

WAYS TO BOLSTER RESILIENCE ACROSS THE LIFE-SPAN

FROM CHILDHOOD TO ADULTS

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BIOGRAPHICAL SKETCH

Donald Meichenbaum, Ph. D, is Distinguished Professor Emeritus, from the University of Waterloo, Ontario from which he took early retirement 25 years ago. Since then he has been the Research Director of the Melissa Institute for Violence Prevention and the Treatment of Victims of Violence in Miami. (Please visit www.melssainstitute.org). Dr. Meichenbaum is one of the founders of Cognitive behavior therapy and in a survey of clinicians, he was voted "one of the ten most influential psychotherapists of the 20th century." He has received a Lifetime Achievement Award from the Clinical Division of the American Psychological Association. He was the Honorary President of the Canadian Psychological Association. He has presented in all of the Canadian Provinces, in all 50 U.S. states, and internationally. He has published extensively and has authored several books including Roadmap to resilience that he has made available as a website for FREE (Please visit roadmaptoresilience.wordpress.com). His most recent article " How to spot HYPE in the field of psychotherapy " was chosen the best article in the field of psychotherapy. His latest book "Treating individuals with addiction disorders: A strengths-based workbook for patients and clinicians" is being published by Routledge Press. He celebrated his 80th birthday publishing "The evolution of cognitive behavior therapy: A personal and professional journey with Don Meichenbaum" (Routledge Press).

WHY YOU SHOULD ATTEND DON MEICHENBAUM'S WORKSHOP

"I'm writing to express my deep appreciation for your work, style, and influence, I have all of your books and frequently cite your articles. I am a sponge when it comes to your interventions and overall approach to therapy.

Please let me tell you how I have made a gift of your work to others. I own a large private practice. I have 90 therapists and interns working with me and we see thousands of clients every year. After I attended your workshop, I was so motivated that I decided to implement your model into the daily work we do with clients. I have been teaching your philosophy, using your handouts and books. I changed the way we keep our progress notes to reflect your Case Conceptualization Model and now require every therapist to complete a Case Conceptualization form for each case.

The therapists who work with me are at all different stages of the profession, from brand new students to experienced professionals and it has been amazing to watch them grasp your concepts and use them in their work. It is common to hear therapists talking to each other about how they use your procedures such as the Timelines to bolster their patient's resilience and how they used the Clock Metaphor to educate their patients to better understand the interconnections between feelings, thoughts and behaviors. I have noticed so much professional growth!"

FACTORS THAT INFLUENCE WHO DEVELOPS PTSD VERSUS THOSE WHO EVIDENCE RESILIENCE: IMPLICATIONS FOR TREATMENT

STIMULUS CHARACTERISTICS OF THE TRAUMATIC EVENTS

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

REACTIONS OR RESPONSE TO THE TRAUMA

(Symptomatic behaviors and level of functioning)

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

DEVELOPMENTAL VULNERABILITY FACTORS

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

RECOVERY ENVIRONMENT

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

Table 1

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

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

Table 2

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

Engage in self-focused cognitions that have a “victim” theme.

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

Hold beliefs.

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

Blame

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

Engage in comparisons.

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

Things to do.

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

What not to do.

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

IN CONTRAST RESILIENT INDIVIDUALS TEND TO:

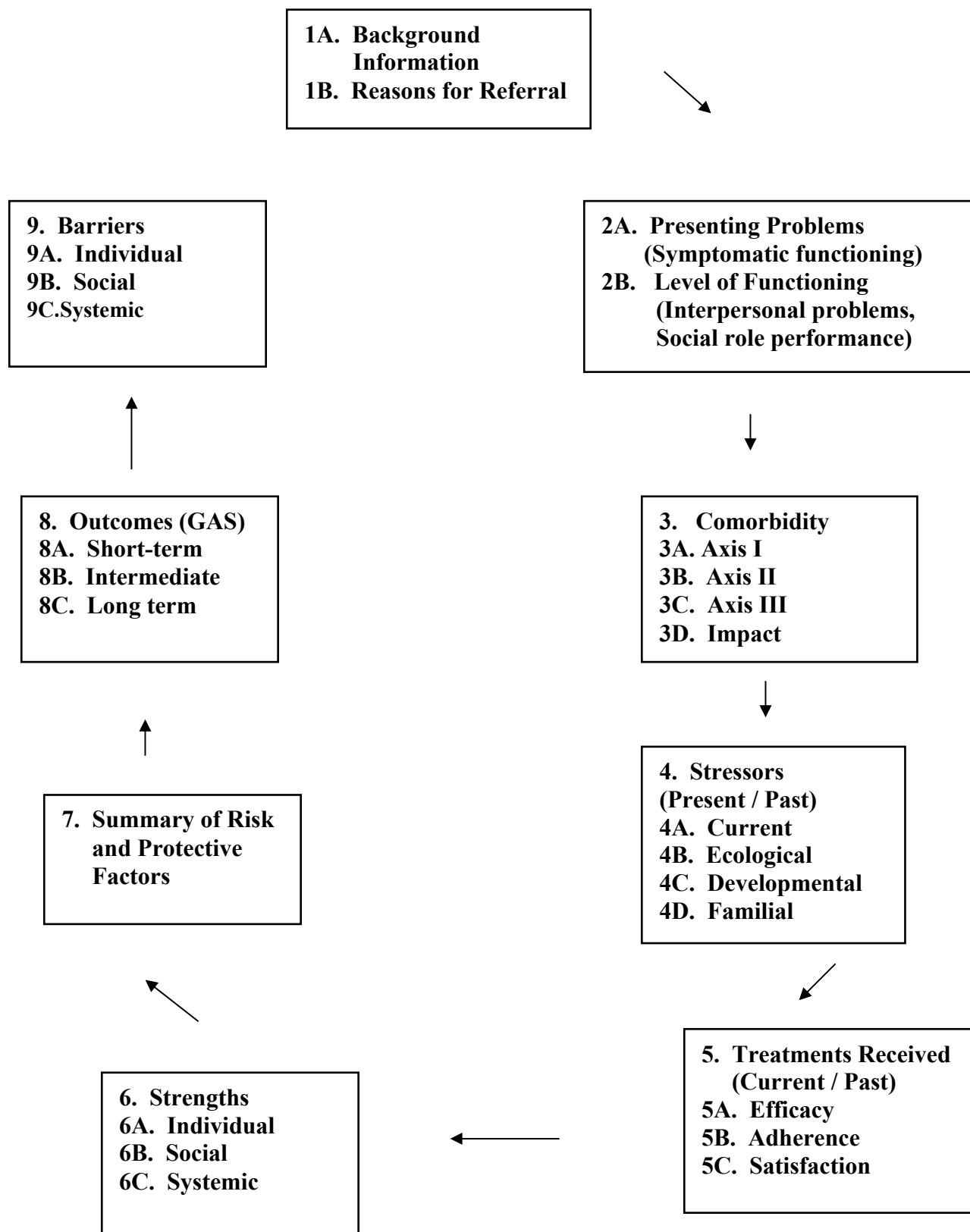
1. **Find and seek benefits that result from the trauma experience that may accrue to oneself and to others (benefit findings)"**
2. **Establish and maintain a future orientation.**
3. **Construct meaning (Use one's faith or spirituality).**
4. **Share their accounts with others and make a "gift" of their experience to others.**
5. **Undertake healing activities such as return to the site of the battle (Evidence courage and do "grief work" - - honoring those who were lost).**

Table 3

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

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

GENERIC CASE CONCEPTUALIZATION MODEL



FEEDBACK SHEET ON CASE CONCEPTUALIZATION

Let me see if I understand:

BOXES 1& 2: REFERRAL SOURCES AND PRESENTING PROBLEMS

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

BOX 3: COMORBIDITY

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

BOX 4: STRESSORS

- “Some of the factors (stresses) that you are currently experiencing that seem to maintain your problems are...or that seem to exacerbate (make worse) are... (Current/ecological stressors)
 “And it’s not only now, but this has been going on for some time, as evident by...” (Developmental stressors)
 “And it’s not only something you have experienced, but your family members have also been experiencing (struggling with)...” “And the impact on you has been...” (Familial stressors and familial psychopathology)

BOX 5: TREATMENT RECEIVED

- “For these problems the treatments that you have received were-note type, time, by whom”
 “And what was most effective (worked best) was... as evident by...
 “But you had difficulty following through with the treatment as evident by...” (Obtain an adherence history)
 “And some of the difficulties (barriers) in following the treatment were...”
 “But you were specifically satisfied with...and would recommend or consider...”

