

21st Annual Conference

Treatment of Victims of Interpersonal Violence: A Life Span Approach

Friday, May 5, 2017, 8:30 a.m. – 4 p.m.

Donna E. Shalala Student Center, University of Miami

1330 Miller Drive, Coral Gables, Florida

WE ARE THE STORIES WE TELL:

A CONSTRUCTIVE NARRATIVE PERSPECTIVE OF PTSD

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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 Posttraumatic Stress Disorder (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 auto-biographical 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.

The prolong exposure to traumatic and victimizing experiences and the accompanying “negativity” 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, 2013), 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 which can provide emotional, informational and practical support, when requested. Resilient individuals also “give to get.”

One 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. Optimism, acceptance, forgiveness, gratitude, humor, love, and a sense of awe with nature contribute to altruistic behaviors “making a gift of one's experiences to others.” Such positive emotions reduce physiological arousal and alter 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, expand and build psycho-social relationships and behavioral responses. In short, the ability to engage in non-negative thinking 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 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 “thrivor.” 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 and unpredictable; that people are untrustworthy and that life has lost its meaning; and moreover, you are a “burden” on others.
4. Ruminates 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 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/grit 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.

REFERENCES

- Bonanno, G.A. (2004). Loss, trauma and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? American Psychologist, *59*, 20-28.
- Brewin, C.R. (2014). Remembering and forgetting. In M. Friedman, T. Keane & P. Resick (Eds.), Handbook of PTSD: Science and practice. (pp. 200-218). New York: Guilford Press.
- Calhoun, L.G. & Tedeschi, R.G. (Eds.), (2006). Handbook of posttraumatic growth: Research and practice. Mahwah, N.J.: Erlbaum Associates.
- Courtois, C.A. (1999). Recollections of sexual abuse: Treatment principles and guidelines. New York, NY: W.W. Norton.
- Duncan, B. (2010). On becoming a better therapist. Washington, DC: American Psychological Association.
- Ehlers, A. & Clark, D.M. (2000). A cognitive model of posttraumatic disorder. Behavior Research and Therapy, *38*, 319-345.
- Fredrickson, B.L. (2011). The role of positive emotions in positive psychology: The broaden-and-build theory of positive emotions. American Psychologist, *56*, 218-226.
- Joseph, S. (2012). What doesn't kill us: The new psychology of posttraumatic growth. New York, NY: Basic Books.
- Lambert, M.J. (2007). What we have learned from a decade of research aimed at improving outcomes in routine care. Psychotherapy Research, *17*, 1-14.
- McAdams, D.P. (1997). The stories we live by: Personal myths and the making of the self. New York, NY: Guilford Press.
- Meichenbaum, D. (2013). Roadmap to resilience. Willston, VT: Crown House Publishing.
- Meichenbaum, D. (2013b) The therapeutic relationship as a common factor: Implications for trauma therapy. In D. Murphy & S. Joseph (Eds.), Trauma and the therapeutic relationship. Basingstoke, UK: Palgrave MacMillan.
- Meichenbaum, D. (2017a). A constructive narrative perspective on trauma and resilience. The role of cognitive and affective processes. In the American Psychological Association Handbook of Trauma Psychology. Washington, DC: American Psychological Association.
- Meichenbaum, D. (2017b) The evolution of cognitive behavior therapy: A personal and professional journey with Don Meichenbaum, New York, NY: Routledge.
- Reich, J.W., Zautra, A.J. & Hill, J.S. (Eds.). (2010). Handbook of adult resilience. New York, NY: Guilford Press.
- Shipherd, J.C. & Beck, J.G. (2005). The role of thought suppression in posttraumatic stress disorder. Behavior Therapy, *36*, 277-287.
- Southwick, S., & Charney, D.S. (2012). Resilience: The science of mastering life's greatest challenges. West Nyack, NY: Cambridge University Press.
- Sperry, L. & Carlson, J. (2013). How master therapists work. New York, NY: Routledge.
- van der Kolk, B. (2015). The body keeps score. New York, NY: Basic Books.
- Vollmer, F. (2005). The narrative self. Journal for the Theory of Social Behavior, *35*, 189-205.
- Wampold, B.E. (2006). The psychotherapist. In J.C. Norcross, L.E. Beutler, R.F. Levant (Eds.). Evidence-based practices in mental health. Washington, DC: American Psychological Association.
- Zoellner, A. & Feeny, N.C. (Eds.). (2014). Facilitating resilience and recovery following trauma. New York, NY: Guilford Press.