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

FACTORS THAT INFLUENCE WHO DEVELOPS PTSD

Donald Meichenbaum, Ph.D.

dhmeich@aol.com

FACTORS THAT INFLUENCE WHO DEVELOPS PTSD

STIMULUS CHARACTERISTICS OF THE TRAUMATIC EVENTS

- Objective Features
- Subjective Features
- Role of Cognitions and PTSD

REACTIONS OR RESPONSE TO THE TRAUMA

(*Symptomatic behaviors and level of functioning)*

- Reactions at the time of the trauma
- Current reactions to the trauma
- Presence of comorbidity and psycho-neuro-immunological sequelae (See Kendall-Tackett, 2009)
- Subjective meaning (perceived implications) of reactions

DEVELOPMENTAL VULNERABILITY FACTORS

- Pre-trauma experiences
- Risk and protective factors (individual, familial, community)

RECOVERY ENVIRONMENT

- Ongoing stressors and barriers
- Individual, social, community/societal features

Table 1

CHARACTERISTICS ASSOCIATED WITH THE DEVELOPMENT AND MAINTENANCE OF POST-TRAUMATIC STRESS DISORDER (PTSD)

1. Experience repetitive human-induced betrayal-trauma in a developmentally sensitive period with little or no support.
2. Experience multiple poly-victimization.
3. Experience PTSD and comorbid psychiatric disorders, especially depression.
4. Selectively focus on ongoing threats and vulnerability.
5. Engage in maladaptive appraisals of trauma and its aftermath.
6. Engage in "catastrophic thinking" and use maladaptive thought control strategies.
7. Exaggerate the probability of future negative consequences occurring and the adverse effects of these events.
8. Ruminate about the ongoing negative implications of the trauma experience. Assign meaning to trauma-related intrusive distress such as
   "I am going crazy." "I am inferior to other people." "My life is ruined."
   "It is my fault." "It will happen again. I am helpless."
9. Suppress feelings and thoughts of the traumatic event.
10. Fail to share your account of your trauma experience with supportive others.
11. Engage in cognitive avoidance (suppression of thoughts and memories), behavioral avoidance (use of substances, isolate self) and engage in safety behaviors that impair the processing of trauma-related memories and that maintain the condition. Fail to become socially reengaged.
12. Fail to recall positive coping memories or what you did to "survive," or what you were able to accomplish "in spite of" victimization.
13. Have accompanying unresolved feelings of anger, disgust, shame, guilt, humiliation, frustration, being slighted and being abandoned.
14. Experience complicated grief and fail to engage in "grief work" that honors loved ones who were lost.
15. Encounter or inadvertently create a stressful environment that is unsupportive and that dismisses (fail to validate) and rejects (offers "moving on" statements) and that secondarily re-victimizes.

Table 2

WHAT YOU NEED TO DO (AND NOT DO) TO DEVELOP CHRONIC POSTTRAUMATIC STRESS DISORDER (PTSD): A CONSTRUCTIVE NARRATIVE PERSPECTIVE

Engage in self-focused cognitions that have a "victim" theme:

1. See self as being continually vulnerable.
2. See self as being mentally defeated.
3. Dwell on negative implications with accompanying disgust, blame, shame, guilt, anger, hostility, depression.
4. Be preoccupied with how others view you.
5. Imagine and ruminate about what might have happened - "Near Miss Experience."

Hold beliefs:

1. Changes are permanent and that you are a "burden" on others.
2. World is unsafe, unpredictable, untrustworthy.
3. Hold negative view of the future.
4. Life has lost its meaning.

Blame:

1. Others with accompanying anger.
2. Self with accompanying guilt, shame, humiliation.

Engage in comparisons:

1. Self versus others.
2. Before versus now.
3. Now versus what might have been.

Things to do:

1. Be continually hypervigilant.
2. Be avoidant – cognitive level *(suppress unwanted thoughts, dissociate, engage in "undoing" behaviors)*
3. Be avoidant – behavioral level (*avoid reminders, use substances, withdraw, abandon normal routines, engage in avoidant safety behaviors)*
4. Ruminate and engage in contrafactual thinking ("Why me?" "Why now?" "Only if..." "Had I only...")
5. Engage in delaying change behaviors.
6. Fail to resolve and share trauma story, "Keep secrets."
7. Put self at risk for re-victimization.

