

**WAYS TO BOLSTER RESILIENCE IN TRAUMATIZED CLIENTS: IMPLICATIONS
FOR PSYCHOTHERAPISTS**

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My mother, Florence, always had a special way of telling her stories about the events in her life. She would regularly include in her accounts a detailed description not only of what happened to her, but also of her accompanying feelings and thoughts before, during and after each event. Moreover, she incorporated in her tales an accompanying editorial commentary about her maladaptive stress-engendering thoughts and feelings, as well as what different, more positive, goal-directed feelings, thoughts and behaviors she should have chosen.

“So, I thought Selma, the woman I worked with for years, insulted me in front of my friends. I started to get mad and on the subway ride home, I was getting down on myself, but then I told myself. ‘Why make myself feel worse?’ and changed what I said to myself. ‘It was much better to let it go, for now. I can give her feedback on Monday. I don’t think she did it on purpose.’”

One evening, while eating dinner with my mother, it dawned on me that my entire professional career had been a validation of her style of story-telling. My research and clinical career has been spent teaching a broad range of clinical populations (e.g., schizophrenics, children, adolescents and adults who have impulse disorders of anger control and aggressive behaviors, substance abuse, depression, and the like), how to talk to themselves differently, and more helpfully - - to become, in short, more adaptive “story tellers”, like my mother.

Recently, in my capacity of being Research Director of the Melissa Institute for Violence Prevention (see www.melissainstitute.org), I have focused my clinical work on people who have been traumatized, including returning service members, victims of violence, natural disasters and injuries. Following any form of what DSM characterizes as life-threatening criterion A traumatic events, 75% of exposed individuals will be affected, but they go onto exhibit resilience, and in some instances post-traumatic growth. In contrast, approximately 25% will develop PTSD, Complex PTSD, comorbid psychiatric disorders, and challenging adjustment difficulties.

If we could determine what differentiates these two groups, then we could develop more informed and effective treatment approaches for all forms of life stressors, including traumatic events. Could part of what contributes to resilience be the way individuals tell themselves and others “stories”? Could my mother’s kitchen table accounts hold any hints worthy of examination?

Keep in mind that PTSD is essentially a reflection of an autobiographical memory of something perceived to be stressful and traumatic, that has occurred in the past. Now, these trauma-exposed individuals have to tell others, as well as themselves, a “story” in which they will draw conclusions and implications about themselves, the world and the future.

As I noted in my recent book, “Roadmap to resilience” (www.roadmaptoresilience.org), human beings are not only homo-sapiens, they are “homo-narrans”, or story tellers. It is human nature to manufacture the meaning of our lives by organizing what happens to us into stories. We tell the stories to understand our experiences and provide a framework for integrating them into our autobiography. We live our stories as if they were true, and are immersed in them throughout our lives.

Research by a number of investigators such as Briere, Ehlers and Clark, McAdams, McNally, and Neimeyer, have identified the key characteristics of traumatic autobiographical memories and distress-engendering story-telling styles. In the aftermath of profound trauma

exposure, memories tend to be made up of fragmented, distorted, sensory-driven images and thoughts, that are triggered by the sights, sounds and smells and similar reminders. Traumatized individuals who develop PTSD tend to have an overgeneralized recall style with jumbled traumatic memories, lacking a coherent time-line which intensifies hopelessness, and impairs problem-solving. The story-telling of these people tends to be stuck on “hot spots” - the worst, most painful and horrifying aspects of trauma- which keeps them from integrating traumatic events into an autobiographical memory or narrative. They may show a “narrative breakdown”, as they continue to search for answers of “what is going on and why.” For example, they tend to engage in what is called “contra-factual” thinking of continually asking “Why” questions for which there are no satisfactory answers, and engage in “Only if” type thinking of trying to undo the traumatic events.

Consider the client who, in an attempt to stop a home break-in, had accidentally shot and killed her nine year old daughter Vicki. Vicki’s mother’s account was “stuck” at the point of the tragic shooting - - the sound of the gun going off, the sight of her daughter’s fallen body, the smells and feel of Vicki’s blood. In the aftermath of such horrific events, one does not “cure” PTSD. There are no treatments that can magically take away the emotional pain and the accompanying guilt, shame, anger and grief, but the therapeutic challenge is how to help such clients continue their life journey and help them transform their losses and pain into a life, still worth living.