BOX 6: STRENGTHS

- “But in spite of...you have been able to...”
 “Some of the strengths (signs of resilience) that you have evidenced or that you bring to the present situation are...”
 “Moreover, some of the people (resources) you can call upon (access)are...” “And they can be helpful by doing...” (Social supports)
 “And some of the services you can access are...” (Systemic resources)

BOX 7: SUMMARY OF RISK AND PROTECTIVE FACTORS

- “Have I captured what you were saying?”
 (Summarize risk and protective factors)
 “Of these different areas, where do you think we should begin?” (Collaborate and negotiate with the patient a treatment plan. Do not become a “surrogate frontal lobe” for the patient)

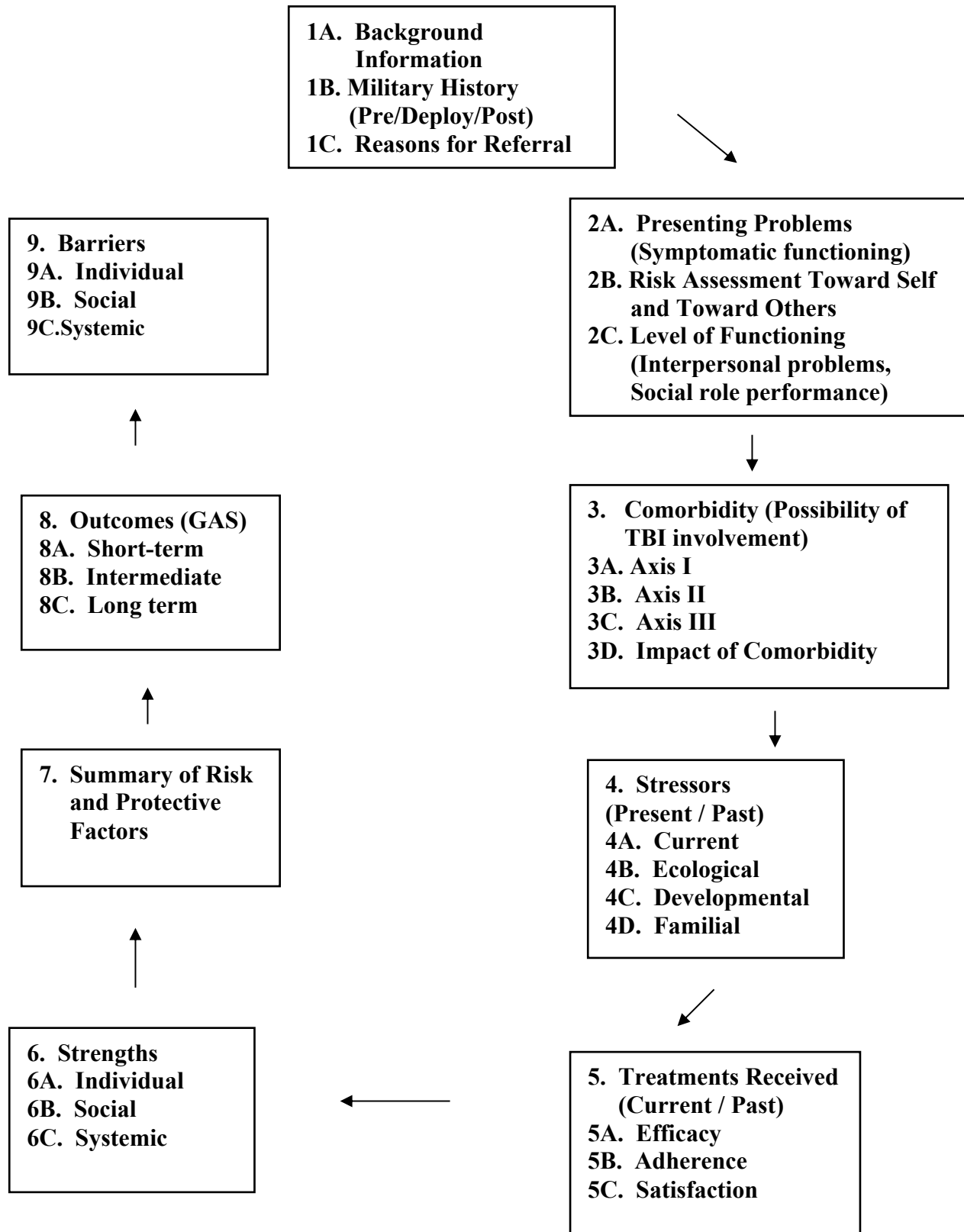
BOX 8: OUTCOMES (GOAL ATTAINMENT SCALING PROCEDURES)

- “Let’s consider what are your expectations about the treatment. As a result of our working together, what would you like to see change (in the short-term)?
 “How are things now in your life? How would you like them to be? How can we work together to help you achieve these short-term, intermediate and long-term goals?”
 “What has worked for you in the past?”
 “How can our current efforts be informed by your past experience?”
 “Moreover, if you achieve your goals, what would you see changed?”
 “Who else would notice these changes?”

BOX 9: POSSIBLE BARRIERS

- “Let me raise one last question, if I may. Can you envision, can you foresee, anything that might get in the way- any possible obstacles or barriers to your achieving your treatment goals?”
 (Consider with the patient possible individual, social and systemic barriers Do not address the potential barriers until some hope and resources have been addressed and documented.)
 “Let’s consider how we can anticipate, plan for, and address these potential barriers.”
 “Let us review once again...” (Go back over the Case Conceptualization and have the patient put the treatment plan in his/her own words.
 Involve significant others in the Case Conceptualization Model and treatment plan. Solicit their input and feedback.
 Reassess with the patient the treatment plan throughout treatment. Keep track of your treatment interventions using the coded activities (2A, 3B, 5B, 4C, 6B, etc) Maintain progress notes and share these with the patient and with other members of the treatment team.

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



OVERVIEW OF TREATMENT

INITIAL PHASE I

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

PHASE II – SKILLS BUILDING

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

PHASE III – “MEMORY WORK” AND FIND MEANING

- Address issues of memory and meaning
- Use Exposure-based Procedures (Imaginal and In vivo)

- Use “Rethinking” activities: Cognitive Restructuring (e.g., guilt, shame)
- Transform trauma – help the patient find meaning: Use rituals, journaling, letter writing, role of spirituality
- Help the patient develop and mobilize supportive relationships
- Involve significant others as part of treatment; Nurture “connectedness”

PHASE IV – TERMINATION

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

USE CLOCK METAPHOR

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

1. Place hand at 9 o'clock and move around imaginary clock and say "It sounds like a vicious...". Allow client to finish this sentence with "cycle" or "circle". Explore how his/her account fits a "vicious cycle".
2. Treat 3 o'clock primary and secondary emotions as a "commodity". What does the client do with all of his/her feelings. For example, "stuff them", "drink them away", "act out".
3. If that is what he/she does with such emotions, ask, "What is the impact, toll, price he/she and others pay, as a result? If the client answers, "I do not know", then the therapist should say "I do not know either, how can we go about finding out? Moreover, how will finding out help you achieve your treatment goals of X (be specific)?"
4. Encourage the client to collect data (self-monitor) when the "vicious cycle", as the client describes it, actually occurs? Explore with the client when he/she engages in such behavior and the "impact, toll, price". "If it has this impact, then what can the client do?" It is not a big step for the client to say, "I should break the cycle or circle". The therapist can then explore how the client now goes about breaking the cycle - - thus, view present symptoms and behaviors as their attempt to "break the vicious cycle". (Use dissociation, substances, avoid, act out). Thus, the patient's current symptoms/behaviours reflect a "stuckiness" problem of using past behaviours (time-sliding to break the "vicious cycle"
5. Explore with the patient more adaptive ways "to break the cycle".

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

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

12 o'clock Interventions- - external and internal triggers

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

3 o'clock Interventions- -primary and secondary emotions

1. Increase awareness of primary (automatic) and secondary emotions. For example, anger may be a secondary emotion to being humiliated, embarrassed, feeling guilty.
2. Explore what the patient does with such emotions. View emotions as a “commodity” that one does something with (e.g., stuff emotions, drink them away, engage in high-risk behaviors).
3. Explore what is the “impact, toll, price” of such acts. Consider the pros and cons of such behaviors.
4. View such coping efforts (e.g., dissociative behaviors) as a “stuckness” problem that worked in the past, but are no longer useful (e.g., hypervigilance in combat soldiers). Consider transitional stressors. For example, in the same ways a soldier had to be “trained” for military duties, returning soldiers also need “training” to become a civilian again. Instead of characterizing or labelling the intervention as “psychotherapy”, use a training analogy to avoid barriers such as stigmatization.
5. Learn various ways to manage hyperarousal that contribute to and exacerbate such feelings (e.g., relaxation and mindfulness activities).

