The Melissa Institute for Violence Prevention and Treatment Trauma-Informed Care Toolkit

Developed and Compiled By:

THE MELISSA INSTITUTE
For Violence Prevention and Treatment

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THE MELISSA INSTITUTE
For Violence Prevention and Treatment

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Program's Goals & Objectives

This program provides an overview of the various forms of trauma, and an introduction to providing Trauma-informed care while mangaing secondary trauma. Specifically, this program will be guiding thought and discussion on the following forms of trauma: trauma and substance abuse, racism and community violence, and interpersonal violence. Additionally, this program will explore how to respond to trauma, beginning with creating safe spaces, understanding and shaping policy, and thinking about self care.

Ground Rules

These are some of the workshop's ground rules that we are asking everyone to follow:

- Mutual respect
- Non-judgmental approach (i.e., agree to disagree with others' views and opinions in a respectful manner)
- No side conversations; only one person can talk at a time
- All questions are valid and important (freedom of expression)
- No cell phone or texting during the group
- Confidentiality

Program's Goals and Objectives

By the end of the group workshop, you will be able to:

- Gain an understanding of various forms of trauma
- Awareness of the impact of trauma
- Understand how to respond to trauma and secondary trauma

Program Leaders

Crecer Team

CRECER is developing and implementing a number of empirically-based, culturally-driven programs in collaboration with local, national, and international community partners. Through our work, we aim to enhance the cultural identities of minority and immigrant children and families, bridge communities, and promote emotional and physical health and wellbeing. For more information please visit: http://sites.education.miami.edu/crecer/our-work/.

The Melissa Institute

On May 5, 1995, Melissa Aptman was murdered in St. Louis. A Miami native, she was just two weeks away from graduation from Washington University. A year after her death, Melissa's family, friends and violence prevention experts established The Melissa Institute for Violence Prevention and Treatment to honor her memory and make a difference by working to prevent violence and assist victims. The Melissa Institute is a non-profit organization dedicated to the study and prevention of violence through education, community service, research support and consultation. The Institute's mission is to prevent violence and promote safer communities through education and application of research-based knowledge. Please visit us for more information, https://melissainstitute.org/

TRAUMA-INFORMED CARE TOP TEN

A CHECKLIST FOR BEHAVIORAL HEALTH ORGANIZATIONS

Trauma is pervasive. Up to 95% of women in the public mental health system report a history of trauma. An individual's experience of trauma impacts every area of human functioning — physical, mental, behavioral, social, spiritual. When we don't ask about trauma in behavioral healthcare, harm is done or abuse is unintentionally recreated by the use of forced medication, seclusion, or restraints. Addressing trauma helps your organization improve the quality and impact of behavioral health services, increase safety for all, reduce no-shows, enhance client engagement, and avoid staff burnout and turnover. **Start today by answering these questions to determine if your organization is truly committed to trauma-informed care.**

Organization Name _____ **Website** _____

Contact Person _____ **Email** _____ **Phone** _____

1	We are committed to increasing our awareness and understanding of the principles and practices of trauma informed care.	YES ☐	NO ☐
2	We want to ensure that we address the needs of our clients affected by trauma as an integral part of our strategic plan.	YES ☐	NO ☐
3	We want to screen and assess for trauma for all our clients in a sensitive and respectful way.	YES ☐	NO ☐
4	We want to offer our clients a range of evidence-informed services – through knowledgeable, skilled, and culturally respectful staff – to address trauma-related adaptations and difficulties.	YES ☐	NO ☐
5	We want our policy and procedures to be informed by the experience and perspectives of consumers and would like to involve them as employees/volunteers/advocates.	YES ☐	NO ☐
6	We want to ensure that our social and physical environment promotes healing and avoids re-traumatizing clients.	YES ☐	NO ☐
7	We want to ensure that our entire workforce is educated about trauma-informed care and know how they contribute.	YES ☐	NO ☐
8	We want to raise awareness of trauma-informed care with other organizations, programs and service systems that interact with our consumers.	YES ☐	NO ☐
9	We want to create an environment that supports staff who may experience work stress and vicarious trauma.	YES ☐	NO ☐
10	We want to use data to monitor and sustain our improvements.	YES ☐	NO ☐
	TOTAL SCORE:	**YES**_____	**NO**_____

What next? The National Council for Behavioral Health's trauma-informed care initiatives have helped hundreds of behavioral health organizations across the country map out and operationalize a plan for delivering trauma-informed care. Our experts can help you devise and implement a complete A-Z trauma-informed care plan for your organization and are available for short-term and long-term consulting and training engagements at your site and can work hands on with your core implementation team.

To engage our consultants, email Daisy Wheeler, Consulting Manager at **DaisyW@TheNationalCouncil.org** or call **202.684.7457**.

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

Prepared by

SAMHSA's Trauma and Justice Strategic Initiative

July 2014

Substance Abuse and Mental Health Services Administration

SAMHSA

www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

U.S. Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

Office of Policy, Planning and Innovation

Acknowledgements

This publication was developed under the leadership of SAMHSA's Trauma and Justice Strategic Initiative Workgroup: Larke N. Huang (lead), Rebecca Flatow, Tenly Biggs, Sara Afayee, Kelley Smith, Thomas Clark, and Mary Blake. Support was provided by SAMHSA's National Center for Trauma-Informed Care, contract number 270-13-0409. Mary Blake and Tenly Biggs serve as the CORs.

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The publication may be downloaded or ordered from SAMHSA's Publications Ordering Web page at http://store.samhsa.gov. Or, please call SAMHSA at 1-877-SAMHSA-7 (1-877-726- 4727) (English and Español).

Recommended Citation

Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Originating Office

Office of Policy, Planning and Innovation, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857. HHS Publication No. (SMA) 14-4884. Printed 2014.

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Introduction

Trauma is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography or sexual orientation. It is an almost universal experience of people with mental and substance use disorders. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. ***In order to maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.***

The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders.[1,2,3,4,5] Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences.[6,7,8,9] However, most people go without these services and supports. Unaddressed trauma significantly increases the risk of mental and substance use disorders and chronic physical diseases.[1,10,11]

With appropriate supports and intervention, people can overcome traumatic experiences.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. Studies of people in the juvenile and criminal justice system reveal high rates of mental and substance use disorders and personal histories of trauma.[12,13] Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems.[5,14] Young people bring their experiences of trauma into the school systems, often interfering with their school success. And many patients in primary care similarly have significant trauma histories which has an impact on their health and their responsiveness to health interventions.[15,16,17]

In addition, the public institutions and service systems that are intended to provide services and supports to individuals are often themselves trauma-inducing. The use of coercive practices, such as seclusion and restraints, in the behavioral health system; the abrupt removal of a child from an abusing family in the child welfare system; the use of invasive procedures in the medical system; the harsh disciplinary practices in educational/school systems; or intimidating practices in the criminal justice system can be re-traumatizing for individuals who already enter these systems with significant histories of trauma. These program or system practices and policies often interfere with achieving the desired outcomes in these systems.