I asked Vicki’s mother if she would be willing to do something that would be very painful and that she should feel free to say no to my request. I said:

“I would be both privileged and honored to get to know more about your daughter Vicki in order to better appreciate the magnitude of your loss. Would you be willing to bring into our next session a family picture album that includes pictures of Vicki?”

Why did I make such a request? Because, her memory of Vicki was stuck at the moment that the gun went off. The review of the picture album was designed to help her retrieve positive memories to balance the horrific traumatic memories of Vicki. I wanted Vicki’s mother to embed the tragic events into a larger biographical narrative. I was trying to help her become “unstuck” from her habitual way of ruminating. Research indicates that various forms of trauma treatment are mediated by their ability to help victimized clients retrieve positive memories and that there is a need to have at least three positive to each negative emotion to facilitate the recovery process. Posttrauma distress and resilience can co-occur and therapists need to help traumatized clients tip the balance.

As you can imagine, the session of reviewing Vicki’s picture album was remarkably emotional. Through painful tears, I asked her to indicate what she saw in Vicki that was so special? She responded that what impressed her most about Vicki was that “she was wise beyond her years”, and gave several examples of Vicki’s perceptiveness, maturity and compassion for others. She offered anecdotes of Vicki’s infectious personality and ways she could make the family laugh. I then asked her, “If Vicki, who was wise beyond her years, was present now, and could curl up into your loving arms and look into your woefully sad eyes, what advice, if any, would Vicki, who was wise beyond her years offer?” After a long pregnant pause filled with

more tears, she answered with one word, “Hope.” She then went on to elaborate with examples of how the family had overcome previous illnesses and crises.

Thus, I was using the absent other Vicki, as a means to alter her narrative. And, if she killed herself, as she was contemplating, what would happen to the memory of Vicki? Vicki’s memory would die with her.

“What is it that Vicki saw in you that made your relationship so special?” She answered poignantly with an account of their intimate sharing of daily events. Out of such gentle discovery-oriented probes, that elicited the “rest of the story”, Vicki’s mother eventually transformed her tragic loss and emotional pain into a personal mission of making a “gift” of her experience to other parents. She took on the task of educating parents of school children on the dangers of keeping guns in the house and she became an advocate for gun safety locks. By using the “art of questioning” and reflective listening, the therapy moved Vicki’s mother from a state of complicated grief to transforming her loss into a “gift” to share with others. For example, here are illustrative questions that helped Vicki’s mother get “unstuck” and undertake meaningful activities. They do not take away the pain or loss, but they facilitate the recovery process.

“Let me see if I understand where you are now”

“This loss has forced you to think about...?”

“So there is a part of you that is still grieving for Vicki, but there is another part of you that is carrying Vicki’s story forward?”

“Some people who have experienced tragic losses have said that they changed in some positive ways by being forced by life to face very difficult traumatic situations? Have you noticed any changes in yourself?”

“Given how horrible this event was, is there any possibility of anything valuable coming from it?”

“Are you saying that hope is a function of a struggle?”

“It sounds like one of the things you are discovering about yourself is...?”

“It is like knowing part of yourself that you have not known before.”

“Do you see yourself differently, now that you are going through all of this?”

“What words would you have used to describe yourself before this tragic event, and what words would you use to describe yourself now?”

“So where does this leave you now?”

“Let me see if I understand what you are committing yourself to doing now?”

Out of such social discourse, over the course of three months of weekly sessions, Vicki’s mother came to embrace Elie Weisel’s, the Holocaust historian adage that “one should never forget.”

***“Whoever survives a test
Whatever it may be
Must tell the story
That is one’s duty.”***

Vicki’s mother was actively constructing templates of meaning that helped her interpret her past, negotiate the present and anticipate her future. She was developing a sense of authorship over her life story. She was freeing herself from the dominant traumatic narrative, and in her parent presentation, recruiting an audience to share her life story. What was initially encoded in an emotionally intense unelaborated, unintegrated, primitive montage of memory fragments and images unordered with no discernible timeline, was being transformed through her presentations to sympathetically supportive parents, into a coherent structural narrative. Her newly constructed life story helped her reduce her level of distress and grief. Therapy helped Vicki’s mother find a workable account that gave meaning to her tragedy and that will continue to change.