6. Consider (question, challenge) the automatic thoughts and cognitive appraisals that contribute to such emotional reactions.

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

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

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

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

“You have seen how trying to control your thoughts does not work very well, and how worrying about things keeps the sense of danger and anxiety going. Do you think you could stop worrying about and analyzing what happened? Perhaps you could run an experiment to see if this is possible. For homework, I would like you to notice worrying or ruminating and say to yourself, “That's a worry. I don't

need to work this out now, I'll work it out later". Then set aside a 10 minute worry period that you can use later in the day. You can even have a worry chart you use. So you are saving up your worry and ruminating until later. You don't actually have to use your worry period -most people find that they don't use it when the time comes".

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

“After an assault, many rape survivors conclude that the world is unpredictable and uncontrollable, and they view the world as dangerous. Another consequence that is common after an assault is that the survivors develop extremely negative views about themselves. For example, you may feel you are less adequate than you thought you were or that you are extremely vulnerable and incapable of coping with stress. Have you had such feelings and thoughts?

What is the impact of such feelings and thoughts? How do such feelings and thoughts affect you on a daily basis?

Such thoughts can cause anxiety, avoidance and depression and make it difficult to recover from the assault.

It will be useful for us to spend some time evaluating the accuracy of these beliefs and whether or not they are helpful to your recovery.

When you begin to catch yourself engaging in such thinking, your distress and difficulties will begin to decrease.”

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

That person who raped you controlled your life for two hours. The question, before us now, is whether you are going to allow him to control the rest of your life?

How can you become the boss of PTSD and take back control?

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

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

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

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

THERAPIST: Here is a metaphor that will help you understand what I am saying. Imagine you are blindfolded and given a bag of tools and told to run through a large field. So there you are, living your life and running through the field. However, unknown to you, there are large holes in this field, and sooner or later you fall in. Now remember you were blindfolded, so you didn't fall in on purpose; it is not your fault that you fell in. You are not responsible for being in that hole. You want to get out, so you open your bag of tools and find that the only tool is a shovel. So you begin to dig. And you dig. But digging is the thing that makes holes. So you try other things, like figuring out exactly how you

fell in the hole, but that doesn't help you get out. Even if you knew every step that you took to get into the hole, it would not help you to get out of it. So you dig differently. You dig fast, you dig slow. You take big scoops, and you take little scoops. And you're still not out. Finally, you think you need to get a "really great shovel" and that is why you are here to see me.

Maybe I have a gold-plated shovel. But I don't and even if I did, I wouldn't give it to you. Shovels don't get people out of holes- they make them.

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

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

Another metaphor offered is as follows:

"Are you familiar with the Chinese finger trap? This toy is a tube generally made of straw. You place your two index fingers in the tube and then try to pull them out. What happens is the more you pull the tighter the straw tube clamps down on your fingers, making it virtually impossible to remove becoming the trap. The more effort you put into escaping, the more uncomfortable you feel- the more trapped you become. Trying to escape negative emotional experiences can work like a Chinese finger trap. The harder you try not to have the emotions, the more the emotions "clamp" down on you. Examples of this kind of problem include excessive drinking to escape anxiety. Now you not only have the problem of anxiety, but you also have the problem of excessive drinking and all that brings with it.

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

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

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

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

CORE TASKS OF PSYCHOTHERAPY WHAT “EXPERT” THERAPISTS DO

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CORE TASKS OF PSYCHOTHERAPY

Donald Meichenbaum, Ph.D.

Role of Case Conceptualization Model (CCM) that informs assessment and treatment decision-making (See CCM below and the accompanying Report Format).

1. Assessment Procedures.

- a) Risk factors toward self and others
- b) Presence of co-occurring disorders
- c) Strengths- - evidence of Resilience, “Islands of competence” and access to social resources and supports

2. Development, maintenance and monitoring of Therapeutic Alliance - - Be culturally, developmentally and gender sensitive.

- a) Use of Motivational Interviewing practices (*See www.motivationalinterviewing.org*)
- b) Use guided discovery probes - - Socratic questioning procedures (*See Art of Questioning below*)
- c) Use Feedback Informed Treatment (FIT) procedures. FIT asks patients to rate on a session-by-session basis, their Progress and the Quality of the Therapeutic Alliance. Bertolino (2017), explains the FIT assessment procedure as follows: (See Bertolino, 2017 use of session-by-session patient ratings)

“Completing this scale is a bit like taking your temperature. In a minute or less, we can get an idea about how you think things are with you and your life. Just as your temperature tells us something about how much distress your body is in, so do the scores on this scale. And like your temperature, this scale will let us know how things have been with you during the past week up through today, - not tomorrow or in a month. Right now we are trying to understand how we can help you which is more difficult if we don’t have a good idea of how you are doing to begin with. Can you help us out?” (Bertolino, 2017, p. 197).

FIT has patients fill out ORS (Outcome Rating Scale) and SRS (Session Rating Scale of the therapeutic alliances). The therapist reviews these scores with the patient “where he/she is at,” and develops a collaboration strengths-based patient-driven treatment plan (see FIT-Outcomes.com).

3. Collaborative goal-setting - - Nurture HOPE

- a) Establish SMART goals (Specific, Measurable, Attainable, Relevant, Timely)
- b) Use Goal-attainment Scaling Procedures - - “As yet”; “So far” statements
- c) Focus on issues of transfer and maintenance of treatment gains across settings and over time in order to achieve “lasting changes”

4. Conduct Psycho-Education

- a) Use CLOCK metaphor
 - i) **12 o’clock** - - External and internal triggers
 - ii) **3 o’clock** - - primary and secondary emotions (Treat emotions as a “commodity” - - “What do you do with your feelings?”)
 - iii) **6 o’clock** - - Automatic thoughts and images
 - Implicit assumptions
 - “If ... then” Rules
 - Beliefs, Developmental Schemas
 - iv) **9 o’clock** - - Behaviors and reactions of others

Use metaphor of “vicious cycle” and *what is the impact, toll, price you and others pay?*

- b) Highlight the Role of Resilience - - Build and broaden positive emotions and activities
- c) Use Time Lines

Timeline 1 - - From birth to the present, enumerate stressors (experiences of trauma and exposure to violence), and interventions, if any

Timeline 2 - - “In spite of behaviors”. Evidence of strengths, signs of resilience from birth to the present. Also, include evidence of intergenerational transmission of “strengths”. What got passed on? Lessons learned.

Highlight “exceptions” - - when problems not present or less. Be solution-focused

Timeline 3 - - present and future – oriented focused. Start now and extend Timeline into the future.

5. Teach Intra- and Interpersonal skills

- a) Focus on emotion-regulation skills and problem-solving skills.
- b) Focus on interpersonal skills - - “scripted” behaviors
- c) Build in generalization guidelines (Do before, during and after training - - put the patient in a Consultative Role). Use Patient Checklist.

6. Conduct Relapse Prevention Procedures and Self-attributable training procedures (“Taking credit” statements). Use meta-cognitive and RE verbs - - “notice, catch, plan”, etc. and RE-new, RE-connect, RE-author.

7. Provide Integrative Treatment approaches, where indicated to address the presence of co-occurring disorders, such as Complex PTSD, depression, Substance abuse disorders. (See Alexander et al. 2013; Jaycox, 2004, 2009, Wolmer et al. 2011).

8. Provide Active Aftercare and Follow-through Procedures. Conduct a:

- a) Risk Analysis-triggers. Use CLOCK Metaphor
- b) Use Booster Sessions
- c) Use Ongoing Internet Consultations
- d) Involve Significant Others in Treatment, throughout, (*See list of Websites for Family-based Interventions*)

ART OF QUESTIONING: USE OF “WHAT” AND “HOW” QUESTIONS

“Let me explain what I do for a living. I work with folks like yourself and try to find out how things are right now in your life and how you would like them to be”

“I want to find out what you have tried in the past to bring about these changes, achieve your goals? What worked, what has not work, as evident by _____? What help did you receive, if any? What did you have difficulty following through with?”

“If we worked together, and I hope we can, how would we know if you were making progress? What would other people notice change in your life?”

“Permit me to ask one last question, if I may. Can you foresee, envision anything that might get in the way of your achieving your goals, changing, improving the situation? Can you think of a plan of action, where you can anticipate such possible obstacles or barriers to change? What do you think can be done?”

OTHER QUESTIONS

(Bertolino, 2017)

“How have you been doing personally?”