What *not* to do.

1. Not believe that anything positive could result from trauma experience.
2. Fail to retrieve, nor accept data of positive self-identity.
3. Fail to seek social supports.
4. Experience negative, unsupportive environments *(indifference, criticism, "moving on' statements).*
5. Fail to use faith and religion as a means of coping.
6. Fail to commit to a life worth living.

IN CONTRAST RESILIENT INDIVIDUALS TEND TO:

1. **Find and seek benefits that result from the trauma experience that may accrue to oneself and to others (benefit findings).**

2. **Establish and maintain a future orientation.**

3. **Construct meaning (Use one's faith or spirituality).**

4. **Share their accounts with others and make a "gift" of their experience to others.**

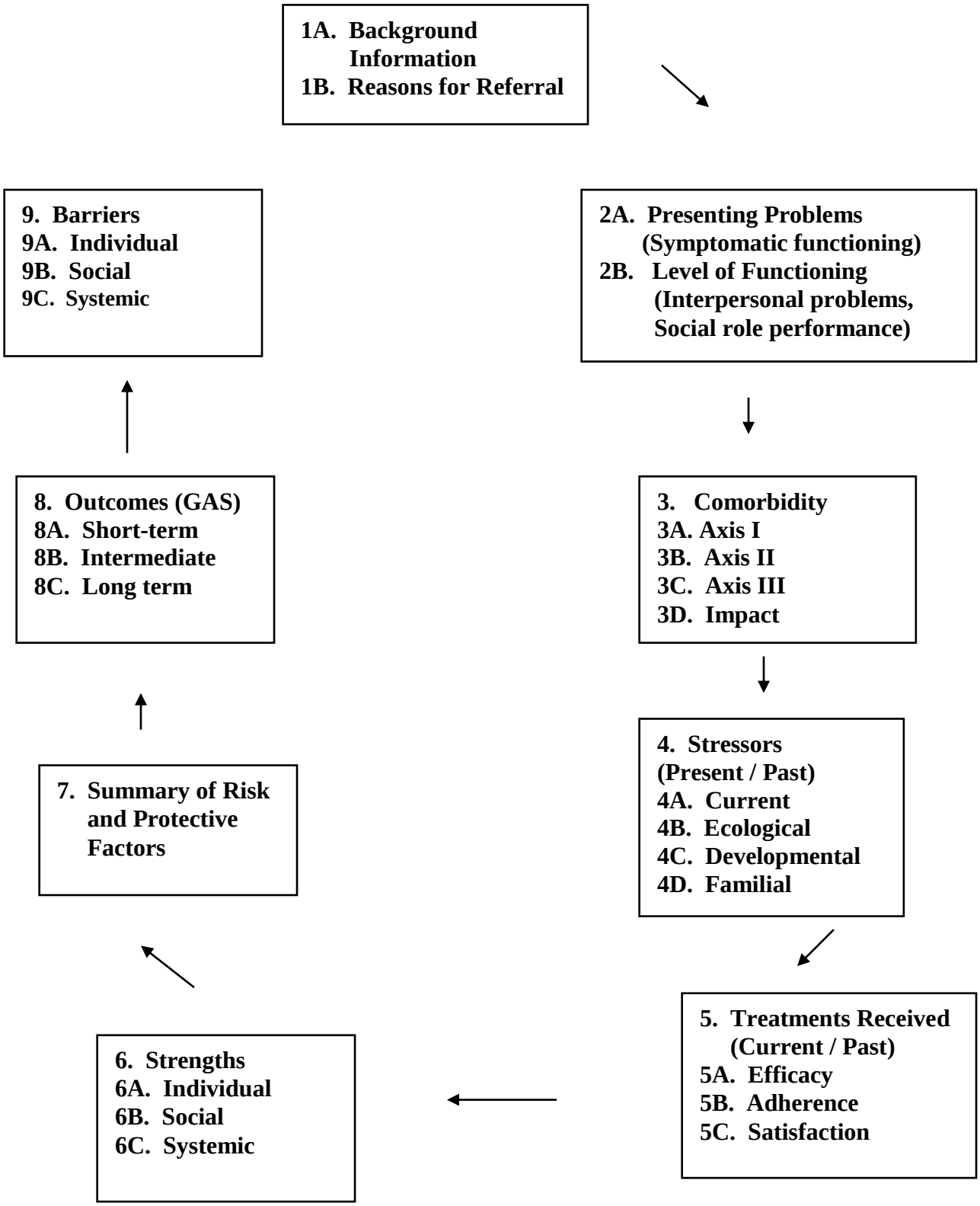
5. **Undertake healing activities such as return to the site of the battle (Evidence courage and do "grief work" - - honoring those who were lost).**