In contrast, clinical research has found that the 25% who keep traumatic events alive evidence persistent distress and adjustment difficulties do not readily share, nor transform their “stories”. In fact, in my Roadmap to resilience book, I suggest an “algorithm” of the cognitive, emotional, interpersonal, behavioral and spiritual characteristics that seem to correlate with the development of persistent PTSD and related adjustment problems. Such people tend to be self-focused and engage in “mental defeating” types of thinking that maintain a “victim”, rather than a “survivor” or “thrifer” mindset. They also often spend a great deal of time in rumination, contra-factual thinking (“why me”, “only if”), avoidant thinking and behaviors like keeping traumatic experiences a “secret” and not seeking help. In addition they often fail to memorialize those who have been lost and have a “spiritual struggle” and see God as having punished, abandoned and betrayed them. Many I’ve seen remind me of the Biblical character Job, crying out against what they regard as an injustice of what has happened to them repeatedly asking “Why?” questions, for which there were no satisfying answers. For instance, clients who evidence persistent PTSD are prone to convey:

“I am a prisoner of the past.”
“I am a walking time bomb.”
“These thoughts and feelings just happen. They arrive like unannounced guests.”
“The depression just comes.”
“I am a born loser.”
“You can’t trust anyone. There is no place that is completely safe.”
“No one will understand what I have been through.”
“What is the point of continuing? I am a burden on others.”

“God could have prevented this from happening. I have lost my faith.”

If there is any merit in the algorithm for developing persistent PTSD and the value of a Constructive Narrative Perspective I advocate, how can therapists help traumatized clients develop coherent “healing stories” and compensatory coping behaviors in several domains (emotional, cognitive, interpersonal, behavioral, and spiritual)? How can therapists help their clients develop narratives with redemptive sequences that bolster hope, strengthen self-confidence and nurture meaning-making activities? How can therapists help clients view trauma as only one part of their lives, rather than the defining aspect?

This is more than a clinical exercise. History, current events and literature is filled with remarkable examples of individuals not only recovering from sometimes almost unimaginable suffering, but drawing from their traumatic past the strength and inspiring deeds. In my “Roadmap to Resilience” book and the accompanying website (www.roadmaptoresilience.org), I have included examples of resilience-engendering behaviors from Viktor Frankl, Nelson Mandela, Maya Angelou, Romeo Dallaire, Christopher Reeve, Michael J. Fox, and Terry Waite). Consider the following accounts of “true grit” and coping strategies:

“A 17 year old suicidal patient was hospitalized for 26 months, at times confined to an isolated secluded room because she engaged in self-injurious behaviors (burning her wrists with cigarettes, slashing her body and head banging). She writes, “I had to tell my story. I owe it to others. I cannot die a coward. One night I was kneeling in prayer, looking up at the cross, and the whole place became gold and suddenly I felt this shimmering experience, and I just ran back to my room and said ‘I loved myself’. It was the first time I remember talking to myself in the first person. I felt transformed.”

These are the words of Dr. Marsha Linshan who developed Dialectical Behavior Therapy for victimized suicidal Borderline Personality Disorder patients, as cited in the New York Times, June 23, 2011.

Another example of a redemptive story involves the tale of a five year old child who watched helplessly as his younger brother drowned. In the same year, glaucoma began to darken his world and his family was too poor to afford medical help that might have saved his sight. Both of his parents died during his teens. Eventually, he was sent to a State Institution for the blind. Because he was African American he was not permitted access to many activities, including music. Given the obstacles he faced, one could not have predicted that he would become a renowned musician. His name is Ray Charles.

Finally, consider the recent account offered by a mother whose son was murdered in the Newtown, Connecticut school shooting. She told how she had her dead son cremated and how she placed his urn on her bedroom night table. She indicated that each morning she greets him by kissing the urn of ashes and prays that at night when she slept, he will visit her in her dreams with their happy moments. This gives her strength to continue and work for gun control legislation.

Each of these accounts highlight ways individuals transform their traumatic life experiences into productive life narratives. For many traumatized individuals, they may need the assistance of a psychotherapist to change their life stories and bolster their resilience. As psychologists who conduct narrative research highlight:

“We don’t just tell stories, stories tell us. They shape our thoughts and memories and even change the way we live our lives.”

A Constructive Narrative Treatment Approach for Client’s with PTSD, Complex PTSD and Comorbid Psychiatric Disorders.

The first and most critical task for psychotherapists is to establish a nonjudgmental, respectful, sensitively attuned, trusting relationship with the traumatized client, and with significant others, where indicated. This relationship has to be culturally, developmentally and gender sensitive. For example, when treating returning service members, there is a need to understand and appreciate military culture. Therapist also must be able to “stand close” to the suffering of the client - - fully empathise with his or her feelings - - without being overwhelmed. The treatment goal should be to empower the client and place him or her “in charge”, by conveying that he or she can disclose as much, or as little, as he or she wishes.