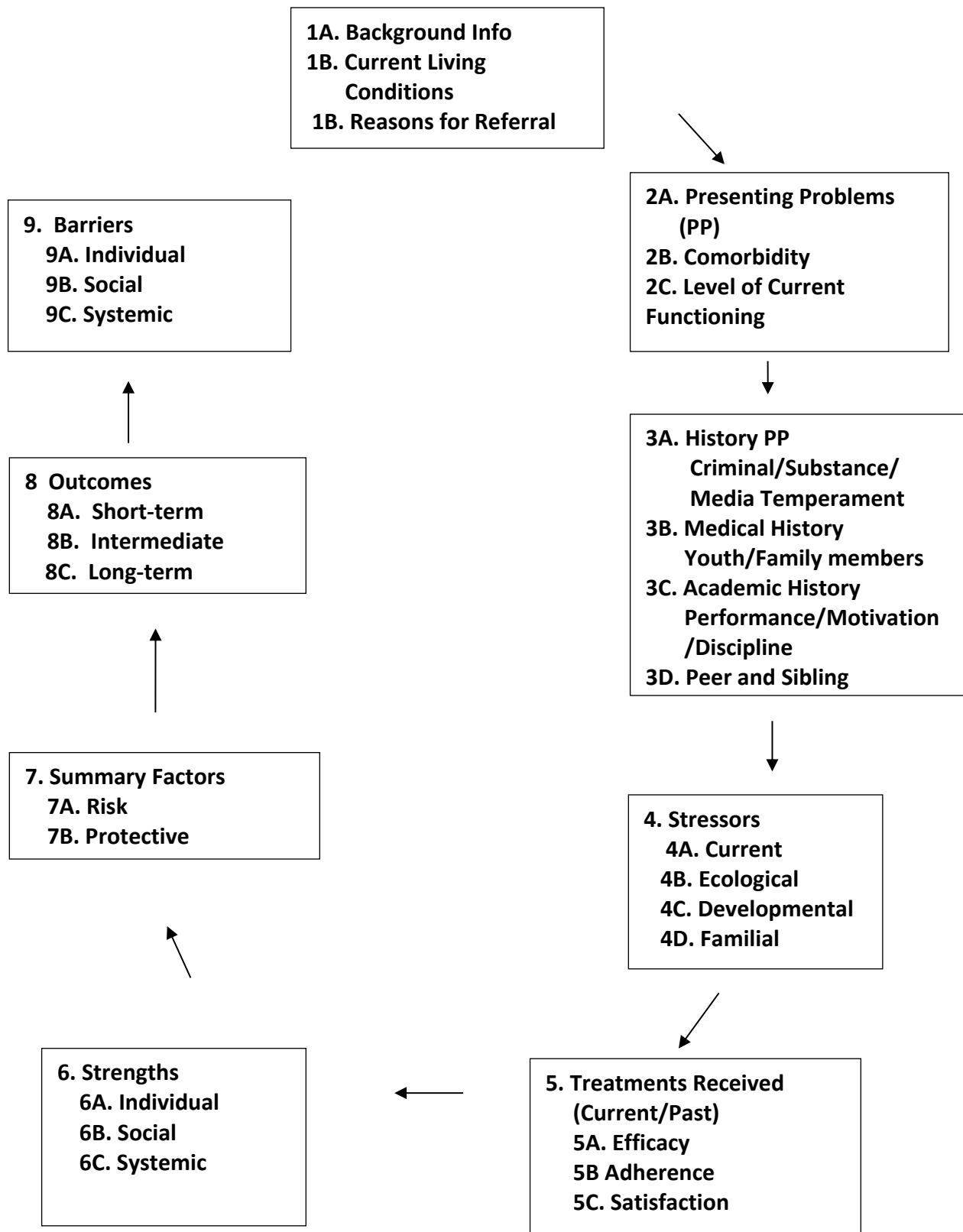
“How have things been going in your relationship? How are you getting along with your parents, friends, boss?”

“How are things going for you socially?”

“How has your life been outside of your home (in your community, school, church, work)?”

“Overall, how are things going in your life?”

GENERIC CASE CONCEPTUALIZATION MODEL



COMPUTER-GENERATED REPORT BASED ON CASE CONCEPTUALIZATION MODEL (CCM)

(The numbers and letters in the report refer to information in the Boxes in the CCM)

Introduction

This (age, gender, race) (**1A** – information) who currently lives indicate geographic area) with (**1B** – information). The housing situation (note any specific concerns about threats to safety – “red flags”). The date and reason for referral by were **1C**.

Presenting Problems

The **presenting problems** include **2A** (Note the source of information and if violence is indicated, the role of weapons, injuries, substance abuse and peers – violence was an isolated act or part of a peer group).

In addition, the youth also experiencing difficulties with (**2B** – comorbidity). These presenting and comorbid problems are having an impact on the level of functioning as evident by...

An examination of the youth’s **developmental history** reveals (review prior record and history of presenting problems and history of comorbid problems – **3A**). These behavioral problems were accompanied by (exacerbated by) – medical history (**3B**) and academic history (**3C**) and by peers and sibling influences such as (**3D**).

An examination of **current and past stressors** for both the youth and his family members reveals (**4A to 4D**). [Note: **In particular, the source of information for developmental stressors such as victimization (4C) and familial stressors (4D).**]

For these various presenting and comorbid problems and stressors, the youth and his family are currently receiving (or have received) the following treatments (cite specific interventions, by whom, when) with what effects (**5A**) (**cite source of information**. Some of the difficulties encountered with this treatment included...(cite source of information for **treatment nonadherence** – **5B**). Based on their treatment experiences the youth and his parents were particularly satisfied with (dissatisfied with) ... because ... (**5C**).

In spite of the difficulties and the presence of ... (list “risk” factors, stressors) the youth and his parents were able to achieve... (cite source for **individual and familial strengths** – **6A** and **6B**). The “strengths” that the youth and his family have going for them are... They can also access (note, **community** and **agency** resources – **6C**).

In **summary**, an examination of the “risk” factors and adversities indicate (**7A**), but a consideration of protective factors (**7B**) also reveals (Note: “challenges” and “opportunities”).

In terms of the goal attainment scale (GAS), the major three target behaviors to be addressed initially include ... The agreed-upon signs of improvement negotiated with the youth and his family are ... **(For each target behavior note what the specific change would look like.)**

Specific Ways Behavior Should Change

Minimal Improvement		Moderate Improvement		Significant Improvement
0% Change	25% Change	50% Change	75% Change	100% Change

Target Behavior 1

Target Behavior 2

Target Behavior 3

In collaboration with the youth and his family, the following assessments and treatment goals and plans have been established, as noted on the **Goal Attainment Scaling (GAS)** procedure. The short-term (**8A**), intermediate (**8B**), and long-term (**8C**) goals that will be worked on are ... More specifically, the individualized treatment plan for the youth and his family indicates that a follow-up assessment should include ... *(What additional information is needed and how and when is it to be obtained); placement (Amount of supervision required – least to most restrictive in light of likelihood of further offences); treatment options (What should be done, by whom, when and how will generalization/transfer and evaluation be built into the treatment plan).*

In order for these changes to occur, the following **barriers** at the individual (**9A**), familial-social (**9B**) and systemic levels (**9C**) have to be addressed. *(Note, how these barriers were identified.)* The intervention plans to address these barriers include ... The evidence that they have been addressed successfully include data that *(Note data like that included on GAS – 0% to 100% change).*

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EXAMPLE OF WEBSITES FOR FAMILY-BASED INTERVENTIONS

Treatment Manual for Coping with Depression Course

www.kpchr.org/acwd.html

Interpersonal Therapy for Adolescents

www.interpersonaltherapy.org

Parent-child Interaction therapy

www.pcit.org

Yale Parenting Center and Child Conduct Clinic

www.yale.edu/childconductclinic

www.oup.com/ptm

www.alankazdin.com

Multidimensional Treatment Foster Care

www.hackney-gov.uk/fostering-MFTC.html

Multisystemic Therapy

www.mstservices.com

Triple-P - Positive Parenting

www.triplep.net

Incredible Years Parenting Program

www.incredibleyears.com

Trauma-focused Cognitive Behavior Therapy

www.musc.edu/tfcbt

Brief Strategic Family Therapy for Adolescent Drug Abuse

www.drugabuse.gov/pdf/Manual5.pdf

Practice Wise – Evidence-based Youth Mental Health Services Literature Database

www.practice-wise.com

Hawaii Department of Health: Child and Adolescent Mental Health Division Annual Evaluation Report