Table 3

TREATMENT IMPLICATIONS AND PROCEDURES OF A CONSTRUCTIVE NARRATIVE PERSPECTIVE OF PERSISTENT POSTTRAUMATIC STRESS DISORDER (PTSD)

1. Develop a supportive, empowering *therapeutic alliance.*
2. Conduct *assessment interview* and use related measures. Provide constructive feedback.
3. Provide *rationale* for treatment plan.
4. Ensure *patient's safety* and *address disturbing symptoms.*
5. *Educate* patients and significant others.
6. *Teach* specific *coping skills* and *build-in generalization-enhancing procedures.*
7. Help patients *change beliefs about implications* of experiencing PTSD and associated symptoms.
8. Reconsider *anything positive* that resulted from the experience.
9. Address issues of guilt, shame, humiliation, anger, complicated grief.
10. "*Uncouple"* traumatic memories from disabling affect – use "Clock" metaphor.
11. Help patients *put into words* or into some other form of expression what happened and what they did to "survive" and cope.
12. Process and *transform emotional pain* – make a "gift" of their experience to others.
13. Help patients *distinguish* "then and there" from "here and now," not overgeneralize danger.
14. Help patients *retell their stories* and share the "*rest of their stories.*" Retrieve "positive identities." (Use imaginal reliving procedure.)
15. Have patients *"spot triggers*" and *reduce unhelpful avoidant safety behaviors.*
16. Reduce maladaptive thought control strategies and consider the advantages (pros) and disadvantages (cons) of using each of these strategies (Metacognitive therapies).
17. Establish a strategy of detached mindfulness.
18. Have patients engage in graduated *in vivo* behavior exposure to places and activities that are safe, but that have been avoided. Have patients undertake safe exposure-based field trips.
19. Develop a plan that can guide thinking and behavior in future potential situations with trauma or reminders like anniversary effects.
20. *Reclaim* their *lives* and *former selves.*
21. Ensure patients *take credit* for changes – self-attributional efforts and self-mastery.
22. Avoid *re-victimization.*
23. Build in *relapse prevention procedures.*
24. Put patients in a "*consultative"* role where they describe and discuss what they learned and what they can now teach others.

GENERIC CASE CONCEPTUALIZATION MODEL



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

"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)