The most valuable clinical tool that the therapist has is the “art of questioning”, especially using discovery-oriented Socratic questions of a “What” and “How” variety, rather than “Why” questions. I often say something like the following to clients, speaking in a slow deliberate pace, pausing between questions:

“Let me explain what I do for a living. I work with clients, like you, and try to find out how things are going right now and how you would like them to be?”

How can I best help you identify and work on your treatment goals?

What have you tried in the past? What worked (as evident by)? What did not work? What did you have difficulty following through with? What, if anything were you satisfied with that you think we can build upon?

If we work together and I hope we can, how would we know that you were making progress? What, if anything, might others notice was changing?

Permit me to ask one last question, if I may? Can you envisage, foresee any things that might get in the way of our working to achieve your treatment goals that you mentioned?”

Note that every question that I asked is a “What” and “How” question. I also solicit from the client, his or her ideas of what is causing current distress and presenting problems, and what he or she believes is needed to change.

In order to tap the client's "story", I lead from behind and use the "art of questioning" as a means of soliciting the client's narrative, at a safe and comfortable pace. But, I do not only tap the story of the traumatic and victimizing events. I also probe for the story of survival and any signs of strengths and resilience. A Constructive Narrative psychotherapeutic perspective probes for the "rest of the story", of what the client has accomplished "in spite of" the traumatic events. The social discourse is filled with the language of possibilities, becoming and resilience. A goal of psychotherapy is that the client take the psychotherapist's voice with him or her (as I took my mother's voice with me). I ask clients the following question:

"Do you ever find yourself, out there, in your everyday life, asking yourself the kind of questions that we ask each other right here?"

In this way the psychotherapist models and helps a client incorporate a style of thinking and a resilient mindset embedded with actionable personal agency "change talk" verbs such as "notice, catch, interrupt, choose, plan, change", and with phrases such as "so far", "as yet", which underscore an ongoing process with a future. Over the course of treatment the client is asked to give examples of how to implement "Re"-verbs - - "RE-author, RE-story, RE-write, RE-visit, RE-frame, RE-interpret, RE-claim, RE-connect, RE-build, and RE-plenish" his or her life? The psychotherapist is a fellow traveler on the client's personal journey helping him or her construct new life stories that are imbued with RE verbs and examples of specific ways to implement each RE activity.

Moreover, it is critical to have the client offer the reasons why engaging in each of these activities will help him or her achieve short-term, intermediate and long-term treatment goals. There is also a need to develop a game-plan and back-up plan on how such potential obstacles can be addressed. There is a need to solicit public commitment statements from clients for engaging in behavioral change. Such collaborative goal-setting is an effective way to nurture the client's hope and encourage him or her to create a "healing story" that builds a sense of purpose and meaning. A major treatment goal is to help the client generate an explanation that he or she can live with and reduce the endless search for meaning. Treatment is designed to help the client re-organize traumatic events into meaningful acts to give back to others. Therapists can use a variety of psychotherapeutic procedures to accomplish these objectives including psychoeducation, journaling, acceptance and exposure-based interventions, Gestalt empty-chair procedures, skills training with role enactments, emotionally-focused couples' treatment and spiritually-based interventions. What is common across each of these diverse interventions is that each helps traumatized clients engage in "personal experiments" that "unfreeze" and "dislodge" the stories they brought to therapy.

Each intervention, regardless of what theoretical perspective is designed to encourage clients to integrate their trauma experiences into coherent autobiographical accounts, in which traumatic events are landmarks, but not the defining elements of their accounts.

Changes in storytelling and in the willingness to share and make a "gift" of the lessons learned, as compared to keep the trauma story a secret, provides access to social support and ways to undertake "pass forward" meaningful activities. The client's ability to generate a coherent narrative helps to reduce distress and hypervigilance, increase a sense of personal control, and lessen feelings of chaos and unpredictability.

Trauma is only one part of an individual's life, rather than the determinant aspect. Effective trauma therapy helps clients learn to let the "past be the past". Clients can learn to disentangle themselves from the lingering impact of traumatic events. It is not that bad things happen to good people, per se, that is critical. Traumatic events, in one form or another, will happen to most people living in North America. Rather, it is the "story", the conclusions that one draws about the future that determines if chronic disabilities or resilience will prevail.

In trauma therapy, no matter what form it may take, clients engage in a narrative healing process. It is like having dinner with my mother!