www.hawaii.gov/health/mental-health.camhd/index.html

National Academy of Parenting Practices

www.parentingacademy.org
www.commissioningtoolkit.org

CORE COMPETENCIES FOR PSYCHOTHERAPISTS

Donald Meichenbaum, Ph.D

- 1. Establish, maintain and routinely monitor the quality of the therapeutic alliance.**
- 2. Actively communicate an accepting, supportive, helpful, empathetic, validating message.**
- 3. Conduct a comprehensive assessment of the reasons for seeking treatment or having been mandated for treatment (e.g., presenting symptoms, current concerns, life problems). Conduct a functional, situational and developmental analysis.**
- 4. Assess for the client's and significant other's explanatory models or implicit theories about the nature of the presenting problems and what it will take to change. (Solicit explanations about the treatment and possible barriers and provide a treatment rationale).**
- 5. Be culturally sensitive, as well as gender and developmentally sensitive. (Be culturally competent).**
- 6. Include assessment of risk to self and to others and risk of revictimization. Ensure client safety.**
- 7. Use the "Art of Socratic Questioning" and a discovery-oriented approach. Encourage the client to tell and retell his/her story at his/her "own pace".**
- 8. Develop and use a Case Conceptualization Model and provide feedback to the client and significant others.**
- 9. Engage the client in collaborative goal-setting that nurtures "hope" and adjust goals collaboratively over the course of treatment. Elicit evidence of "strengths". Use "In spite of" statements and use Time Lines.**
- 10. Use Motivational Interviewing procedures (Express Empathy, Avoid Argumentation, Develop Discrepancy, Support Self-efficacy).**
- 11. Conduct ongoing psychoeducation - - Use "clock" explanation. Increase client's self-awareness of how he/she inadvertently, unwittingly, and unknowingly produce reactions that confirm these beliefs.**

12. **Routinely solicit feedback about the therapeutic alliance and outcome from the client. Conduct feedback-informed treatment. Monitor change, lack of improvement and deterioration.**
13. **Address therapy-interfering behaviors, therapeutic impasses (“ruptures” to therapeutic alliance) and reasons for treatment nonadherence. Consider the therapists possible contribution to alliance problems.**
14. **Document, Document, Document. Maintain progress reports using the Case Conceptualization Model.**
15. **Keep the treatment focused and structured. Maintain a sense of direction (use “journey” metaphor). Use language of becoming and sense of possibilities. (Metacognitive and “RE” verbs). Be “principal-driven”, not “protocol-driven” - - be clinically flexible.**
16. **Improve credibility of the therapist by fostering client change early in treatment (e.g., symptom reduction, improve relationships).**
17. **Help the client engage in inter-session activities (Homework” assignments).**
18. **Train intra emotional self-regulation and interpersonal skills. Build in generalization guidelines. (Do not “train and hope” for transfer). Provide integrative treatments for clients with comorbid disorders.**
19. **Where indicated, incorporate spiritually-based interventions.**
20. **Provide corrective experiences within and outside of treatment. Use gradual exposure- based interventions with traumatized/victimized clients, where indicated. But be sensitive to other dominant emotional reactions including, guilt, shame, complicated grief, anger and “moral injuries” and tailor interventions accordingly.**
21. **Conduct relapse prevention and self-attribution training (“Taking credit” activities).**
22. **Help the client become his/her “own therapist”/”detective”. “Restory” one’s life.**
23. **Prepare for termination (Taking stock of changes and planning for the future).**
24. **Engage in self-care behaviors and experience vicarious resilience.**
25. **Work to enhance mastery by means of deliberate practice and self-reflection, pursuing learning opportunities.**

26. Behave in an ethically responsible manner. (Respect boundaries and be aware of psychological treatment that cause harm.)

CHECKLIST OF THERAPY BEHAVIORS TO FACILITATE 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.

CONSTRUCTIVE NARRATIVE INTERVENTIONS

(See the list of Websites and Reference list)

- a. **Exposure-based Treatment**
- b. **Cognitive Processing Therapy**
- c. **Imagery Rescripting**
- d. **Adaptive Disclosure**
- e. **Cognitive Restructuring**
- f. **Journaling**

Timothy Wilson's book "Redirect: Changing the stories we live by" identifies a number of techniques designed to direct and revise people's narratives (New York: Little Brown and Company, 2011). As he notes:

"It's what in people's heads that really matters." (p. 294)

"In order to change people's behavior we have to see the world through their eyes." (p. 238)

"Changes in interpretations can have self-sustaining effects leading to long-lasting changes in behavior." (p. 238)

Wilson describes three techniques that can be used to redirect people's self-defeating thinking narratives into positive self-affirming coherent accounts.

1. Writing exercises (As described below).
2. Nurturing a sense of optimism, purpose and meaning by the use of story-editing and story-promoting procedures
3. Using a "Do good and be good approach", namely, implementing the adage that "the best way to change people's self-views (personal narratives) is to change their behaviors first." People draw conclusions about themselves by watching what they do. For example, Wilson provides an example of reducing teenage pregnancy by having them volunteer for community service.

Story-editing procedures are a set of techniques designed to redirect people's narratives by editing their stories in beneficial ways that lead to self-sustaining behavioral changes and that

reap large benefits. For example, help individuals develop a “Growth Mindset” (ala the work of Carol Dweck) that conveys a set of coping strategies of potential that can be implemented by means of effort, hard work and practice. This is in contrast to a “Fixed Mindset” that conveys that individuals have a fixed amount of talent and ability, that “one’s history is one’s destiny.” For example, by having students and clients hear accounts of how others have coped successfully with stressful events can instill a hopeful mindset and lead them to implement self-affirming behaviors.

As Kurt Vonnegut, in his book, “Mother Night” observed:

“We are what we pretend to be, so we must be careful about what we pretend.”

Self-prompting procedures provide individuals information that suggests a new interpretation to their situations and feeling state. For example, labeling one’s feelings that are elicited by evaluation as “excitement”, rather than as “anxiety”. By naming and taming feelings, one can help individuals revise, reframe and restructure their narratives.

The set of studies that Wilson summarizes is consistent with the present Constructive Narrative Perspective of psychotherapy that the personal narrative individual’s construct about themselves, others, and the social world act as filters, influence interpretations, and lead to self-sustaining behavioral changes.

WRITING EXERCISES

“I write to define myself - an act of self-correction - part of the process of becoming” (Susan Sontag “Reborn”, 2008).

Jamie Pennebaker, and many follow-up investigators, have demonstrated the healing power of expressing emotions, the need to gain perspective, and the value of writing to heal. Wilson (2011), highlights that a story-prompting approach serves several functions, including helping individuals:

1. make sense of negative events and outcomes;
2. develop a framework within which to gain a more distant perspective from traumatic experiences and to better understand them;
3. change their personal narratives from a fragmented, jumbled, sensory-driven account into a more coherent, redemptive personal account;
4. engage in value-affirming story-telling and reduce the likelihood of engaging in a self-defeating cycle of negative thinking.

Engaging in writing exercises such as “step-back-and-ask why”, or write about “Your life in the future,” or write about a marital disagreement from a “third-person perspective,” have each been found to produce beneficial effects. Individuals tend to ruminate less, become more dispassionate, find meaning, overcome negative stereotypes, as a result of engaging in such writing exercises.

ILLUSTRATIVE WRITING EXERCISES

Step Back and Analyze the Events From a Distance

Instead of having the individual immerse oneself in the original experience, this writing procedure invites the person to take a “step back, in one’s mind’s eye, move away from the situation to a point where he/she is watching the event unfold from a distance.” Watch the event unfold from the perspective of a neutral observer, as opposed to a first person perspective. Focus on the “why” did you have these feelings?

Individuals are asked to write about this event for at least 15 minutes on three or four consecutive days. This writing exercise should be undertaken some time after the traumatic event has occurred.

Another writing exercise designed to help individuals develop a “best possible self”, requests that they write for 20 minutes on four consecutive days about “how everything has gone well as they possibly could, as if your life dreams have come true.”

Variations of this approach include asking individuals to write about important self-affirming values and “islands of competence” they possess. This writing approach has been described as requesting that they write “the rest of the story” of any strengths, or signs of resilience, that they evidence, “in spite of” the traumatic and victimizing experiences.

For more detailed descriptions of such writing exercises see the following references.

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**TREATMENT of INDIVIDUALS WITH PROLONGED and COMPLICATED GRIEF
AND TRAUMATIC BEREAVEMENT**

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CORE TASKS AND PROCESSES OF GRIEVING

Worden (2009) has described the core tasks of grieving as consisting of:

- a) acknowledging and accepting the reality of the loss, (balancing denial and reality);
- b) experiencing and processing the pain and grief, (externalizing emotional pain);
- c) adjusting to the world without the deceased, (adapting life assumptions and meanings);
- d) finding an enduring connection with the deceased in the midst of embarking on a new life, (continuing bonds with their deceased loved ones or other loss object).

These overlapping tasks are flexible, since they can be addressed in different orders depending on the client's needs and can be revisited and reworked over time.

