

Chapter 8: 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, prolonged 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 “thrivers”, 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 “homonarrans”, or “story-tellers”.

Overview of Stress Inoculation Training

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 in 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.

Phases of Stress Inoculation Training

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, Measurable, 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 ways to broaden and build 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 prolonged 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 PRESIT 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.

As a result, she experienced prolonged 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.

Stress Inoculation Training and Related Intervention Resources

There are variety of educational and training resources available on SIT and related interventions focused on bolstering resilience. The most commonly used are below.

1. Visit www.roadmaptoresilience.com for a description of ways to bolster resilience and www.melissainstitute.org for follow-up articles including treatment manuals on

Prolonged and Complicated Grief, Ways to integrate spirituality and psychotherapy, and Ways to bolster resilience in LGBTQ youth.

2. Monson & Schneider (2014, pp. 89-90) and Meichenbaum (2007, pp. 501-507) provide procedural treatment guidelines. Meichenbaum (1985) Stress Inoculation Training provides an initial description. (Elmsford, NY: Pergamon Press)

3. Smith, R.E. & Ascough, J.C. (2016) Promoting emotional resilience: Cognitive-affective stress management training. New York: Guilford Press overlaps with SIT.

4. Meichenbaum conducts workshops on SIT (dhmeich@aol.com).

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

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, Measurable, 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.

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