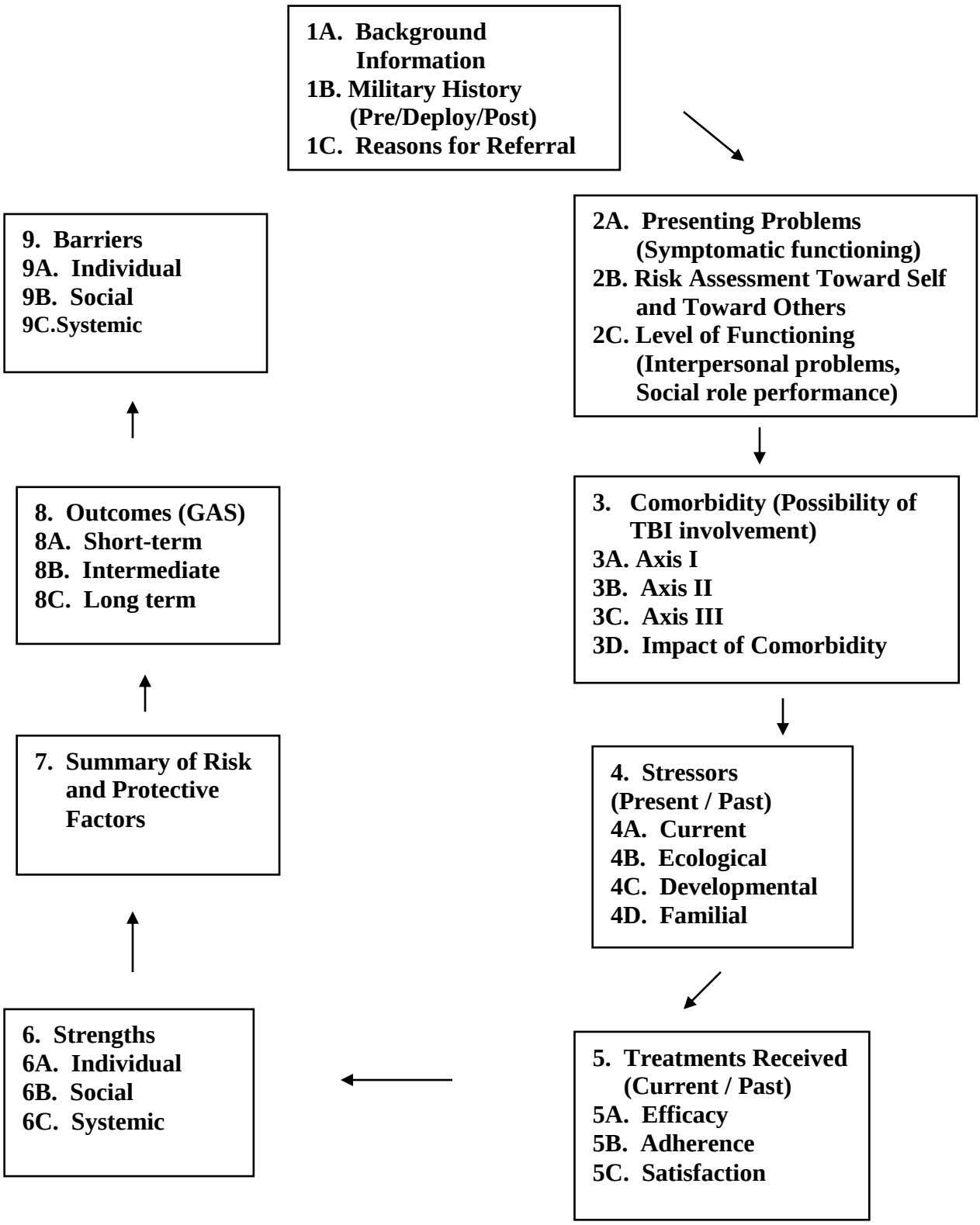
BOX 8: OUTCOMES (GOAL ATTAINMENT SCALING PROCEDURES)

"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.

GENERIC CASE CONCEPTUALIZATION MODEL TAILORED TO RETURNING SOLDIERS
(A Multiple-focused Assessment Strategy - - see Meichenbaum, 2009)



OVERVIEW OF TREATMENT

INITIAL PHASE I

- Establish and monitor therapeutic alliance (Address therapy-interfering behaviors)
- Ensure the patient's safety
- Address immediate needs
- Normalize and validate the patient's experiences
- Educate the patient about PTSD and treatment – Use Clock Metaphor
- "Commend" the patient for "distress" - - Example of a "Stuckiness" problem
- Conduct assessment and provide feedback: Use Case Conceptualization Model
- Nurture hope – Use Time Lines and "In spite of" observations
- Collaboratively generate treatment goals: Motivate the patient to change