Rando (1993, 2013, 2014) and Pearlman et al., (2014) have outlined the tasks of psychotherapy as the need for survivors to progress through six "R" processes:

1. Recognize the loss
2. React to the separation
3. Recollect and reexperience the deceased and the relationship
4. Relinquish the old attachments to the deceased and the old assumptive world
5. Readjust to move adaptively into the New World
6. Reinvest in life

Neimeyer (2002) has highlighted that the mourner needs to:

1. formulate a coherent narrative of the loss;
2. retain access to the bittersweet memories and emotions and cope with troubling feelings;
3. revise, rather than relinquish one's relationship with the deceased;
4. redefine one's life goals and experiment with new roles and relationships.

IMPLICATIONS FOR PSYCHOTHERAPY

An analysis of the grieving processes underscore the variety of core psychotherapy tasks that need to be incorporated in work with individuals who evidence Prolonged and Complicated Grief and Traumatic Bereavement. The Core Tasks include the need to:

1. Establish, maintain and monitor the psychotherapeutic alliance with the client and significant others;
2. Conduct initial and ongoing assessments and provide the client with feedback, using a Case Conceptualization Model of risk and protective factors. Be sure to assess for the client's "strengths" and for any evidence of resilience. Be sensitive to cultural, developmental gender issues, and the presence of any co-occurring disorders. Also, assess for the client's implicit theory or belief about the potential to change, as being a member of his/her ethnic or religious group. How should one cope with loss and negotiate the mourning process in a culturally-sensitive fashion?
3. Ensure the client's safety (possible suicidal tendencies), and address self-care needs and the presence of any therapy-interfering factors. Do so on an ongoing basis;
4. Employ motivational enhancement procedures and involve significant others, where indicated;
5. Conduct psychoeducation about grief. Validate and help normalize the client's grief. Use the **CLOCK** metaphor to help clients learn how feelings, thoughts and behaviors are interconnected, and how the client may inadvertently, unknowingly, and unwittingly contribute to his/her adjustment difficulties. Help the client appreciate the nature and influence of their narratives and "story-telling" style;
6. Engage the client in collaborative goal-setting that nurtures hope. Help the client create concrete plans with **SMART** goals (Specific, Measurable, Attainable, Relevant, Timely). Help clients identify new aspirations and activities;
7. Encourage the client to reengage in pleasurable and reconfirming activities with others (seek new companionship). For example, use Behavioral Activation (exercise) with others. Promote social reengagement. Use the Strategies for Coping with Grief Checklist;
8. Conduct emotion-regulation and behavioral skills training in order to nurture self-efficacy and as a way to enhance social supports (networking). Build in generalization guidelines and reinforce any resilience-engendering activities. Include self-attribution ("taking credit") training;

9. Use Cognitive Restructuring procedures in order to help clients identify and correct any inappropriate self-blaming, mental defeating and unhelpful thoughts, and accompanying behaviors;
10. Have clients engage in loss-focused restorative retelling and reconnecting exercises that may take various forms such as:
 - A. Intentional repeated retelling that facilitates the acceptance and emotional processing of the reality of the loss. Vividly narrate with eyes closed, the loss and listen to the tape of the narrative account;
 - B. Use the Gestalt empty-chair procedure, art expressive and journaling procedures, writing about positive and negative memories of the deceased;
 - C. Use graduated exposure exercises in order to help clients confront people, places and events that they have been avoiding. Use imaginal and behavioral exposure activities.
11. Engage in meaning-making activities, including the client's use of his/her faith and spirituality, where indicated. Incorporate the client's cultural group's ceremonial rituals, as part of the grieving process;
12. Address specific bereavement issues such as "Anniversary" events, evocative reminders of the loss, lingering legal and medical issues, and the like. Conduct relapse prevention and provide ongoing follow-up contacts.

EXAMPLES OF THE CORE TASKS OF PSYCHOTHERAPY

1. Establishing, Maintaining and Monitoring the Psychotherapeutic Alliance

The psychotherapist should act as a non-judgmental, “compassionate guide” who uses empathetic attunement, encouragement, supportive collaboration, understanding and respect for the client’s symptoms and struggles. For instance, validate the client’s feelings so the client feels heard and understood.

“I am so sorry this happened to your loved one.”

“I think you are brave for seeking help in the midst of your grief.”

“You seem connected to your experience and can still be able to talk about it.”

“I wonder if you have allowed yourself to express and share the full (fear, anger, guilt) you experience?”

“What do you fear will happen if you allow yourself to feel (your emotions, grief, anger, fears)?”

“I can see that you are learning to express your feelings without trying to escape from them.”

“There may be obstacles along your path, but we can address them in a way that frees you up.”

The therapist can also employ the language of possibilities, change and becoming. For example, bathe the social discourse with such evocative verbs as “notice, catch, handle, tolerate, confront, take control, choose” and a variety of “**RE**” verbs - - “regain, reclaim, redefine, reaffirm, reauthor, restore, reconcile, reengage, remind, reconnect.” See Meichenbaum’s Roadmap to resilience book (pp. 127-128 and 136-137 for a discussion of how psychotherapists can ask clients for examples for each “RE” activity, and moreover, what does this mean for the client’s journey? In this way, the psychotherapist can use a Constructive Narrative strength-based approach to help client’s develop a “coherent healing story.”

As Perlman (2016) highlights, the therapist needs to explore collaboratively with the client, empathize, educate and encourage.

2. Conducting Psychoeducation

Psychoeducation may take various forms that include the art of questioning; client feedback on assessment; descriptive sharing of information about specific topics such as the nature and rationale of treatment; the role of avoidance, specific bereavement issues; “myths” about the mourning process; self-monitoring procedures, coping skills and self-attributional training and relapse prevention procedures.

Psychoeducation is not a didactic process, but a highly collaborative, discovery-oriented Socratic questioning approach. Psychoeducation is ongoing and occurs throughout the

course of treatment. It is not as if one does psychoeducation and then one does treatment. The two processes are highly interweaved, as in the case of the Coping with Grief Checklist.

Examples of Psychoeducation

1. Provide a description of what therapy entails and the rationale for each aspect of treatment. Check for the client's understanding throughout.
2. Discuss the nature of grief and the mourning process. Highlight the following:
 - a) Grief is often accompanied with sadness, anxiety and uncertainty about the future, and feelings of yearning and longing;
 - b) There is no one right way to cope with the death of loved ones. There is no timetable. The grief process unfolds naturally over time.
 - c) There are no specific stages that individuals go through in the mourning process.
 - d) Most individuals are impacted by the death of loved ones, but they go onto evidence resilience or the ability to "bounce back". Some individuals need the assistance (help) of others. Joy and sorrow can co-exist.
 - e) Individuals can learn to contain their grief, like putting it in a "grief drawer" (see Harris, 2016). They can choose when and to whom to share their grief. They can put their emotional pain into words, or into some other forms of expression (painting, dance), and they can embed their loss into a life-time autobiographical history. Some individuals go back and look at photographs and cherish their memories and their legacy. They learn to support themselves in ways that no other person can. They come to live life fully, even in the wake of their losses.
 - f) Highlight that relationships are not really lost when a loved one dies, and who is not physically present, but the relationship is "changed."
 - g) Ask if the client can learn to leave a space in his or her life for their loved one's presence?"
3. Discuss the nature of avoidance and its impact. For instance:

"It is human nature for individuals to desire to avoid painful events, disturbing thoughts and distressing feelings about the loss and avoid any reminders that may trigger such emotional pain. But such avoidance actually prolongs the pain in the long run. Unfortunately, such avoidance usually does not work, and pain finds its way into our lives, one way or another" (with the therapist's assistance, have the client give examples).

Convey how treatment can help individuals, in a safe and supportive environment, develop the courage to express and share their emotional pain, without becoming overwhelmed, and even learn to view such “emotional pain” as a form of connection with the deceased (reframe the pain). Address the client’s attitude toward expressing feelings and discuss and train emotion-regulation skills on how to tolerate and manage negative emotions and “broaden and build” positive emotions (See Meichenbaum, 2013).

4. Use a **CLOCK** metaphor to help clients better appreciate the interconnections, and links between how they appraise events, experience primary and secondary emotions, have automatic thoughts and beliefs, and behave and the consequent reactions from others.
5. Psychoeducation can also be used to have the client reexamine “realistically”, the nature of his/her relationship with the deceased (both positive and any negative/disappointing aspects) of their relationships. The therapist can ask:

“What are some things you most appreciated in your relationship with your loved one (spouse, parent, friend, coworker)? What do you miss the most?”

“Permit me to ask, what do you wish could have been different in your relationship with X? Is there anything you did not appreciate or wish was different in your relationship with X?”

