

**A CONSTRUCTIVE NARRATIVE PERSPECTIVE ON TRAUMA AND RESILIENCE:
THE ROLE OF COGNITIVE AND AFFECTIVE PROCESSES**

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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 (Perkonig 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 individual's 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 prolonged 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 Health 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 than 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 storytelling) 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 not 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, Measurable, 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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