Thus, the pervasive and harmful impact of traumatic events on individuals, families and communities and the unintended but similarly widespread re-traumatizing of individuals within our public institutions and service systems, makes it necessary to rethink doing "business as usual." In public institutions and service systems, there is increasing recognition that many of the individuals have extensive histories of trauma that, left unaddressed, can get in the way of achieving good health and well-being. For example, a child who suffers from maltreatment or neglect in the home may not be able to concentrate on school work and be successful in school; a women victimized by domestic violence may have trouble performing in the work setting; a jail inmate repeatedly exposed to violence on the street may have difficulty refraining from retaliatory violence and re-offending; a sexually abused homeless youth may engage in self-injury and high risk behaviors to cope with the effects of sexual abuse; and, a veteran may use substances to mask the traumatic memories of combat. The experiences of these individuals are compelling and, unfortunately, all too common. Yet, until recently, gaining a better understanding of how to address the trauma experienced by these individuals and how to mitigate the re-traumatizing effect of many of our public institutions and service settings was not an integral part of the work of these systems. Now, however, there is an increasing focus on the impact of trauma and how service systems may help to resolve or exacerbate trauma-related issues. These systems are beginning to revisit how they conduct their "business" under the framework of a trauma-informed approach.

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Purpose and Approach: Developing a Framework for Trauma and a Trauma-Informed Approach

PURPOSE

The purpose of this paper is to develop a working concept of trauma and a trauma-informed approach and to develop a shared understanding of these concepts that would be acceptable and appropriate across an array of service systems and stakeholder groups. SAMHSA puts forth a framework for the behavioral health specialty sectors, that can be adapted to other sectors such as child welfare, education, criminal and juvenile justice, primary health care, the military and other settings that have the potential to ease or exacerbate an individual's capacity to cope with traumatic experiences. In fact, many people with behavioral health problems receive treatment and services in these non-specialty behavioral health systems. SAMHSA intends this framework be relevant to its federal partners and their state and local system counterparts and to practitioners, researchers, and trauma survivors, families and communities. The desired goal is to build a framework that helps systems "talk" to each other, to understand better the connections between trauma and behavioral health issues, and to guide systems to become trauma-informed.

APPROACH

SAMHSA approached this task by integrating three significant threads of work: trauma focused research work; practice-generated knowledge about trauma interventions; and the lessons articulated by survivors

of traumatic experiences who have had involvement in multiple service sectors. It was expected that this blending of the research, practice and survivor knowledge would generate a framework for improving the capacity of our service systems and public institutions to better address the trauma-related issues of their constituents.

To begin this work, SAMHSA conducted an environmental scan of trauma definitions and models of trauma informed care. SAMHSA convened a group of national experts who had done extensive work in this area. This included trauma survivors who had been recipients of care in multiple service system; practitioners from an array of fields, who had experience in trauma treatment; researchers whose work focused on trauma and the development of trauma-specific interventions; and policymakers in the field of behavioral health.

From this meeting, SAMHSA developed a working document summarizing the discussions among these experts. The document was then vetted among federal agencies that conduct work in the field of trauma. Simultaneously, it was placed on a SAMHSA website for public comment. Federal agency experts provided rich comments and suggestions; the public comment site drew just over 2,000 respondents and 20,000 comments or endorsements of others' comments. SAMHSA reviewed all of these comments, made revisions to the document and developed the framework and guidance presented in this paper.

The key questions addressed in this paper are:

- **What do we mean by trauma?**
- **What do we mean by a trauma-informed approach?**
- **What are the key principles of a trauma-informed approach?**
- **What is the suggested guidance for implementing a trauma-informed approach?**
- **How do we understand trauma in the context of community?**

SAMHSA's approach to this task has been an attempt to integrate knowledge developed through research and clinical practice with the voices of trauma survivors. This also included experts funded through SAMHSA's trauma-focused grants and initiatives, such as SAMHSA's National Child Traumatic Stress Initiative, SAMHSA's National Center for Trauma Informed Care, and data and lessons learned from other grant programs that did not have a primary focus on trauma but included significant attention to trauma, such as SAMHSA's: Jail Diversion Trauma Recovery grant program; Children's Mental Health Initiative; Women, Children and Family Substance Abuse Treatment Program; and Offender Reentry and Adult Treatment Drug Court Programs.

Background: Trauma — Where We Are and How We Got Here

The concept of traumatic stress emerged in the field of mental health at least four decades ago. Over the last 20 years, SAMHSA has been a leader in recognizing the need to address trauma as a fundamental obligation for public mental health and substance abuse service delivery and has supported the development and promulgation of trauma-informed systems of care. In 1994, SAMHSA convened the Dare to Vision Conference, an event designed to bring trauma to the foreground and the first national conference in which women trauma survivors talked about their experiences and ways in which standard practices in hospitals re-traumatized and often, triggered memories of previous abuse. In 1998, SAMHSA funded the Women, Co-Occurring Disorders and Violence Study to generate knowledge on the development and evaluation of integrated services approaches for women with co-occurring mental and substance use disorders who also had histories of physical and or sexual abuse. In 2001, SAMHSA funded the National Child Traumatic Stress Initiative to increase understanding of child trauma and develop effective interventions for children exposed to different types of traumatic events.

The American Psychiatric Association (APA) played an important role in defining trauma. Diagnostic criteria for traumatic stress disorders have been debated through several iterations of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with a new category of Trauma- and Stressor-Related Disorders, across the life-span, included in the recently released DSM-V (APA, 2013). Measures and inventories of trauma exposure, with both clinical and research applications, have proliferated since the 1970's.[18,19,20,21] National trauma research and practice centers have conducted significant work in the past few decades, further refining the concept of trauma, and developing effective trauma assessments and treatments.[22,23,24,25] With the advances in neuroscience, a biopsychosocial approach to traumatic experiences has begun to delineate the mechanisms in which neurobiology, psychological processes, and social attachment interact and contribute to mental and substance use disorders across the life-span.[3,25]

Simultaneously, an emerging trauma survivors movement has provided another perspective on the understanding of traumatic experiences. Trauma survivors, that is, people with lived experience of trauma, have powerfully and systematically documented their paths to recovery.[26] Traumatic experiences complicate a child's or an adult's capacity to make sense of their lives and to create meaningful consistent relationships in their families and communities.

Trauma survivors have powerfully and systematically documented their paths to recovery.

The convergence of the trauma survivor's perspective with research and clinical work has underscored the central role of traumatic experiences in the lives of people with mental and substance use conditions. The connection between trauma and these conditions offers a potential explanatory model for what has happened to individuals, both children and adults, who come to the attention of the behavioral health and other service systems.[25,27]

People with traumatic experiences, however, do not show up only in behavioral health systems. Responses to these experiences often manifest in behaviors or conditions that result in involvement with the child welfare and the criminal and juvenile justice system or in difficulties in the education, employment or primary care system. Recently, there has also been a focus on individuals in the military and increasing rates of posttraumatic stress disorders.[28,29,30,31]

With the growing understanding of the pervasiveness of traumatic experience and responses, a growing number of clinical interventions for trauma responses have been developed. Federal research agencies, academic institutions and practice-research partnerships have generated empirically-supported interventions. In SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) alone there are over 15 interventions focusing on the treatment or screening for trauma.

These interventions have been integrated into the behavioral health treatment care delivery system; however, from the voice of trauma survivors, it has become clear that these clinical interventions are not enough. Building on lessons learned from SAMHSA's Women, Co-Occurring Disorders and Violence Study; SAMHSA's National Child Traumatic Stress Network; and SAMHSA's National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraints, among other developments in the field, it became clear that the organizational climate and conditions in which services are provided played a significant role in maximizing the outcomes of interventions and contributing to the healing and recovery of the people being served. SAMHSA's National Center for Trauma-Informed Care has continued to advance this effort, starting first in the behavioral health sector, but increasingly responding to technical assistance requests for organizational change in the criminal justice, education, and primary care sectors.