Such questioning reduces the likelihood of the survivor idealizing the past relationship and may help the client be open to developing new relationships. Also, conduct goal-setting that nurtures hopefulness and the language of becoming.

“What would you like to be doing if you were no longer grieving?” (See the Section on Questioning)

6. Psychoeducation should include a discussion of possible barriers/obstacles that may undermine the client's personal journey of mourning. Reinforce the client’s development of a “New Identity”, a “New Me.” The therapist can convey:

“Each person is unique. Each person’s situation is different. Each person negotiates the mourning process at his/her own pace and manner. What, if anything, might get in the way of your personal journey? How can you learn to anticipate these potential barriers and address them ahead of time?”

“How can you learn to reengage the most painful aspects of your account of loss (narrative), while also learning how to contain the emotional pain and come to terms with it?”

“Is there any way you can mobilize social supports?”

“Healing, in the case of grief, involves hearing. Is there someone in your life you can count on, or with whom you can share your story?”

3. Restorative Retelling Procedures

Restorative retelling procedures may take many different forms (Neimeyer, 2002, 2012). Each of these procedures are designed to help the survivor to process grief and establish a new relationship with the deceased, but maintain the deceased person's presence in the life of the survivor. One prominent procedure is to use the Gestalt empty-chair technique ("chair work" Paivio & Greenberg, 1995). In Litz et al.'s (2016) Adaptive Disclosure therapeutic approach, they use the "empty chair" procedure as a vehicle to generate a conversation with the deceased person. It facilitates corrective information, especially when loss and guilt are entangled. They divide the imaginal dialogue into three sequential steps:

1. Preparing the client for the processing of the loss;
2. Engaging in this breakout procedure of loss in which the client has a conversation with the deceased person, in real time (right now);
3. Post breakout component discussion about the meaning and implications of the loss and the client's experience of talking to his or her lost person.

As described by Litz et al. (2016, pp. 107-117), the following clinical guidelines should be followed. (A similar approach has been used with clients who have experienced "moral injuries" (See Litz et al., 2016 pp. 117-139). When clients experience moral injuries, the empty chair procedure may employ a "moral mentor", rather than a deceased person (Litz, 2004).

I. Preparing the client for the Breakout Imaginal Dialogue Procedure

The therapist should describe the "empty chair" procedure and address the client's questions, concerns and possible sources of resistance. The therapist should offer a rationale for the need to emotionally process the nature of the loss. Discuss the impact of avoidance behaviors. The therapist can ask the client:

"By focusing on the impact of the death of X, you will have an opportunity to understand and begin to recover and heal and master your grief. This can create a positive ripple effect in your life. Does this make sense? Do you have any questions?"

"What do you imagine may be any concerns you may have in engaging in this empty-chair activity? Can we discuss these?"

II. Imaginal Dialogue with the Deceased

1. The client is asked to have a conversation with the deceased person, in real time right now, as if the deceased person was sitting in the empty chair.
2. The conversation with the deceased uses the first person present tense and the client is encouraged to tell the deceased anything he/she wants, highlighting how the loss is affecting him or her. The client should be encouraged to provide a real emotional confession of how the client feels (haunted, guilty, unhappy). The client may wish to close his/her eyes when conducting the empty chair activity. The therapist may use prompts, as suggested by Litz et al. 2016, p. 108).

“Now I want you to go back to the image of [person who died]. This time, I want you to have an actual conversation with X. What would you like to tell him/her, here, now?”

“I know he/she is gone, but take this chance to talk to him/her and make it real.”

If the client gets stuck, the therapist should guide him/her by suggesting:

“Why don’t you start with what you remember from when he or she was alive? Why don’t you talk a bit about how much you miss him/her; how sorry you are and why?”

After a period of time, the therapist can ask the client to tell the deceased person what has changed behaviorally in him/her since the loss. As suggested by Litz et al. (2016, p.108).

“Tell him/her what changed for you after his/her death, and tell him/her how his/her death has affected you. Tell him/her how his/her death has changed your views of yourself, others, and the world.”

“Tell him/her how stuck you are, and be sure to describe any struggles you are now having.”

To this imaginal dialogue, the client can be encouraged to share what efforts he/she has taken to honor the memory of the deceased and what coping activities he/she has taken. To facilitate level of resilience, Litz et al. (2016) propose that the therapist ask the client to share what the dead person would say to him/her right now, after hearing all of this.

“What is she/he telling you now, after hearing all you have said?”

“What advice would he/she have for you?”

If the client has difficulty coming up with positive forgiveness-type statements, the therapist can offer suggestions:

Does he/she want:

“You to carry on?”

“What is best for you?”

“You to live the fullest life possible?”

“You to claim your life and live it fully for both of you?”

The imaginal dialogue may be repeated during multiple sessions in order to help the client shift his/her perspective and contribute to benefit-finding, meaning-making narratives that nurture healing. This form of restorative retelling can contribute to the reconstructing, rather than to severing one’s relationship with the deceased.

III. Post-breakout Component

The therapist starts this phase by asking the client to open his eyes and return to the here and now and then to discuss his/her experience of what just happened.

“What was that like for you?”

“What are you going to take from this session to think about throughout this week?”

“What really stood out for you?”

The therapist can also provide normalizing and reassuring comments, and encourage the use of coping behaviors should the client become emotionally upset. Litz et al. (2016, p.117) offer the following examples of possible therapist’s comments:

“I know this was difficult, and more than likely you will continue to think about it from time to time throughout this week. This is normal.”

“I often find that as clients start to look at difficult experiences, they sometimes have more unwanted thoughts about the experience. This usually goes away with time.”

See work by Pearlman, Rando, Shear for additional examples of ways to conduct Restorative Retelling Procedures.

Restorative retelling and empty-chair interventions provide individuals with opportunities to reconstruct and reframe the “stories” they tell themselves and others. Making meaning through the construction of stories and the use of metaphorical language contributes to the healing process (Meichenbaum, 2013; Neimeyer et al., 2010).

4. Exposure-based and Supplemental Interventions

In order to address the lingering impact of trauma and to confront avoidance behaviors that undermine recovery, various forms of imaginal and in vivo exposure-based interventions have been developed. Foa et al., (2007), Pearlman et al. (2014), and Steenkamp et al., (2011) provide specific treatment guidelines on how to conduct such exposure-based interventions so clients learn to purposefully tolerate and manage their fears and overcome any avoidant activities. In the case of imaginal exposure, clients are asked to tell and retell their “story” in the first person using the present tense and to listen to the tape recordings of these sessions as “homework”. The in vivo exposure activities are arranged along a gradual hierarchy of increasing demanding challenges. Such exposure exercises should be conducted for at least 45 minutes, three times a week to the point where the client can learn to tolerate his/her fears. The exposure activities may be learning to use coping skills such as breathing retraining and cognitive restructuring.

Jordan and Litz (2014) raise questions about the use of imaginal exposure therapies of having clients repeatedly retell (relive) memories of the moment of death, or related scenes. Such exposure-based interventions follow from trauma-focused treatment approaches that embrace a conditioning model that targets fear-based memories. They note that PCG is not characterized by such fearful memories and

“therapeutic rationale for repeated and sustained reliving of the traumatic moment is unclear. Moreover, there is no evidence that ‘working through’ a loss by sustained focus on it is necessary for healing for all individuals” (Jordan & Litz, 2014, p. 186).

Restorative retelling and exposure-based interventions may be supplemented by cognitive restructuring procedures that address the client’s Automatic Thoughts and beliefs (shattered “Assumptive World”). Another procedure is the use of Activity Scheduling that provides a means to address the client’s depression, inactivity and withdrawal by means of physical exercise and related engaging social activities (exercise with others).

The therapist should encourage the client to reengage in pleasurable activities, reattach with others, and pursue various wellness activities. As suggested by Litz et al. (2016, p.114), the therapist can ask:

“What type of pleasurable or healthy activities are you keeping yourself from doing since the death/loss of X?”

“Of those who care about you in your life, who are you not spending quality time with?”

“Are there new challenges you might attempt or activities you might devote specifically to the memory of X? Are there life experiences that you might plan to honor X?”

“Are there ways to memorialize (remember and honor) X?”

The therapist can use the Coping with Grief Checklist (see pages 21 to 25) as a way to review possible coping activities. In a collaborative manner, the therapist should elicit specific client commitments and discuss possible barriers that may interfere with the client implementing specific “homework” activities between sessions.

“What do you think would be useful for you to do before our next session?”

“What would you be willing to try to work on for next week?”

“What kind of practice assignment seems doable in the next week?”

Neimeyer (2012) has proposed another cognitive restructuring activity that asks clients to share “stories” of their relationships with the deceased as a way to reaffirm and reorganize their attachment with their loved one. He proposes the use of the following set of questions as a way to initiate such accounts:

Could you introduce me to _____ ?