PHASE II – SKILLS BUILDING

- Address target symptoms of PTSD (intrusive ideation, hyperarousal, avoidance, dissociation, sleep disturbances)
- Address symptoms of comorbidity in an integrative treatment fashion
- Teach coping skills – Stress Inoculation Training, Problem-solving and Acceptance skills
- Address adherence issues ("Homework", medication)
- Build-in Generalization Guidelines

PHASE III – "MEMORY WORK" AND FIND MEANING

- Address issues of memory and meaning
- Use Exposure-based Procedures (Imaginal and *In vivo*)
- Use "Rethinking" activities: Cognitive Restructuring (e.g., guilt, shame)
- Transform trauma – help the patient find meaning: Use rituals, journaling, letter writing, role of spirituality
- Help the patient develop and mobilize supportive relationships
- Involve significant others as part of treatment; Nurture "connectedness"

PHASE IV – TERMINATION

- Attribution training – ensure that patients "takes credit" for improvement
- Conduct relapse prevention: Consider possible anniversary effects
- Build in follow-up and ongoing assessments

USE CLOCK METAPHOR

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

1. Place hand at 9 o'clock and move around imaginary clock and say "It sounds like a vicious…" Allow client to finish this sentence with "cycle" or "circle." Explore how his/her account fits a "vicious cycle."

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

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

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

5. Explore with the patient more adaptive ways "to break the cycle."

WAYS THE THERAPIST CAN HELP THE PATIENT BREAK THE "VICIOUS CYCLE": USE OF THE CLOCK METAPHOR

(See Wells et al. 2008 "Chronic PTSD Treated with Metacognitive Therapy". Cognitive and Behavioral Practice, 15, 85-92 for further examples)

12 o'clock Interventions- - external and internal triggers

1. Have the patient become aware of how they are hypervigilant about possible threats.
2. Collaboratively consider if threat assessment is inflated.
3. Consider the "impact, toll, price" of such threat monitoring behaviors. Consider the advantages and disadvantages (pros-cons) of such behaviors.
4. Examine underlying beliefs that contribute to such hypervigilance. For example, ***"Paying attention to danger means I can avoid it in the future." "If I worry about bad things, in the future I won't be blindsided."***
5. Practice redirecting attention to nonthreatening features of external and internal environments.
6. Check out perceptions with trusted others.

3 o'clock Interventions- -primary and secondary emotions

1. Increase awareness of primary (automatic) and secondary emotions. For example, anger may be a secondary emotion to being humiliated, embarrassed, feeling guilty.
2. Explore what the patient does with such emotions. View emotions as a "commodity" that one does something with (e.g., stuff emotions, drink them away, engage in high-risk behaviors).
3. Explore what is the "impact, toll, price" of such acts. Consider the pros and cons of such behaviors.

4. View such coping efforts (e.g., dissociative behaviors) as a "stuckiness" problem that worked in the past, but are no longer useful (e.g., hypervigilance in combat soldiers). Consider transitional stressors. For example, in the same ways a soldier had to be "trained" for military duties, returning soldiers also need "training" to become a civilian again. Instead of characterizing or labelling the intervention as "psychotherapy," use a training analogy to avoid barriers such as stigmatization.
5. Learn various ways to manage hyperarousal that contribute to and exacerbate such feelings (e.g., relaxation and mindfulness activities).
6. Consider (question, challenge) the automatic thoughts and cognitive appraisals that contribute to such emotional reactions.

6 o'clock Interventions- - **cognitive events** (automatic thoughts and images-"hot" cognitions);
cognitive processes (rumination, mental heuristics, thinking patterns, distortions and errors); **cognitive structures**, schemas and beliefs.