FEDERAL, STATE AND LOCAL LEVEL TRAUMA-FOCUSED ACTIVITIES

The increased understanding of the pervasiveness of trauma and its connections to physical and behavioral health and well-being, have propelled a growing number of organizations and service systems to explore ways to make their services more responsive to people who have experienced trauma. This has been happening in state and local systems and federal agencies.

States are elevating a focus on trauma. For example, Oregon Health Authority is looking at different types of trauma across the age span and different population groups. Maine's "Thrive Initiative" incorporates a trauma-informed care focus in their children's systems of care. New York is introducing a trauma-informed initiative in the juvenile justice system. Missouri is exploring a trauma-informed approach for their adult mental health system. In Massachusetts, the Child Trauma Project is focused on taking trauma-informed care statewide in child welfare practice. In Connecticut the Child Health and Development Institute with the state Department of Children and Families is building a trauma-informed system of care throughout the state through policy and workforce development. SAMHSA has supported the further development of trauma-informed approaches through its Mental Health Transformation Grant program directed to State and local governments.

Increasing examples of local level efforts are being documented. For example, the City of Tarpon Springs in Florida has taken significant steps in becoming a trauma-informed community. The city made it its mission to promote a widespread awareness of the costly effects of personal adversity upon the wellbeing of the community. The Family Policy Council in Washington State convened groups to focus on the impact of adverse childhood experiences on the health and well-being of its local communities and tribal communities. Philadelphia held a summit to further its understanding of the impact of trauma and violence on the psychological and physical health of its communities.

SAMHSA continues its support of grant programs that specifically address trauma.

At the federal level, SAMHSA continues its support of grant programs that specifically address trauma and technical assistance centers that focus on prevention, treatment and recovery from trauma.

Other federal agencies have increased their focus on trauma. The Administration on Children Youth and Families (ACYF) has focused on the complex trauma of children in the child welfare system and how screening and assessing for severity of trauma and linkage with trauma treatments can contribute to improved well-being for these youth. In a joint effort among ACYF, SAMHSA and the Centers for Medicare and Medicaid Services (CMS), the three agencies developed and issued through the CMS State Directors' mechanism, a letter to all State Child Welfare Administrators, Mental Health Commissioners, Single State Agency Directors for Substance Abuse and State Medicaid Directors discussing trauma, its impact on children, screening, assessment and treatment interventions and strategies for paying for such care. The Office of Juvenile Justice and Delinquency Prevention has specific recommendations to address trauma in their Children Exposed to Violence Initiative. The Office of Women's Health has developed a curriculum to train providers in primary care on how to address trauma issues in health care for women. The Department of Labor is examining trauma and the workplace through a federal interagency workgroup. The Department of Defense is honing in on prevention of sexual violence and trauma in the military.

As multiple federal agencies representing varied sectors have recognized the impact of traumatic experiences on the children, adults, and families they serve, they have requested collaboration with SAMHSA in addressing these issues. The widespread recognition of the impact of trauma and the burgeoning interest in developing capacity to respond through trauma-informed approaches compelled SAMHSA to revisit its conceptual framework and approach to trauma, as well as its applicability not only to behavioral health but also to other related fields.

SAMHSA's Concept of Trauma

Decades of work in the field of trauma have generated multiple definitions of trauma. Combing through this work, SAMHSA developed an inventory of trauma definitions and recognized that there were subtle nuances and differences in these definitions.

Desiring a concept that could be shared among its constituencies — practitioners, researchers, and trauma survivors, SAMHSA turned to its expert panel to help craft a concept that would be relevant to public health agencies and service systems. SAMHSA aims to provide a viable framework that can be used to support people receiving services, communities, and stakeholders in the work they do. A review of the existing definitions and discussions of the expert panel generated the following concept:

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

THE THREE "E'S" OF TRAUMA: EVENT(S), EXPERIENCE OF EVENT(S), AND EFFECT

Events and circumstances may include the actual or extreme threat of physical or psychological harm (i.e. natural disasters, violence, etc.) or severe, life-threatening neglect for a child that imperils healthy development. These events and circumstances may occur as a single occurrence or repeatedly over time. This element of SAMHSA's concept of trauma is represented in the fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which requires all conditions classified as "trauma and stressor-related disorders" to include exposure to a traumatic or stressful event as a diagnostic criterion.

The individual's **experience** of these events or circumstances helps to determine whether it is a traumatic event. A particular event may be experienced as traumatic for one individual and not for another (e.g., a child removed from an abusive home experiences this differently than their sibling; one refugee may experience fleeing one's country differently from another refugee; one military veteran may experience deployment to a war zone as traumatic while another veteran is not similarly affected). How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic. Traumatic events by their very nature set up a power differential where one entity (whether an individual, an event, or a force of nature) has power over another. They elicit a profound question of "why me?" The individual's experience of these events or circumstances is shaped in the context of this powerlessness and questioning. Feelings of humiliation, guilt, shame, betrayal, or silencing often shape the experience of the event. When a person experiences physical or sexual abuse, it is often accompanied by a sense of humiliation, which can lead the person to feel as though they are bad or dirty, leading to a sense of self blame, shame and guilt. In cases of war or natural disasters, those who survived the traumatic event may blame themselves for surviving when others did not. Abuse by a trusted caregiver frequently gives rise to feelings of betrayal, shattering a person's trust and leaving them feeling alone. Often, abuse of children and domestic violence are accompanied by threats that lead to silencing and fear of reaching out for help.

How the event is experienced may be linked to a range of factors including the individual's cultural beliefs (e.g., the subjugation of women and the experience of domestic violence), availability of social supports (e.g., whether isolated or embedded in a supportive family or community structure), or to the developmental stage of the individual (i.e., an individual may understand and experience events differently at age five, fifteen, or fifty).[1]

The long-lasting adverse **effects** of the event are a critical component of trauma. These adverse effects may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. In some situations, the individual may not recognize the connection between the traumatic events and the effects. Examples of adverse effects include an individual's inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; to manage cognitive processes, such as memory, attention, thinking; to regulate behavior; or to control the expression of emotions. In addition to these more visible effects, there may be an altering of one's neurobiological make-up and ongoing health and well-being. Advances in neuroscience and an increased understanding of the interaction of neurobiological and environmental factors have documented the effects of such threatening events.[1,3] Traumatic effects, which may range from hyper-vigilance or a constant state of arousal, to numbing or avoidance, can eventually wear a person down, physically, mentally, and emotionally. Survivors of trauma have also highlighted the impact of these events on spiritual beliefs and the capacity to make meaning of these experiences.

SAMHSA's Trauma-Informed Approach: Key Assumptions and Principles

Trauma researchers, practitioners and survivors have recognized that the understanding of trauma and trauma-specific interventions is not sufficient to optimize outcomes for trauma survivors nor to influence how service systems conduct their business.