What did knowing _____ mean to you?

Are there particular times, places, or ways in which you recall _____ importance to you?

What kind of things did _____ teach you about life, and about how you could manage the challenges you now face?

What might _____ say he/she appreciated most about you?

What strengths did _____ see in you?

In what ways might you strive to grow closer to _____ across time, rather than more distant?

What difference might it make to keep _____ stories and memories alive?

What has _____ given you that has had enduring value?

What do you want _____ to know about you and your relationship?

Can you describe the lasting impact, of _____ on your life?

Litz et al. (2016, pp.115-116) have offered the following exercises as a way to help clients express their grief and develop possible coping strategies. They ask the client to:

“Think or write about the following:

- ***How has losing _____ affected me?***
- ***How would _____ say I impacted him/her?***
- ***How did _____ impact me? How have I grown as a person because of _____?***
- ***How can I honor _____ now and move forward in my life?***
- ***What are some of the positive memories I have of _____?***

The therapist may ask the client to “write a goodbye letter to _____. Include how the loss has changed you; what you will miss most about the person lost; how do you want to remember him/her; and how will you continue to honor him/her?”

The average length of this comprehensive treatment program for clients with Complicated Grief and Traumatic Bereavement is 19 sessions, as described by Pearlman et al., (2014) (See www.guilford.com/pearlman-materials for a collection of client worksheets). Also see Harris (2011) and Jeffreys (2011) for examples of additional supportive activities.

5. Addressing Bereavement Specific Issues

Bereavement-specific issues focus on reawakened intense waves of grief when one least expects it. Rando (1993) have termed these acute grief responses to varied triggers that underscore the absence of the deceased, as Subsequent Temporary Upsurge of Grief (STUG) reactions. These triggers, may occur in social settings, at cyclical times like anniversaries, holidays or in response to particular occasions such as weddings, graduations. The **STUG** reactions, or powerful unexpected waves of grief that trigger a crisis of memory and undermine adaptive functioning, can lead to feelings of losing control, embarrassment, and result in withdrawal and avoidance that reinforces a loss grief cycle.

Psychotherapists need to “validate and normalize” such **STUG** reactions as part of the mourning process. Such emotional pain can be viewed as one way of staying connected to the deceased. In a collaborative fashion, the therapist should help clients anticipate and prepare (have coping strategies in place) in order to handle such episodes or “rough patches”. Role plays and exposure activities can be employed to address **STUG** reactions. There is also a therapeutic need to address any accompanying self-critical automatic thoughts. The therapist can use the **CLOCK** analysis to help clients cope with **STUG** reactions, as well as conduct relapse prevention stress inoculation interventions (Meichenbaum, 2013).

6. Self-attribution training or helping clients “take credit” for changes

A key aspect of relapse prevention interventions is to help clients develop coping skills for bereavement-specific upsurges (“rough patches”) and to ensure that clients monitor their progress and attribute any positive changes to their own personal coping efforts. Psychotherapists can facilitate this process by using Client Checklists, engage in discussions of how clients have handled tough situations, and ways they can anticipate and address future potential challenges (anniversary dates, reminders, and the like). The therapist can “go public with the data” of reported or observed changes. For instance, *“It sounds like you have learned to:*

“Draw upon your resources.”

“Identify warning signs.”

“Tolerate strong feelings.”

“Move back and forth (oscillate) between your loved one and beginning your life again”

“Reach out for help.”

“Do so many of the things your spouse used to do.”

“Trust your judgment.”

“Express difficult feelings.”

“Catch and challenge your negative automatic thoughts.”

“View your emotional pain as a way of remaining in touch with your loved one.”

“That in spite of your fears, you were able to be courageous and not withdraw.

COPING WITH YOUR PATIENT'S SUICIDE

Donald Meichenbaum, Ph.D.

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

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

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

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

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

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

1. Procedural (Immediate) Steps

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

2. Meeting your emotional needs.

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

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

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

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

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

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A “TO DO” LIST

See www.melissainstitute.org

1. Discuss what distinguishes the 75% who evidence resilience in the aftermath of experiencing traumatic and victimizing events VERSUS the 25% who develop PTSD and related adjustment difficulties. Include neurobiological and psychosocial differences.

See the following article:

Tabibnia, G. & Radecki, D. (2018). Resilience training can change the brain. Consulting Psychology Journal, 70, 59-88

2. What is a Constructive Narrative Perspective of PTSD and Resilience and what are the implications for treatment?
3. Use a Case Conceptualization Model (CCM) (Boxes) to describe a clinical case. Summarize your session with a client using the Boxes.
4. Enumerate ways to bolster resilience in adults in six domains (Physical, Interpersonal, Emotional, Cognitive, Behavioral and Spiritual).
5. Enumerate the Core Tasks of Psychotherapy that lead to “lasting behavioral changes”.
6. Use a CLOCK metaphor to educate your clients about the interconnections between their appraisals of external and internal events (12 o’clock); their primary and secondary emotions (3 o’clock); their thinking processes (6 o’clock); and their behavior and the resultant consequences (9 o’clock) How can you use the CLOCK metaphor to help your clients appreciate the “vicious” cycle? How can you help your clients “take credit” for behavior change using the CLOCK metaphor?
7. Describe how you will incorporate each of the following into your treatment of clients.
 - a. Focus on the quality of the therapeutic alliance and the use of Feedback informed treatment, session-by-session feedback
 - b. The “Art of Questioning” - - use “What” and “How” questions and Motivational Interviewing
 - c. Use of Psycho-education - - highlighting the “Rest of the client’s story”. How you use Timelines to nurture HOPE?
 - d. How can you use collaborative goal-setting (SMART goals Specific, Measurable, Attainable, Relevant, Timely) to nurture hope?

- e. How can you build in generalization guidelines when teaching intra- and interpersonal skills?
 - f. How can you conduct integrative treatment for clients with co-occurring disorders (e.g., PTSD and Substance abuse disorders)?
8. How can you spot HYPE in the field of psychotherapy?
9. How can you bolster resilience in the following groups?
- a. “High risk” children and their families?
 - b. Adolescents such as LGBTQ youth and victims of Human Trafficking?
 - c. Depressed and suicidal adolescents?
 - d. Elder adults?
 - e. Psychotherapists?
10. How can you treat specific clinical populations such as:
- a. Individuals who have experienced Prolong and complicated grief and traumatic bereavement?
 - b. Rape victims who receive exposure-based interventions?
 - c. Substance abusing individuals who have problems with anger and self-control problems with aggression?
 - d. Individuals who have a history of Complex PTSD (Borderline Personality Disorder)?
11. How can you integrate spirituality and psychotherapy?
12. List all of the reasons you are not going to do any of these “TO DO” tasks.

WEBSITES

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Email Address: dhmeich@aol.com

Melissa Institute: www.melissainstitute.org

(See Resilience Resources for articles and COVID-19 Resources)

FREE Book: roadmaptoresilience.wordpress.com

See You Tube video “Alive Day Memories: Home from Iraq”

Motivational Interviewing.org

www.motivationalinterviewing.org

Competence Curriculum for Cognitive Behavior Therapy

<http://www.uclac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks>

Cognitive Processing Therapy

www.CPT-forPTSD.com

Cognitive-behavioral Couple Therapy

www.coupletherapyforPTSD.com

Other Treatment Websites

www.self-compassion.org

<http://www.ptsd.va.gov>

www.seekingsafety.org

CHILD AND ADOLESCENT WEBSITES

Adverse Childhood Experiences

www.acestudy.org

Listen to the Webinar by Dr. Kate McLaughlin "Neuro-developmental mechanisms linking childhood adversity and psychopathology"

<http://youtu.be/n5hvdnR4xks>

Dr. Nadine Burk Harris TED TALK on You Tube

Helping children and families cope with COVID 19 pandemic: A resilience-engendering activity book

www.7-dippity.com

National Child Traumatic Stress Network

www.nctsn.net

Trauma-focused Cognitive Behavioral Therapy

www.musc.edu/tfcbt

Center for School Mental Health (SHAPE)

www.shape.org/TRA-IA

<http://theshapesystem.com/trauma>

Cognitive Behavioral Interventions for Trauma in Schools (CBITS)

www.cbitsprogram.org

Center for Childhood Resilience

www.childhoodresilience.org

Adolescent Trauma Training Center Integrative Treatment of Complex Trauma (ITCT-A)

www.attc.usc.edu

Effective Child Therapy

<http://effectivechildtherapy.com>

Problem Solving Discourse - - You Tube with Dr. James Larson

<http://www.youtube.com/watch?v=SQLbeAk-6FA>