1. Normalize and validate feelings and accompanying beliefs.
2. Assess for occurrence and impact of cognitive activity (emotional "hot spots", rumination, suppression).
3. Use cognitive restructuring procedures of monitoring and testing out automatic thoughts. "Personal scientist" or "detective" metaphor.
4. Explore metacognitive beliefs about symptomatology or the nature of the "story" the patient tells him/herself and others. Consider the pros and cons of holding such beliefs- - "impact, toll, price".
5. Use healing metaphor ala Wells et al. (2008, pp. 90-91)

"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 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."

6. Teach a detached mindfulness of acceptance, rather than challenging thoughts. Choose <u>not</u> to influence or engage thoughts by analyzing them, pushing them away or actively trying to change their content.
7. Learn how to apply <u>worry-postponement.</u> As Wells et al. (2008 p. 91) convey to the patient.

"You have seen how trying to control your thoughts does <u>not</u> work very well, and how worrying about things keeps the sense of danger and anxiety going. Do you think you could stop worrying about and analyzing what happened? Perhaps you could run an experiment to see if this is possible. For homework, I would like you to notice worrying or ruminating and say to yourself, "That's a worry. I don't need to work this out now, I'll work it out later". Then set aside a 10 minute worry period that you can use later in the day. You can even have a worry chart you use. So you are saving up your worry and ruminating until later. You don't actually have to use your worry period -most people find that they don't use it when the time comes."

8. Help the patient appreciate how engaging in contrafactual thinking such as "Why did this happen to me?" "What have I done to deserve this?" "Am I mentally weak?" and "What if questions" works to perpetuate the "cycle." Once again, have them appreciate the "impact, toll, price" of engaging in such cognitive activities.
9. Help the patient appreciate the nature of his/her beliefs. As Foa et al. (1995) convey to victimized individuals,

"After an assault, many rape survivors conclude that the world is unpredictable and uncontrollable, and they view the world as dangerous. Another consequence that is common after an assault is that the survivors develop extremely negative views about themselves. For example, you may feel you are less adequate than you thought you were or that you are extremely vulnerable and incapable of coping with stress. Have you had such feelings and thoughts? What is the impact of such feelings and thoughts? How do such feelings and thoughts affect you on a daily basis? Such thoughts can cause anxiety, avoidance and depression and make it difficult to recover from the assault. It will be useful for us to spend some time evaluating the accuracy of these beliefs and whether or not they are helpful to your recovery. When you begin to catch yourself engaging in such thinking, your distress and difficulties will begin to decrease."

10. Help the patient exert control over thoughts and behavior. The therapist can convey to the patient who has been assaulted:

That person who raped you controlled your life for two hours. The question, before us now, is whether you are going to allow him to control the rest of your life? How can you become the boss of PTSD and take back control?

11. Reassure the patient that he/she survived the victimization experience (e.g. rape), that he/she will be able to survive the telling and retelling of what happened. Highlight that we can stop at any time and he/she is "in charge." Provide a rationale of why sharing is important. Use metaphors of "unfinished business," "undigested processes that need to be metabolized," avoidance behaviors and keeping secrets contribute to symptoms and difficulties, need to reorder thoughts and feelings like a cabinet door that will not close. Need to rearrange thoughts and feelings so the cabinet door could be opened and closed when one wants to share, process. In short, the therapist prepares the patient for constructive narrative work to help the patient get "unstuck" from "hot spots." (See Ehers and Clark, 2000)
12. Use prolonged direct therapy exposure procedures.

9 o'clock Interventions- - behavioral acts and resultant consequences.

1. Help the patient appreciate how he/she presently attempts to "break the cycle." Be specific. Also consider how long this pattern of coping has been going on. Conduct a developmental analysis. For example, is the use of substances a way to self-medicate, or avoidance as a way to "dose oneself," or intrusive ideation as a way to make sense of what happened? Use metaphor of the "wisdom of the body." "Nature's way of healing." Reframe symptoms. Use phrase "***Wow, what a relief!***" Use paradoxical procedures. Commend patient for "survival skills."
2. Consider the "impact, toll, and price" of using such coping efforts. Are they working or are they making things worse? Consider pros and cons of engaging in such behavioral acts.
3. Use Motivational Interviewing procedures as a means to engage patients to work on changing such behaviors.
4. Use metaphors as a way to have the patient appreciate the self-defeating nature of his/her behavior.