The context in which trauma is addressed or treatments deployed contributes to the outcomes for the trauma survivors, the people receiving services, and the individuals staffing the systems. Referred to variably as "trauma-informed care" or "trauma-informed approach" this framework is regarded as essential to the context of care.[22,32,33] SAMHSA's concept of a trauma-informed approach is grounded in a set of four assumptions and six key principles.

***A program, organization, or system that is trauma-informed* realizes *the widespread impact of trauma and understands potential paths for recovery;* recognizes *the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and* responds *by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively* resist re-traumatization.**

A trauma informed approach is distinct from trauma-specific services or trauma systems. A trauma informed approach is inclusive of trauma-specific interventions, whether assessment, treatment or recovery supports, yet it also incorporates key trauma principles into the organizational culture.

Referred to variably as "trauma-informed care" or "trauma-informed approach" this framework is regarded as essential to the context of care.

THE FOUR "R'S: KEY ASSUMPTIONS IN A TRAUMA-INFORMED APPROACH

In a trauma-informed approach, all people at all levels of the organization or system have a basic **realization** about trauma and understand how trauma can affect families, groups, organizations, and communities as well as individuals. People's experience and behavior are understood in the context of coping strategies designed to survive adversity and overwhelming circumstances, whether these occurred in the past (i.e., a client dealing with prior child abuse), whether they are currently manifesting (i.e., a staff member living with domestic violence in the home), or whether they are related to the emotional distress that results in hearing about the firsthand experiences of another (i.e., secondary traumatic stress experienced by a direct care professional).There is an understanding that trauma plays a role in mental and substance use disorders and should be systematically addressed in prevention, treatment, and recovery settings. Similarly, there is a realization that trauma is not confined to the behavioral health specialty service sector, but is integral to other systems (e.g., child welfare, criminal justice, primary health care, peer–run and community organizations) and is often a barrier to effective outcomes in those systems as well.

People in the organization or system are also able to **recognize** the signs of trauma. These signs may be gender, age, or setting-specific and may be manifest by individuals seeking or providing services in these settings. Trauma screening and assessment assist in the recognition of trauma, as do workforce development, employee assistance, and supervision practices.

The program, organization, or system **responds** by applying the principles of a trauma-informed approach to all areas of functioning. The program, organization, or system integrates an understanding that the experience of traumatic events impacts all people involved, whether directly or indirectly. Staff in every part of the organization, from the person who greets clients at the door to the executives and the governance board, have changed their language, behaviors and policies to take into consideration the experiences of trauma among children and adult users of the services and among staff providing the services. This is accomplished through staff training, a budget that supports this ongoing training, and leadership that realizes the role of trauma in the lives of their staff and the people they serve. The organization has practitioners trained in evidence-based trauma practices. Policies of the organization, such as mission statements, staff handbooks and manuals promote a culture based on beliefs about resilience, recovery, and healing from trauma. For instance, the agency's mission may include an intentional statement on the organization's commitment to promote trauma recovery; agency policies demonstrate a commitment to incorporating perspectives of people served through the establishment of client advisory boards or inclusion of people who have received services on the agency's board of directors; or agency training includes resources for mentoring supervisors on helping staff address secondary traumatic stress. The organization is committed to providing a physically and psychologically safe environment. Leadership ensures that staff work in an environment that promotes trust, fairness and transparency. The program's, organization's, or system's response involves a universal precautions approach in which one expects the presence of trauma in lives of individuals being served, ensuring not to replicate it.

A trauma-informed approach seeks to **resist re-traumatization** of clients as well as staff. Organizations often inadvertently create stressful or toxic environments that interfere with the recovery of clients, the well-being of staff and the fulfillment of the organizational mission.[27] Staff who work within a trauma-informed environment are taught to recognize how organizational practices may trigger painful memories and re-traumatize clients with trauma histories. For example, they recognize that using restraints on a person who has been sexually abused or placing a child who has been neglected and abandoned in a seclusion room may be re-traumatizing and interfere with healing and recovery.

SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific.

SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

1. **Safety**
2. **Trustworthiness and Transparency**
3. **Peer Support**
4. **Collaboration and Mutuality**
5. **Empowerment, Voice and Choice**
6. **Cultural, Historical, and Gender Issues**

From SAMHSA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration.

The six key principles fundamental to a trauma-informed approach include:[24,36]

1. **Safety:** Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority.

2. **Trustworthiness and Transparency:** Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with clients and family members, among staff, and others involved in the organization.

3. **Peer Support:** Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing. The term "Peers" refers to individuals with lived experiences of trauma, or in the case of children this may be family members of children who have experienced traumatic events and are key caregivers in their recovery. Peers have also been referred to as "trauma survivors."

4. **Collaboration and Mutuality:** Importance is placed on partnering and the leveling of power differences between staff and clients and among organizational staff from clerical and housekeeping personnel, to professional staff to administrators, demonstrating that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. As one expert stated: "one does not have to be a therapist to be therapeutic."[12]

5. **Empowerment, Voice and Choice:** Throughout the organization and among the clients served, individuals' strengths and experiences are recognized and built upon. The organization fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. The organization understands that the experience of trauma may be a unifying aspect in the lives of those who run the organization, who provide the services, and/or who come to the organization for assistance and support. As such, operations, workforce development and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice and choice and are often recipients of coercive treatment. Clients are supported in shared decision-making, choice, and goal setting to determine the plan of action they need to heal and move forward. They are supported in cultivating self-advocacy skills. Staff are facilitators of recovery rather than controllers of recovery.[34] Staff are empowered to do their work as well as possible by adequate organizational support. This is a parallel process as staff need to feel safe, as much as people receiving services.

6. **Cultural, Historical, and Gender Issues:** The organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender-identity, geography, etc.); offers, access to gender responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma.

Guidance for Implementing a Trauma-Informed Approach

Developing a trauma-informed approach requires change at multiples levels of an organization and systematic alignment with the six key principles described above. The guidance provided here builds upon the work of Harris and Fallot and in conjunction with the key principles, provides a starting point for developing an organizational trauma-informed approach.[20] While it is recognized that not all public institutions and service sectors attend to trauma as an aspect of how they conduct business, understanding the role of trauma and a trauma-informed approach may help them meet their goals and objectives. Organizations, across service-sectors and systems, are encouraged to examine how a trauma-informed approach will benefit all stakeholders; to conduct a trauma-informed organizational assessment and change process; and to involve clients and staff at all levels in the organizational development process.

The guidance for implementing a trauma-informed approach is presented in the ten domains described below. This is not provided as a "checklist" or a prescriptive step-by-step process. These are the domains of organizational change that have appeared both in the organizational change management literature and among models for establishing trauma-informed care.[35,36,37,38] What makes it unique to establishing a trauma-informed organizational approach is the cross-walk with the key principles and trauma-specific content.

TEN IMPLEMENTATION DOMAINS

1. **Governance and Leadership**
2. **Policy**
3. **Physical Environment**
4. **Engagement and Involvement**
5. **Cross Sector Collaboration**
6. **Screening, Assessment, Treatment Services**
7. **Training and Workforce Development**
8. **Progress Monitoring and Quality Assurance**
9. **Financing**
10. **Evaluation**

GOVERNANCE AND LEADERSHIP: The leadership and governance of the organization support and invest in implementing and sustaining a trauma-informed approach; there is an identified point of responsibility within the organization to lead and oversee this work; and there is inclusion of the peer voice. A champion of this approach is often needed to initiate a system change process.