Implications for Psychotherapists

1. ***Remember the relationship.*** Research has repeatedly shown that the therapy relationship is the most important single factor in therapy, regardless of treatment type. This is especially true for traumatized clients, who must feel safe, supported, respected and empowered to tell their stories at their own pace if therapy is to succeed. The therapist needs to keep tabs on the therapeutic alliance and solicit real-time feedback, address any therapy-interfering beliefs and behaviors and immediately address any "ruptures" in the therapeutic relationship.
2. ***Ask artful and compassionate questions.*** The psychotherapist should use the "art of questioning" and demonstrate "compassionate curiosity" to solicit the client's multiple stories of victimization and survival. The client should be encouraged to give voice to any emotions of suffering, despair and related feelings of grief, shame, guilt, anger, and the like. Keep in mind that post trauma distress and resilience can coexist.
3. ***Be alert to "Toxic" Stories.*** The therapist should probe for the presence of any "toxic" conclusions and implications about the client's self, the world and the future that linger from the trauma experience in order to help the client co-construct more healing stories with redemptive features. You should be sensitive to any "hidden stories" about prior victimization experiences – before the traumatic events under consideration- that undermine the normal recovery process. [Address at the outset of treatment any distressing presenting problems like sleep disturbance, physical pain, substance abuse, risk-taking behaviors, suicidality in an integrated manner that considers the interconnections between PTSD and comorbid psychiatric disorders.]
4. ***Get the whole story.*** There is a need to solicit the "rest of the story" of what the client was able to accomplish "in spite of" the traumatic experiences. The core of recovery is the narrative construction on which coping rests. The psychotherapist needs to provide an attentive, non-judgmental setting in which the client can experiment with ("try on") a new story and extend it to everyday experiences. Help the client move from viewing him or herself as being a "victim", to becoming a "survivor", if not a "thrifer". The therapist can ask "hinge questions" that open the gate of possibilities.

***"How did going through this 'seismic event' change you?"
"How did this change the direction of your life?"***

“Has anything at all positive come from this event?”

“How did going through this traumatic event shake up your belief system, your life pattern?”

“Where does this leave you now?”

5. **Foster more coherent, resilient-building stories.** The psychotherapist can help the client co-construct and revise his or her account in a way that integrates and processes traumatic memories, as well as the disturbing thoughts and feelings arising from them, into more coherent autobiographical accounts. In this process the client can begin coming to terms with losses and transform emotional pain into something positive that can be shared with others. These revised narratives foster a sense of meaning and nurtures a resilient-engendering mindset. Examples from clients include:

“I am much stronger than I ever expected.”

“I am not who I used to be.”

“If I lived through this, I can live through just about anything.”

“I had to live with my major suffering and losses. Now little things don’t get to me anymore.”

“I can make a gift of what happened to me and my family to others.”

“I can live with my not understanding and not having all the answers.”

“I have developed a good enough explanation and I stopped searching for meaning.”

“I have learned how not to distress myself.”

“I am in the midst of discovering....”

“I am on a journey and I can begin to write a new chapter.”

“My faith has saved me.”

6. **Help the client develop a “tool-kit” of coping behaviors.** It is easier and more effective to add positive behaviors, rather than eliminate negative ones. Therefore, besides learning to create “healing stories”, the client needs to develop a coping “tool kit” of both direct-action proactive problem-solving and emotionally palliative accepting coping behaviors. The therapist should help the client become aware of and build upon capacities for resilience, in order to develop more social supports, soothe negative emotions while increasing positive ones, become more cognitively flexible and optimistic, undertake meaning-making activities either individually or as part of a group activity, and practice his or her faith.

7. **Prevent revictimization.** The therapist should help the client avoid revictimization by exploring past victimization experiences, identifying high-risk situations, and attending accompanying warning signs, and developing escape and safety behaviors. In addition the therapist and client should consider any potential barriers that might undermine the recovery process and the possible impact of anniversary effects that can be anticipated and addressed.

8. **Help the client appreciate his or her “new self”.** Finally, help the client more fully appreciate a changed sense of self, a new philosophy of life, rearranged priorities and improved relationships with loved ones. Ensure that the client “takes credit” for specific changes that he or she has made in these areas.

As my mother reminded me, “A psychotherapist is an instructor in the art of story-telling and helps clients construct more adaptive narratives”. She would comment that “If I had difficulty achieving these treatment goals, have them visit with me for dinner?”

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