   Walser and Hayes (2006, pp. 160-163) offer the following metaphors as ways to engage patients into treatment.

THERAPIST: Here is a metaphor that will help you understand what I am saying. Imagine you are blindfolded and given a bag of tools and told to run through a large field. So there you are, living your life and running through the field. However, unknown to you, there are large holes in this field, and sooner or later you fall in. Now remember you were blindfolded, so you didn't fall in on purpose; it is not your fault that you fell in. You are not responsible for being in that hole. You want to get out, so you open your bag of tools and find that the only tool is a shovel. So you begin to dig. And you dig. But digging is the thing that makes holes. So you try other things, like figuring out exactly how you fell in the hole, but that doesn't help you get out. Even if you knew every step that you took to get into the hole, it would not help you to get out of it. So you dig differently. You dig fast, you dig slow. You take big scoops, and you take little scoops. And you're still not out. Finally, you think you need to get a "really great shovel" and that is why you are here to see me. Maybe I have a gold-plated shovel. But I don't and even if I did, I wouldn't give it to you. Shovels don't get people out of holes- they make them.

CLIENT: So what is the solution? Why should I even come here?

THERAPIST: I don't know, but it is not to help you dig your way out. Perhaps, we should start with what your experience tells you; that what you have been doing hasn't been working. And what I am going to ask you to consider is that what you have been doing can't work. Until you open up to that reality, that bottom line, you will never let go of the shovel because as far as you know, it's the only thing you've got. But until you let go of it, you can't take hold of anything else.

Another metaphor offered is as follows: ***"Are you familiar with the Chinese finger trap? This toy is a tube generally made of straw. You place your two index fingers in the tube and then try to pull them out. What happens is the more you pull the tighter the straw tube clamps down on your fingers, making it virtually impossible to remove becoming the trap. The more effort you put into escaping, the more uncomfortable you***

feel - the more trapped you become. Trying to escape negative emotional experiences can work like a Chinese finger trap. The harder you try not to have the emotions, the more the emotions "clamp" down on you. Examples of this kind of problem include excessive drinking to escape anxiety. Now you not only have the problem of anxiety, but you also have the problem of excessive drinking and all that brings with it.

Walser, R.D. & Hayes, S.C. (2006). Acceptance and commitment therapy in the treatment of PTSD. In V.M. Follette & J.I. Ruzek (Eds). Cognitive-behavioral therapies for trauma. (pp. 146-197). New York: Guilford Press.

5. Teach intra- and interpersonal skills and build in treatment guidelines to foster generalization.

PROCEDURAL CHECKLIST FOR CONDUCTING SELF-MONITORING AND OTHER EXTRA-THERAPY ACTIVITIES

1. Provide opportunity for the patient to come up with the suggestion for self-monitoring. Use a situational analysis.
2. Provide a rationale. Highlight the connection between doing "homework" and the patient achieving his/her therapy goals.
3. Keep the request simple (Use behavioral tasks and a "foot-in-the-door" approach and build-in reminders).
4. Ensure that the patient has the skills to perform the task. Give the patient a "choice" as to how best to conduct the assignment.
5. Use implementation intention statements ("When and where," "If …then," "Whenever" statements).
6. Clarify and check the patient's comprehension (use role-reversal, behavioral rehearsal).
7. Use desirable rewards and peer/family supports.
8. Anticipate possible barriers and collaboratively develop coping strategies.
9. Elicit both commitment statements and patient-generated "reasons."
10. Inquire routinely at the beginning of the session about self-monitoring (other "homework" activities).
11. Nurture the patient's self-attributions (Ensures that the patient "takes credit" for changes).
12. Reinforce effort and not just product.
13. Help the patient view any failures as "learning opportunities."
14. Keep a record of patient's compliance.