POLICY: There are written policies and protocols establishing a trauma-informed approach as an essential part of the organizational mission. Organizational procedures and cross agency protocols, including working with community-based agencies, reflect trauma-informed principles. This approach must be "hard-wired" into practices and procedures of the organization, not solely relying on training workshops or a well-intentioned leader.

PHYSICAL ENVIRONMENT OF THE ORGANIZATION: The organization ensures that the physical environment promotes a sense of safety and collaboration. Staff working in the organization and individuals being served must experience the setting as safe, inviting, and not a risk to their physical or psychological safety. The physical setting also supports the collaborative aspect of a trauma informed approach through openness, transparency, and shared spaces.

ENGAGEMENT AND INVOLVEMENT OF PEOPLE IN RECOVERY, TRAUMA SURVIVORS, PEOPLE RECEIVING SERVICES, AND FAMILY MEMBERS RECEIVING SERVICES: These groups have significant involvement, voice, and meaningful choice at all levels and in all areas of organizational functioning (e.g., program design, implementation, service delivery, quality assurance, cultural competence, access to trauma-informed peer support, workforce development, and evaluation.) This is a key value and aspect of a trauma-informed approach that differentiates it from the usual approaches to services and care.

CROSS SECTOR COLLABORATION: Collaboration across sectors is built on a shared understanding of trauma and principles of a trauma-informed approach. While a trauma focus may not be the stated mission of various service sectors, understanding how awareness of trauma can help or hinder achievement of an organization's mission is a critical aspect of building collaborations. People with significant trauma histories often present with a complexity of needs, crossing various service sectors. Even if a mental health clinician is trauma-informed, a referral to a trauma-insensitive program could then undermine the progress of the individual.

SCREENING, ASSESSMENT, AND TREATMENT SERVICES: Practitioners use and are trained in interventions based on the best available empirical evidence and science, are culturally appropriate, and reflect principles of a trauma-informed approach. Trauma screening and assessment are an essential part of the work. Trauma-specific interventions are acceptable, effective, and available for individuals and families seeking services. When trauma-specific services are not available within the organization, there is a trusted, effective referral system in place that facilitates connecting individuals with appropriate trauma treatment.

TRAINING AND WORKFORCE DEVELOPMENT: On-going training on trauma and peer-support are essential. The organization's human resource system incorporates trauma-informed principles in hiring, supervision, staff evaluation; procedures are in place to support staff with trauma histories and/or those experiencing significant secondary traumatic stress or vicarious trauma, resulting from exposure to and working with individuals with complex trauma.

PROGRESS MONITORING AND QUALITY ASSURANCE: There is ongoing assessment, tracking, and monitoring of trauma-informed principles and effective use of evidence-based trauma specific screening, assessments and treatment.

FINANCING: Financing structures are designed to support a trauma-informed approach which includes resources for: staff training on trauma, key principles of a trauma-informed approach; development of appropriate and safe facilities; establishment of peer-support; provision of evidence-supported trauma screening, assessment, treatment, and recovery supports; and development of trauma-informed cross-agency collaborations.

EVALUATION: Measures and evaluation designs used to evaluate service or program implementation and effectiveness reflect an understanding of trauma and appropriate trauma-oriented research instruments.

To further guide implementation, the chart on the next page provides sample questions in each of the ten domains to stimulate change-focused discussion. The questions address examples of the work to be done in any particular domain yet also reflect the six key principles of a trauma-informed approach. Many of these questions and concepts were adapted from the work of Fallot and Harris, Henry, Black-Pond, Richardson, & Vandervort, Hummer and Dollard, and Penney and Cave.[39, 40, 41,42]

While the language in the chart may seem more familiar to behavioral health settings, organizations across systems are encouraged to adapt the sample questions to best fit the needs of the agency, staff, and individuals being served. For example, a juvenile justice agency may want to ask how it would incorporate the principle of safety when examining its physical environment. A primary care setting may explore how it can use empowerment, voice, and choice when developing policies and procedures to provide trauma-informed services (e.g. explaining step by step a potentially invasive procedure to a patient at an OBGYN office).

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH

KEY PRINCIPLES					
Safety	**Trustworthiness and Transparency**	**Peer Support**	**Collaboration and Mutuality**	**Empowerment, Voice, and Choice**	**Cultural, Historical, and Gender Issues**
10 IMPLEMENTATION DOMAINS					
Governance and Leadership	• How does agency leadership communicate its support and guidance for implementing a trauma-informed approach? • How do the agency's mission statement and/or written policies and procedures include a commitment to providing trauma-informed services and supports? • How do leadership and governance structures demonstrate support for the voice and participation of people using their services who have trauma histories?				
Policy	• How do the agency's written policies and procedures include a focus on trauma and issues of safety and confidentiality? • How do the agency's written policies and procedures recognize the pervasiveness of trauma in the lives of people using services, and express a commitment to reducing re-traumatization and promoting well-being and recovery? • How do the agency's staffing policies demonstrate a commitment to staff training on providing services and supports that are culturally relevant and trauma-informed as part of staff orientation and in-service training? • How do human resources policies attend to the impact of working with people who have experienced trauma? • What policies and procedures are in place for including trauma survivors/people receiving services and peer supports in meaningful and significant roles in agency planning, governance, policy-making, services, and evaluation?				

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH *(continued)*

10 IMPLEMENTATION DOMAINS *continued*	
Physical Environment	• How does the physical environment promote a sense of safety, calming, and de-escalation for clients and staff? • In what ways do staff members recognize and address aspects of the physical environment that may be re-traumatizing, and work with people on developing strategies to deal with this? • How has the agency provided space that both staff and people receiving services can use to practice self-care? • How has the agency developed mechanisms to address gender-related physical and emotional safety concerns (e.g., gender-specific spaces and activities).
Engagement and Involvement	• How do people with lived experience have the opportunity to provide feedback to the organization on quality improvement processes for better engagement and services? • How do staff members keep people fully informed of rules, procedures, activities, and schedules, while being mindful that people who are frightened or overwhelmed may have a difficulty processing information? • How is transparency and trust among staff and clients promoted? • What strategies are used to reduce the sense of power differentials among staff and clients? • How do staff members help people to identify strategies that contribute to feeling comforted and empowered?
Cross Sector Collaboration	• Is there a system of communication in place with other partner agencies working with the individual receiving services for making trauma-informed decisions? • Are collaborative partners trauma-informed? • How does the organization identify community providers and referral agencies that have experience delivering evidence-based trauma services? • What mechanisms are in place to promote cross-sector training on trauma and trauma-informed approaches?
Screening, Assessment, Treatment Services	• Is an individual's own definition of emotional safety included in treatment plans? • Is timely trauma-informed screening and assessment available and accessible to individuals receiving services? • Does the organization have the capacity to provide trauma-specific treatment or refer to appropriate trauma-specific services? • How are peer supports integrated into the service delivery approach? • How does the agency address gender-based needs in the context of trauma screening, assessment, and treatment? For instance, are gender-specific trauma services and supports available for both men and women? • Do staff members talk with people about the range of trauma reactions and work to minimize feelings of fear or shame and to increase self-understanding? • How are these trauma-specific practices incorporated into the organization's ongoing operations?

