instilling a sense of healthy self-doubt in clinicians. We encourage consumers of interventions, especially those that are largely or entirely untested, to bear this checklist in mind when appraising the scientific status of treatment claims. We also believe, however, that users will find this checklist helpful even for evaluating well-established therapies.

Science, including clinical science, is fundamentally a prescription for intellectual humility, as it reminds us that we can all be fooled (Lilienfeld et al., 2017; McFall, 1991;
Tavris & Aronson, 2007). Such humility should extend to all domains of clinical practice, including the marketing, promotion, evaluation, selection, and administration of treatments.
References


Psychotherapy, 46, 71-77.


Table 1

**Psychotherapy “Hype” Checklist**

1. Substantial exaggeration of claims of treatment effectiveness
2. Conveying of powerful and unfounded expectancy effects
3. Exploitation of "guru omniscience fantasy"
4. Heavy reliance on endorsements from presumed experts
5. Use of a slick sales pitch
6. Establishment of accreditation and credentialing procedures
7. Tendency of treatment followers to insulate themselves from criticism
8. Use of extensive promotional efforts, including sale of paraphernalia
9. Use of "psychobabble"
10. Use of "neurobabble"
11. Tendency of advocates to be defensive and dismissive of critics
12. Heavy reliance on anecdotal evidence
13. Selective reporting of contradictory findings, such as results of dismantling studies
14. Claims that treatment "fits all"
15. Claims that treatment is "evidence-based" on the basis of informal clinical observations
(16) Limited reports or omission of treatment outcome information, such as patient selection criteria, drop-out rates, and follow-up data

(17) Vague claims of superiority without citations of specific references to studies

(18) No proposed scientific basis for change mechanisms

(19) Proposed theoretical treatment mechanism lacks "connectivity" with extant science

(20) Repeated use of implausible ad hoc maneuvers to explain away negative findings

(21) Comparison of treatment with weak and "intent to fail" treatment groups

(22) Comparison of treatment with only partial (incomplete) treatment conditions

(23) Failure to consider allegiance and decline effects

(24) Failure to consider differential credibility checks across treatment groups

(25) Failure to consider the role of non-specific factors, such as therapeutic alliance