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH *(continued)*

10 IMPLEMENTATION DOMAINS *continued*	
Training and Workforce Development	• How does the agency address the emotional stress that can arise when working with individuals who have had traumatic experiences? • How does the agency support training and workforce development for staff to understand and increase their trauma knowledge and interventions? • How does the organization ensure that all staff (direct care, supervisors, front desk and reception, support staff, housekeeping and maintenance) receive basic training on trauma, its impact, and strategies for trauma-informed approaches across the agency and across personnel functions? • How does workforce development/staff training address the ways identity, culture, community, and oppression can affect a person's experience of trauma, access to supports and resources, and opportunities for safety? • How does on-going workforce development/staff training provide staff supports in developing the knowledge and skills to work sensitively and effectively with trauma survivors. • What types of training and resources are provided to staff and supervisors on incorporating trauma-informed practice and supervision in their work? • What workforce development strategies are in place to assist staff in working with peer supports and recognizing the value of peer support as integral to the organization's workforce?
Progress Monitoring and Quality Assurance	• Is there a system in place that monitors the agency's progress in being trauma-informed? • Does the agency solicit feedback from both staff and individuals receiving services? • What strategies and processes does the agency use to evaluate whether staff members feel safe and valued at the agency? • How does the agency incorporate attention to culture and trauma in agency operations and quality improvement processes? • What mechanisms are in place for information collected to be incorporated into the agency's quality assurance processes and how well do those mechanisms address creating accessible, culturally relevant, trauma-informed services and supports?
Financing	• How does the agency's budget include funding support for ongoing training on trauma and trauma-informed approaches for leadership and staff development? • What funding exists for cross-sector training on trauma and trauma-informed approaches? • What funding exists for peer specialists? • How does the budget support provision of a safe physical environment?
Evaluation	• How does the agency conduct a trauma-informed organizational assessment or have measures or indicators that show their level of trauma-informed approach? • How does the perspective of people who have experienced trauma inform the agency performance beyond consumer satisfaction survey? • What processes are in place to solicit feedback from people who use services and ensure anonymity and confidentiality? • What measures or indicators are used to assess the organizational progress in becoming trauma-informed?

Next Steps: Trauma in the Context of Community

Delving into the work on community trauma is beyond the scope of this document and will be done in the next phase of this work. However, recognizing that many individuals cope with their trauma in the safe or not-so safe space of their communities, it is important to know how communities can support or impede the healing process.

Trauma does not occur in a vacuum. Individual trauma occurs in a context of community, whether the community is defined geographically as in neighborhoods; virtually as in a shared identity, ethnicity, or experience; or organizationally, as in a place of work, learning, or worship. How a community responds to individual trauma sets the foundation for the impact of the traumatic event, experience, and effect. Communities that provide a context of understanding and self-determination may facilitate the healing and recovery process for the individual. Alternatively, communities that avoid, overlook, or misunderstand the impact of trauma may often be re-traumatizing and interfere with the healing process. Individuals can be re-traumatized by the very people whose intent is to be helpful. This is one way to understand trauma in the context of a community.

A second and equally important perspective on trauma and communities is the understanding that communities as a whole can also experience trauma. Just as with the trauma of an individual or family, a community may be subjected to a community-threatening event, have a shared experience of the event, and have an adverse, prolonged effect. Whether the result of a natural disaster (e.g., a flood, a hurricane or an earthquake) or an event or circumstances inflicted by one group on another (e.g., usurping homelands, forced relocation, servitude, or mass incarceration, ongoing exposure to violence in the community), the resulting trauma is often transmitted from one generation to the next in a pattern often referred to as historical, community, or intergenerational trauma.

Communities can collectively react to trauma in ways that are very similar to the ways in which individuals respond. They can become hyper-vigilant, fearful, or they can be re-traumatized, triggered by circumstances resembling earlier trauma. Trauma can be built into cultural norms and passed from generation to generation. Communities are often profoundly shaped by their trauma histories. Making sense of the trauma experience and telling the story of what happened using the language and framework of the community is an important step toward healing community trauma.

Many people who experience trauma readily overcome it and continue on with their lives; some become stronger and more resilient; for others, the trauma is overwhelming and their lives get derailed. Some may get help in formal support systems; however, the vast majority will not. The manner in which individuals and families can mobilize the resources and support of their communities and the degree to which the community has the capacity, knowledge, and skills to understand and respond to the adverse effects of trauma has significant implications for the well-being of the people in their community.

Conclusion

As the concept of a trauma-informed approach has become a central focus in multiple service sectors, SAMHSA desires to promote a shared understanding of this concept. The working definitions, key principles, and guidance presented in this document represent a beginning step toward clarifying the meaning of this concept. This document builds upon the extensive work of researchers, practitioners, policymakers, and people with lived experience in the field. A standard, unified working concept will serve to advance the understanding of trauma and a trauma-informed approach for public institutions and service sectors.

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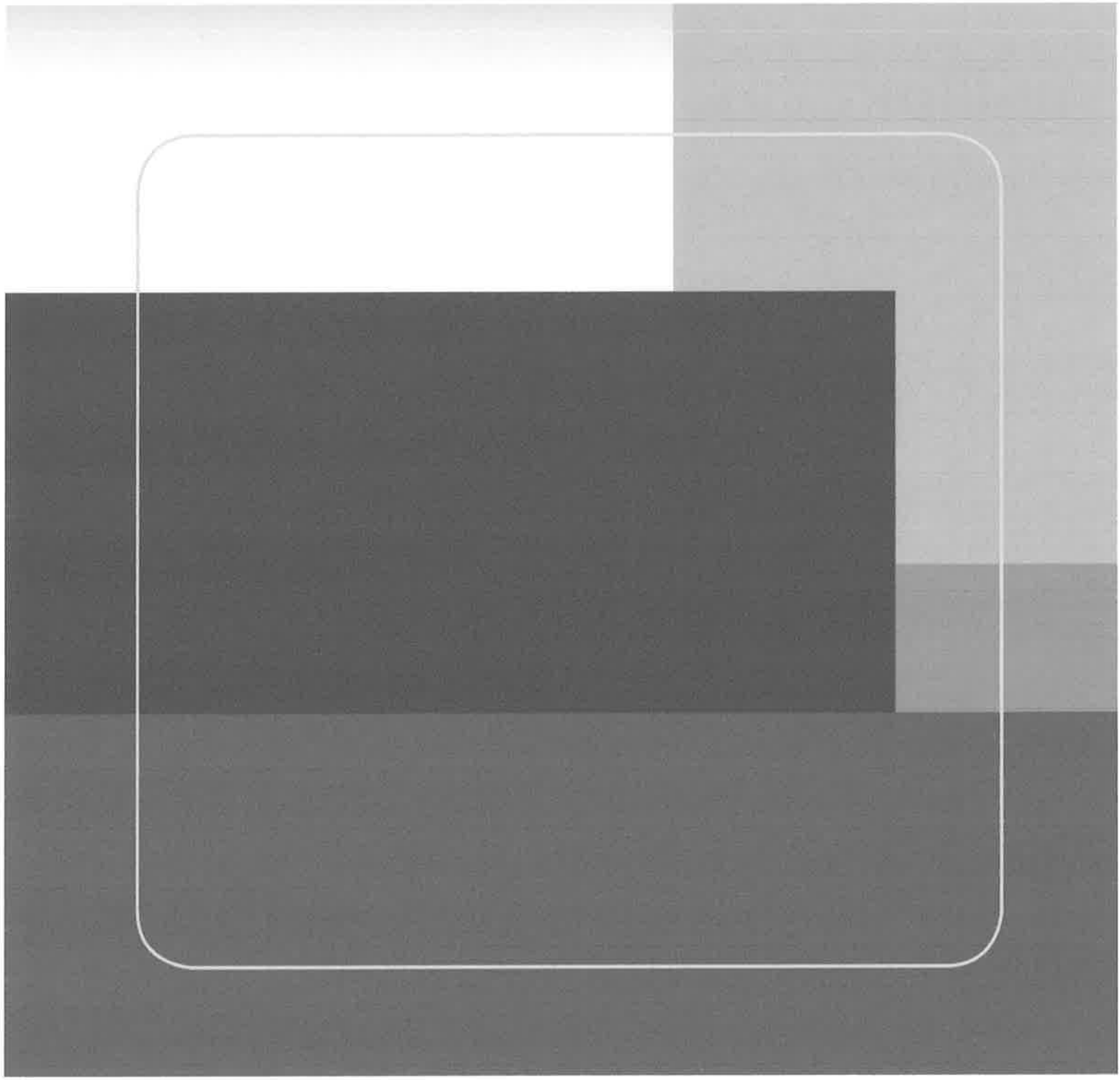
Paper Submitted by: SAMHSA's Internal Trauma and Trauma-Informed Care Work Group with support from CMHS Contract: National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint.

A very special thank you to the Expert Panelists for their commitment and expertise in advancing evidence-based and best practice models for the implementation of trauma-informed approaches and practices.



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SMA 14-4884
First printed 2014

Self-Care Inventory

Rate the following areas in frequency:

5 = frequently
4 = occasionally
3 = rarely
2 = never
1 = it never occurred to me

Physical Self-Care	5	4	3	2	1
Eat regularly (e.g. breakfast, lunch and dinner)					
Eat healthy foods					
Exercise consistently					
Get regular medical care for prevention					
Get medical care when necessary					
Take time off when sick					
Dance, swim, walk, run, play sports, sing or do some other physical activity that is enjoyable to self					
Take time to be sexual					
Get enough sleep					
Take vacations					
Wear clothes you like					
Take day trips or mini-vacations					
Make time away from telephones					
Other:					

Psychological Self-Care	5	4	3	2	1
Make time for self-reflection					
Engage in personal psychotherapy					
Write in a journal					
Read literature that is unrelated to work					
Do something in which you are not an expert or in charge					
Cope with stress in personal and/or work life					
Notice inner experience (e.g. listen to and recognize thoughts, judgments, beliefs, attitudes and feelings)					
Provide others with different aspects of self (e.g. communicate needs and wants)					
Try new things					
Practice receiving from others					
Improve ability to say "no" to extra responsibilities					
Other:					

Emotional Self-Care	5	4	3	2	1
Allow for quality time with others whose company you enjoy					
Maintain contact with valued others					
Give self affirmations and praise					
Love self					
Reread favorite book or review favorite movies					
Identify and engage in comforting activities, objects, people, relationships and places					
Allow for feeling expression (laugh, cry, etc.…)					
Other:					

Spiritual Self-Care	5	4	3	2	1
Allow time for reflection					
Spend time with nature					
Participate in a spiritual community					
Open to inspiration					
Cherish own optimism and hope					
Be aware of nonmaterial aspects of life					
Cultivate ability to identify what is meaningful and its place in personal life					
Meditate/pray					
Contribute to causes in which you believe					
Read inspirational literatures (lectures, music, etc.)					
Other:					

Workplace or Professional Self-Care	5	4	3	2	1
Allow for breaks during the workday					
Engage with co-workers					
Provide self quiet time/space to complete tasks					
Participate in projects or tasks that are exciting and rewarding					
Set limits/boundaries with clients and colleagues					
Balance workload/cases					
Arrange work space for comfort					
Maintain regular supervision or consultation					
Negotiate needs (benefits, bonuses, raise, etc.)					
Participate in peer support group					
Other:					

Adapted from Child Welfare Training Toolkit, March 2008. Original source unknown

A 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. 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 affective 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-Palumberc, & 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 story-telling 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 prolong 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. Elhers 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 "mentalize" 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 <u>not</u> 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 THERAPEUTIC RELATIONSHIP AS A COMMON FACTOR: IMPLICATIONS FOR TRAUMA THERAPY

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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:[i]

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.** [ii] 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), Keijsers 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, significantly more than does the specific type of therapy (Duncan et al. 2009). 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 story-telling 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.

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[i] 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.

[ii] 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.

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IMPORTANT FACTS ABOUT RESILIENCE: A CONSIDERATION OF RESEARCH FINDINGS ABOUT RESILIENCE and IMPLICATIONS FOR ASSESSMENT AND TREATMENT

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THE NATURE OF THE CHALLENGE

About 1 in 8 children under the age of 17 reported some form of serious maltreatment by adults in the last year.

Approximately 3.6 million of children received an investigation by a service agency for child maltreatment.

It is estimated that 20 million children live in households with an addicted caregiver and of these approximately 675,000 are suspected of being abused and neglected.

Up to 10 million children are believed to be exposed to domestic violence annually. For example, in California it is estimated that 10%-20% of all family homicides are witnessed by children.

Such stressors are compounded by poverty. 25% of children (some 15 million) in the U.S. live below the poverty line.

Research indicates that ½ to 2/3 of children living in such extreme circumstances grow up and "overcome the odds" and go on to achieve successful and well adjusted lives.

Only about one-third of abused and neglected children in clinical settings meet diagnostic criteria for PTSD or what is being called a Developmental Trauma Disorder (van der Kolk; 2005, Psychiatric Annals, 35, 401-408).

This Conference is designed to explore what factors contribute to such resilience. Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress. Resilience is not a trait that individuals either have or do not have. Resilience involves behaviors, thoughts and accompanying feelings that can be nurtured, developed and learned.

WHAT IS RESILIENCE

RESILIENCE is the capacity of people to effectively cope with, adjust, or recover from stress or adversity.

RESILIENCE is the process and outcome of successfully adapting to difficult or challenging life experiences and the ability to rise above one's circumstances.

RESILIENCE reflects the ability to confront and handle stressful life events, ongoing adversities and difficulties, and traumatic experiences, both while deployed and also when reintegrating into civilian life.

RESILIENCE reflects the ability to maintain a stable equilibrium and relatively stable healthy level of psychological and physical functioning, even in the face of highly disruptive stressful and traumatic events.

RESILIENCE reflects the ability to

- bounce back
- beat the odds
- transform one's emotional and physical pain into something "positive"
- evidence a relatively stable trajectory of healthy functioning across time
- move from being a victim to being a "survivor" and even to becoming a "thriver"
- be "stress hardy" adapting to whatever life sends, and for some, even evidencing "post- traumatic growth"

As a result of experiencing traumatic events, some individuals will experience **POST-TRAUMATIC GROWTH (PTG)**. PTG is the ability to experience positive personal changes that result from the struggle to deal with trauma and its consequences. PTG highlights that strengths can emerge through suffering and struggles with adversities. Individuals may develop a renewed appreciation of life and a commitment to live life to the fullest, valuing each day; improved relationships with loved ones; a search for new possibilities and enhanced personal strengths and new spiritual changes. This **ROADMAP** to **RESILIENCE** project provides practical tools to increase your ability to develop Post-traumatic growth. Not only to **LEARN IT,** but **LIVE IT**.

Perhaps, the concept of **RESILIENCE** was best captured by Helen Keller who was born blind and deaf when she observed,

> ***"Although the world is full of suffering, it is also full of overcoming it."***

As one returning Vet commented:

> ***"Resilience is moving from taking orders or completing other people's missions to creating your own missions and bringing on-line your own decision-making abilities. I have a deeper meaning of life as a result of my deployments."***

As often observed:

> "***Man has never made a material more resilient than the human spirit.***"

SOME FACTS ABOUT RESILIENCE

Following a natural catastrophe or a traumatic event no one walks away unscathed by such events, but neither do most survivors succumb in the aftermath to despair. Most show remarkable levels of resilience.

The ceiling for harmful effects is about 30% of those exposed.

People are much more resilient under adverse conditions than they might have expected.

A person may be resilient in some situations and with some type of stressors, but not with other stressors.

Resilience may be available and more accessible to a person at one period of time in his/her life than at other times in his/her life. Individuals may go through periods of extreme distress, negative emotions and poor functioning and still emerge resilient.

Resilience is more accessible and available to some people than for others, but everyone can strengthen their resilience.

Resilience (positive emotions) and negative emotions can co-occur side-by-side.

Research indicates that individuals who have a ratio of 3 times as many experiences of positive emotions to 1 of negative emotions on a daily basis (3-to-1 ratio) are more likely to be resilient and have a successful reintegration.

Resilience does not come from rare and special or extraordinary qualities or processes. Resilience develops from the everyday magic of ordinary resources. Resilience is not a sign of exceptional strength, but a fundamental feature of normal, everyday coping skills.

There are many different pathways to resilience. A number of factors contribute to how well people adapt to adversities. Predominant among them are:

a) the perceived availability of social relationships and the ability to access and use social supports;

b) the degree of perceived personal control and the extent to which individuals focus their time and energies on tasks and situations over which they have some impact and influence;

c) the degree to which they can experience positive emotions and self-regulate negative emotions;

d) the ability to be cognitively flexible, using both direct-action problem-solving and emotionally-palliative acceptance skills, as the situations call for;

e) the ability to engage in activities that are consistent with one's values and life priorities that reflect a stake in the future;

There are many roads to travel and many forks along the pathway to resilience. It is possible to change course at many points.

Individuals who are low in resilience are at risk for experiencing stress, depression, anxiety and interpersonal difficulties.

A **RESILIENCE REINTEGRATION PROGRAM** can promote subjective well-being.

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LEVELS OF INTERVENTION

Universal (Primary Prevention) focuses on all students in a given population.

- Reduce Risk Factors, especially those tied to poverty.
- Conduct initial screening. See Adverse Childhood Experience Scale (ACE). Assess cumulative exposure to stressors.
- Focus on schools as a critical setting. "Report Card" for Principals. Do not implement programs that will exacerbate the situation. (***See Meichenbaum "How to make a violent youth - - www.melissainstitute.org)***.
- Improve school climate, school satisfaction and school connectedness and promote well-being (See reference list for illustrative programs).
- Bolster resilience-enhancing behaviors. Use "ordinary magic" procedures (***See Ann Master on resilience on www.melissainstitute.org).***

Selected (Secondary Prevention) comprised of more intensive interventions for those students who may be at risk for developing particular problems or those students who do not adequately respond to Universal strategies.

- Target at-risk students (offspring of "high-risk parents"; High ACE scoring students). For example see Cognitive-behavioral Intervention For Trauma in Schools - - CBITS. ***(See Marlene Wong on www.melissainstitute.org).***
- Use peer-based intervention programs.

Indicated (Tertiary Prevention) characterized by highly individualized specialized interventions for those who exhibit clear problems and also have not adequately responded to Universal and Selected levels of prevention and intervention.

- Provide wrap-around services, where indicated.
- Maintain continuity of care across the life-span.
- Build in evaluation.

For a discussion of evidence-based interventions to bolster resilience see D. Meichenbaum Bolstering resilience: Benefiting from lessons learned. This is available on www.melissainstitute.org. Click on Subject Index Resilience.

SOCIAL ECOLOGICAL MODEL

Illustrative Interventions at the Levels of Individual, Relationships, Community, Societal

At the Individual Level

Reduce risk exposure from conception onward

Nurture skill development - - attachment behaviors, emotional regulation, interpersonal competence, academic performance, especially reading comprehension competence, conflict resolution skills and skills needed to gain employment (Build in generalization guidelines in any training program).

Strengthen positive self-efficacy and future orientation ("I have …"; "I can …"; "I am …").

Put student in a "helper role" - - others, pet, foster child. Nurture empathy training.

Build on strengths and "islands of competence".

Offer health care programs that provide the building blocks for resilience.

At the Relationship Level

Provide home-visiting and parent training programs (compliance-discipline procedures; monitoring; attachment-enhancing behaviors; academic supportive behaviors).

Nurture school connectedness.

Provide mentoring programs ("Guardian Angels").

Encourage association with prosocial peers and positive role models.

At the Community Level

Encourage and reward voluntary community altruistic behaviors.

Support participation in prosocial community activities such as church attendance and other ties.

At the Societal Level

Support groups and initiate policies and that advocate for children like the Children's Movement of Florida ala the work of David Lawrence (***See http://childrensmovementflorida.org***).

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WEBSITES

www.devereauxearlychildhood.org

www.apa.org/helpcenter

http://Resilnet.uiuc.edu/library/grotb95b.html

www.asu.edu/resilience

CDC List of PROTECTIVE FACTORS FOR YOUTH VIOLENCE
(*See www.vetoviolence.org/pop*)

Protective Factors – factors that provide a buffer against risk for violence

Individual/Family/Peer/School

- High IQ
- High Grade Point Average
- Positive social orientation
- Intolerant attitude toward deviance
- Religiosity
- Connectedness to family or adults outside of the family
- Ability to discuss problems with parents
- Perceived parental expectations about school performance are high
- Frequent shared activities with parents
- Consistent presence of the parent during at least one of the following activities: when awakening; when arriving home from school; at evening mealtime; at bedtime
- Involvement in social activities with prosocial peers
- Connectedness and commitment to School
- Involvement in school activities

THE MELISSA INSTITUTE
For Violence Prevention and Treatment

Recommended Reading List

- The Courage to Heal – Bass and Davis
- Treating Abused Adolescents – Eliana Gil
- Helping Abused and Traumatized Children – Eliana Gil
- Treatment of Adult Survivors of Childhood Abuse – Eliana Gil
- Treating the Trauma of Rape – Edna Foa and Barbara Rothbaum
- Trauma and Recovery – Judith Herman
- Therapy for Adults Molested as Children – John Briere
- Child Abuse Trauma – John Briere
- The Secret Trauma – Diana Russell
- How Long Does it Hurt? – Cynthia Mather and Kristina Debye
- Treating Trauma and Traumatic Grief in Children and Adolescents – Cohen, Mannarino and Deblinger
- Waking the Tiger: Healing Trauma – Peter Levine
- The Post-Traumatic Stress Disorder Sourcebook – Schiraldi
- Transforming Trauma – Anna Salter